Title: "The remedy of grievances in the National Health Service with particular reference to the Health Service Commissioner for Scotland"

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KEY TO ABBREVIATIONS

A & EU	Accident and Emergency Unit
AHA	Area Health Authority
AR	Annual Report
AVMA	Action for the Victims of Medical Accidents
BMA	British Medical Association
BMJ	British Medical Journal
CABx	Citizens Advice Bureaux
CA-G	Comptroller and Auditor-General
CAMO	Chief Administrative Medical Office
CLG	Commission for Local Government
CMND	Command
DHSS	Department of Health and Social Security
ECT	Electro-convulsive Therapy
FPC's	Family Practitioner Committee
GGHB	Greater Glasgow Health Board
GLC	Greater London Council
GMC	General Medical Council
GP	General Practitioner
HAS	Hospital Advisory Service
HC	House of Commons
HL	House of Lords
HSC	Health Service Commissioner
LHC's	Local Health Councils
MDU	Medical Defence Union
MWC	Mental Welfare Commission
NHS	National Health Service
PCA	Parliamentary Commissioner for Administration
PQW	Parliamentary Question - Written
RHA	Regional Health Authority
SC on PCA	Select Committee on the PCA
SHAS	Scottish Hospital Advisory Service
SHHD	Scottish Home and Health Department

CONTENT

SUMMARY BY CHAPTERS

INTRODUCTION.

The purpose of this thesis is to examine the means by which citizens obtain redress when things go wrong in the National Health Service. There are many different ways of complaining the main emphasis in this work being on how complaints are dealt with by the Health Service Commissioner (HSC) or, as he is sometimes known, the NHS Ombudsman.

The HSC came into being in 1974 some seven years after creation of the Parliamentary Commissioner for Administration (PCA) on whom he is modelled. Perhaps because of this the PCA has attracted more attention. Certainly, there is very little writing on the HSC per se. This is unfortunate because, as succeeding chapters will make clear, the structure of the NHS and the state of the art of medicine pose some peculiar problems of their own. The first chapters then (Chs. 1-2) are necessarily of an historical and descriptive character.

The thesis is divided into three parts. Part I (Chapters 1-2) discusses the background to the problem. Part II (Chapters 3-5) considers the HSC in detail. Part III (Chapters 6-7) Ch. 6 examines the work of the House of Commons Select Committee on the PCA on the PCA and its contribution to the effectiveness of the HSC, while Chapter 7 looks at other external agencies working in approximately the same field as the HSC.

Section/...

Section I of the conclusion draws together possible criticisms and Section II proposes how to remedy these.

1. Chapter 1 considers the inexact nature of medicine and the significance of this fact in the field of complaints-handling in the NHS. Staff and patient expectations about the standards of treatment and hope of success may be unrealistic or inconsistent and this has consequences in that it affects the type of patient who complains and the nature of the complaint. The chapter concludes by surveying the existing channels of redress.

2. The NHS was omitted from the PCA Bill of 1967. This section explains the political circumstances of the time and the hospital scandals which were then circulating which made the timing inappropriate. The government reserved its option to extend the remit of the PCA or introduce an independent figure, an option which it exercised in a more stable period of NHS administration. The medical profession, through its trade union and professional association, the British Medical Association (BMA), wielded its power to lobby Parliament and ensure that its views were taken into consideration.

3-5. Chapter 3 is the first of three chapters which consider the HSC in detail. It begins by rehearsing the statutory provisions regulating the HSC and, by reference to these, delineating his function, powers and area of jurisdiction. The following chapter uses the HSC published reports of selected investigations to illustrate the HSC powers and limitations and to focus/...

focus on borderline cases where the HSC is required to exercise his discretion. Case-law is quoted extensively to show how the HSC has interpreted the constituent legislation and developed his office over the years. The Annual Reports are especially valuable material and Chapter 5 cites them as proof of the limitations on the HSC and as examples of the ways in which he is obstructed.

6. In his work, the HSC is aided by the House of Commons Select Committee on the PCA (HC SC on PCA). The SC on the PCA is possibly unique in the world of ombudsmen and is worthy of our attention. The SC gives guidance to the HSC on the interpretation of the enabling legislation and is partially responsible for the increasingly liberal approach which succeeding HSCs have shown when they are called upon to interpret their own powers. In addition, the SC comments upon the HSC Annual Reports. It uses these opportunities to assist the HSC to have his case report recommendations implemented by calling witnesses to give evidence before it. Chapter 6 evaluates the work of the SC, the ambiguous nature of its relationship with the HSC and explores the possible expansion of its role.

7. As the introductory chapter indicates, the HSC is not alone in attempting to resolve complaints in the NHS. Other agencies also exist and their work and philosophy impinge on the HSC office. Chapter 7 looks at the external agencies in more detail and briefly suggests in what ways they have failed or are open to criticism and the light this casts on the HSC./...

HSC.

In the Conclusion, the discussion in the thesis is drawn together under the heading "Issues and Themes". The chapter is divided into two sections. The first reviews the issues which have given rise to criticism and assesses the validity of these criticisms. It also takes account of certain themes which have recurred throughout the thesis and judges how far these can realistically be incorporated into any proposals for change. The second argues that extensive reform is politically unlikely, and unwelcome to the protagonists. It argues for lesser reforms which are within the discretion of the office-holder. The thesis concludes despite many criticisms, that the HSC is of more than merely symbolic importance and contends that it constitutes a firm foundation for future growth.

CHAPTER I.

1. INTRODUCTION - THE NATURE OF MEDICINE AND HEALTH CARE

"Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks.... We cannot take the benefits without taking the risks." per Denning, L.J. Roe v. Ministry of Health, 1954 (2 QB at 83). Medicine is not yet an exact science. It is a blend of science and skill. The medical profession cannot guarantee that the adoption of a particular procedure will produce a certain result.[1] Nevertheless, patients may feel a sense of grievance when a course of treatment fails to achieve the desired result. They may attribute this failure to the negligence of the medical staff.

Doctors owe their patients a duty of care. In the course of their profession, medical men must exercise a reasonable degree of skill and knowledge having regard to the circumstances of the case, their own qualifications and experience, and the medical standards prevailing at the time.[2] Where doctors fall short of this high standard of care, and the patient is injured as a result, the patient may hold the doctor liable for damages in a court of law.

However, there are many complaints which are administrative and not clinical in nature. In this area/...

area the rights of citizens are less clear-cut.

Following the nationalisation of other public services, the government established consumer consultative committees to voice the opinions of the taxpayer.[3] When the health services were nationalised in 1946 the government did not set up a similar structure. This decision was partly political - Bevan, the then Minister of Health, thought he had already stretched the tolerance of the hospital consultants to breaking point when he laid down the conditions for the new National Health Service.[4] But the decision was also taken because it was felt that the NHS was not analogous to other nationalised industries.

Patients are not consumers in the conventional sense of the word;[5] they do not purchase medical services on a fee-for-item basis but pay for them indirectly through general taxation. Private medical services in Great Britain are very limited so even if the "consumers" of health had the expertise to exercise their right of choice responsibility it would be to no avail. And, unlike other nationalised industries, a system of accountability already existed vis a vis the NHS in the form of the Secretary of State for Scotland, who is answerable in Parliament for the performance of the NHS in Scotland.[6] In reality, the Minister normally only lays down broad policy guidelines and the area health boards have a wide discretion in law as to how to implement these.

2. CHANGING ATTITUDES OF DOCTOR AND PATIENT

Why then is there a growing interest in how complaints can be made against the NHS? The interest does not seem to arise from a widespread dissatisfaction with the NHS.[7] Indeed, the NHS is a popular institution.[8] However, Ian Kennedy has pointed out that the "consumer" movement - emphasising the citizen's desire to participate in the decision-making processes which affect him - has not left the NHS unaffected.[9] Research has shown that the public is more complaints-conscious now than fifteen years ago.[10]

Increased public awareness of medical issues means that the patient no longer stands in such awe of his doctor and is more likely to ask questions. To some extent doctors welcome this development. The success of preventative medicine depends on the active interest of patients in their health. At the same time medical information can confuse patients causing them needless worry. Doctors believe that the irresponsible dissemination of information by the media is to blame for the large proportion of patients complaining needlessly.[11]

The NHS is under pressure, too, and this gives rise to ground for dissatisfaction. Waiting lists are longer than most people would like. NHS staff complain of chronic under-staffing and this results in charges of patient neglect. The NHS has not yet solved the problem of how to cope with the increasing population of the elderly.[12]

Some/...

Some of the problems are created by the relative successes of the NHS. The discovery of new drugs and treatments means that the NHS can cater for an increasing proportion of the population. This compounds the existing problem of under-staffing.

More recently management has changed its attitude towards complaints. Complaints are no longer seen as time-wasting or frivolous but a means of improving efficiency.[13] In the free market consumers express their views by switching to other products. This option is not open to patients.[14] Only a small percentage of the population choose their health care from the private market and the range of services it offers is limited.[15] In a monopoly service like the NHS, complaints are one way of drawing defects in the service to the attention of the administration.

Despite the renewed emphasis on the need for and the right of patient to complain, there has not been a discernible increase in the rate of complaints in relation to the number of doctor-patient contacts in the year.[16] The reluctance of patients to complain has been well researched. Patients are dependent on their doctor and are loathe even to ask questions, in case this is construed as implying criticism.[17] The social and educational background of doctors can inhibit free and easy communication between patient and doctor.[18] Carstairs has noted that when the patient can identify with the doctor, by reason of age, sex or background, communication between doctor and patient becomes possible. Established channels/...

channels of communication between doctor and patient are a prerequisite of an informal complaints machinery.[19]

Similarly, doctors may find it difficult to talk to their patients.[20] It is not always considered good medical practice to disclose details of diagnosis and treatment to a patient. This self-imposed restraint can become a habit even when it is not necessary or is directly contrary to the patient's expressed wishes. The medical profession argues that it is a standard of medical practice which is ultimately in the patient's interest even if it seems overly paternalistic.[21]

3. KINDS OF COMPLAINTS

When patients do make complaints they do so over a wide range of subjects. One end of the spectrum might be labelled "administrative" and the other "clinical". "Administrative" complaints relate to housekeeping matters, e.g. catering, appointments systems, ward routine and so forth. "Clinical" complaints relate to decisions taken by a doctor in the course of treatment but the category is wider than that suggested solely by the process of diagnosis and treatment. Doctors make many decisions which contain both clinical and administrative elements. Some of the most testing complaints relate to decisions which are ostensibly administrative but which a doctor alleges were made on clinical grounds. Normally, however, administrative and clinical decisions are taken by different sections of the NHS and with different results./...

results.

Administrative mistakes may cause annoyance or even distress but their effect is not long lasting. Errors in clinical judgement, whether anyone's fault or not, may cause irreparable mental or physical harm. The harm suffered will determine the kind of solution people seek and to some extent, has determined the remedies made available. Where only distress is caused by an administrative error the patient may be satisfied with an explanation.[22] At the other extreme, if a patient has sustained injuries attributable to negligence by the doctor, he will be looking for monetary damages as recompense.

4. COMPLAINTS PROCEDURES

Broadly speaking, there are two categories of redress procedure: judical and non-judical. In addition, there are a number of bodies whose activities are significant though not central to this which are worthy of comment.

i. Judicial Remedies.

Doctors owe their patients a duty of care but the law is uncertain as to what constitutes this duty. Merely to make a mistake is not negligence.[23] The law recognises that doctors must have the opportunity to acquire their skills and experience without the constant threat of legal action hanging over them. The reasonable exercise of professional judgement is deemed to allow for errors. To adopt/...

adopt any other course might result in the practice of defensive medicine. In the U.S.A. this takes the form of undertaking unnecessary and expensive diagnostic procedures and inhibiting the performance of experimental surgery.[24] Defensive medicine implies a degree of caution which is not in the public interest.

Actions for medical negligence have less chance of succeeding than other types of delictual action.[25] This factor, accompanied by the costs and time involved in legal actions, deters complainants. The Pearson Committee on civil liability also pointed out that a court is not always the best forum in which to resolve complaints. Our adversarial system deals only with a narrow range of precise issues and complainants find this frustrating. The legal system does not cater for cases where something has gone wrong but no-one is at fault, or at least, it cannot be proved. Judges say that they are being asked to make decisions which they would prefer not to make.[26] In adhering strictly to the law they are having to ignore the real needs of victims who appear before them. Consequently, there is increasing interest in and support for the idea of a no-fault system to compensate accident victims, of the kind which operate in New Zealand and Sweden.[27]

ii. Service Committee Procedure.

If a patient has a complaint against a GP he/...

he may sue in the courts in the ordinary way. In the event of a finding of negligence the GP will be personally liable.[28] The Health Board (HB) will not be vicariously liable for damages since GPs, unlike hospital doctors, are not HB employees.[29] Similarly the HB does not involve itself directly in investigating informal complaints against GPs.

Informal complaints against a GP should be directed to the Area Primary Care Administrator (APCA). The APCA will clarify the issues, obtain evidence from the GP concerned and, on the basis of this, decide whether the complaint should be referred to a medical services committee (MSC) for investigation. The Medical Services Committee consists jointly of GPs and laymen and is constituted under the NHS service regulations.[30] The Medical Services Committee cannot look at complaints relating to clinical treatment. It can only look at a complaint alleging a breach of the service regulations.[31]

These regulations set out, in a very general way, the duties of a GP. Few complainants are succesful in obtaining a finding against a GP.[32] Many complaints are not fully encompassed by the service regulations or the regulation is too vague to form the basis of a finding. The ban on legal representation or paid advocacy can put the complainant at a disadvantage in presenting his case. The Scottish Association of Local Health/...

Health Councils are pressing for the admission of CABx members to assist the complainant in order to redress the balance.[33] An amendment to the service regulations has gone some way towards mitigating the effect of the ban on legal representation.[34] Legally qualified assistance is now permitted providing the advocate is acting without payment. Local Health Councils argue that this does nothing to contribute to the informality of the occasion nor to aid the complainant who generally does not have legal contacts. In England, too, the Medical Services Committee or, as they are known there, the Family Practitioner Committees (FPC) have come under fire for their opposition to what are seen as much needed changes.[35]

NHS complaints procedures are full of "special cases". GPs are one such, another is the field of mental health.

iii. The Mental Welfare Commission (MWC)

In Scotland, the Mental Welfare Commission was constituted in 1960 to safeguard the interests of the mentally ill.[36] The majority of commissioners are lay people but the commission also contains a number of doctors and other individuals who have experience in the field of mental health. It is this mix of personnel which the Mental Welfare Commission believes will retain the confidence of staff and patients when investigating allegations of improper detention. The Mental Welfare Commission/...

Commission also hears complaints relating to care and the administration of patients' property. The Mental Welfare Commission will not investigate complaints relating to clinical matters. The majority of the complaints it receives allege ill-treatment of patients by staff members.

One of the difficulties the Mental Welfare Commission faces is that many of the complaints it hears are completely unfounded but arise from the nature of the patient's illness. Other patients who are abused by staff are incapable of complaining on their own behalf. The Mental Welfare Commission is dependent to a large extent on staff reporting deficiences. This system has its obvious drawbacks and some hospitals have an unnaturally good record.[37]

The Mental Health (Scotland) Act, 1960 requires the commissioners to visit hospitals regularly.[38] This gives the Mental Welfare Commission the opportunity to talk to the patients at first hand and hear complaints. In this way many matters are brought to their attention which would otherwise pass unnoticed.

Scotland's record in the field of mental health is better than England's and this is sometimes attributed to the existence of the Mental Welfare Commission. Its success was recognised publicly at an enquiry into the escape of two prisoners from Carstairs Hospital./...

hospital. The Sheriff-Principal who conducted the inquiry reported: "It is clear that self-appointed groups of unqualified persons with no legal powers to investigate complaints are in a position to do little compared with the range of action open to the Mental Welfare Commission. The existence of this powerful and independent body reduces to near vanishing point the necessity for other guardians of the interest of patients."[39]

The local Medical Services Committee structure has existed since the inception of the NHS and is formalised in the NHS Service regulations. The statutory responsibilities of the Medical Welfare Commission have already been mentioned. In the hospital service there is no comparable statutory procedure. Different methods of handling complaints have arisen as they were required.

iv. Formal Inquiries.

One of these methods is a formal inquiry set up by a Health Board to investigate the occurence of serious incidents, e.g. the death of a patient under anaesthetic. Normally the chairman is a legally qualified person but the committee of inquiry does not have the powers of a court of law to compel the presence of witnesses or take evidence on oath. The principles the committee should observe were regularised by the publication of the Elliott-Binns/..

Elliott-Binns report in 1969.[40]

The decision to set up a committee of inquiry on what action should be taken on the basis of the committee's recommendations rests entirely with the Health Board. It is not open to the complainant to request an inquiry. In the event of such an inquiry being held the complainant will not usually be present nor see the full report. If the Health Board refuses to set up an inquiry the Secretary of State for Scotland[41] has power to set up a formal inquiry with powers of compulsion. However such inquiries are exceptional and will be determined by the public interest.

Formal inquiries arise from matters which cause general concern and may have far-reaching implications; they do not exist to resolve individual complainants' anxieties. So from the complainant's viewpoint the inquiry procedure is not entirely satisfactory. But the existence of this process reassures the public that Health Boards are committed to uncovering errors and not to maintaining a defensive face against external criticism.

Ultimately the complaints handling system is dependent on the goodwill and co-operation of staff. When medical staff withdraw their help the system becomes unworkable.[42] Recently, medical defence and protection societies have advised their members not to give/...

give evidence before hospital inquiries or co-operate with them in any other way.[43] Their advice is based on the case of Waugh v. BRB (1980) AC 521 which they believe now prejudices the rights of doctors in civil proceedings following on an inquiry.[44] In Waugh, the Court of Appeal held that a railway inspectorate report into the death of an engine driver, which was the best evidence available and had not been prepared for the chief purpose of determining legal liability, was not legally privileged and could be used in evidence in court by the other party to the action. Medical defence societies believe that this means that anything a doctor says before an inquiry could be used later in civil proceedings against him. The legal position has not yet been tested in court. The Minister of Health is at present trying to regularise the position by arranging for written statements to be taken.[45]

v. Non-Clinical Complaints arising in Hospitals.

In addition to the formal inquiry, all Health Boards have adopted local procedures for dealing with non-clinical complaints.[46] In 1968, The Farquharson-Lang report drew the attention of the old hospital boards of management to the fact that despite the existence of the NHS for twenty years, hospitals still did not have a recognised complaints channel nor any means of recording and monitoring those complaints which were made./...

made. The report said that boards had a responsibility to represent the consumer. One of a board's duties had to be the maintenance of standards, and complaints could play a part in fulfilling this duty:

> "Boards should make use of reasonable complaints as an aid to efficient management and should therefore obtain regular reports, both to ensure that individual complaints are being handled effectively and to ascertain in what respects the services provided are not meeting the needs of the patients collectively".
>
> SHHD " Administrative Practices in Hospital Boards in Scotland" HMSO, Edinburgh, 1968, para 159.

The report also recommended that a working party should be set up to devise a complaints procedure to fill the gap it had identified. A working party was set up and reported in 1969 under the chairmanship of Elliott-Binns.[47] Elliott Binns stated that the final procedure had to contain certain elements if it were to be effective. Firstly, the staff and patients had to know how to complain. In the case of staff this was to be done by training, in the case of the patients it was to be achieved by issuing information booklets to the patients on their admission to hospital or giving the information on appointment cards and on noticesin out-patient departments. Secondly, the emphasis was to be on informality. Oral complaints were preferred to written ones. Thirdly, it was essential to keep records of complaints. "Comments"/...

"Comments" books were to be kept in the wards. An officer of the board was to maintain a register of complaints received by mail. Fourthly, each board was to designate one officer as their "nominated recipient" who would handle investigations into written comments.

Hospital boards were asked by the Secretary of State to introduce the procedures recommended by the report as soon as possible.[48] The boards recognised the need for a complaints procedure but thought it would be impossible to produce one system which would meet all the varied situations in the NHS or all the varieties of complaint which could be made. Elliott-Binns had recommended that to ensure consistency of approach there should only be one system. Finally, the Health Boards compromised by introducing a complaints system which abided by the basic principles set out in the Elliot-Binns report but allowed for variations to cope with local circumstances.

The major drawback to the system is that it does not deal with complaints relating to the exercise of clinical judgement. In 1977 the Select Committee on the Parliamentary Commissioner for Administration commented adversely on this state of affairs.[49] The Select Committee recommended the introduction of amending legislation to permit the Health Service Commissioner to look at clinical complaints. This proposal was opposed by almost/...

almost the entire medical profession.[50] Doctors did not welcome the scrutiny of a layman in such a specialised field nor being judged by the very high standards of The Royal Colleges represented by the nominees who would assist him. The government made it clear to the profession that if these proposals were unacceptable an alternative would have to be found or the Select Committee recommendations would be implemented without the agreement of the profession.

vi. Clinical Complaints Arising in Hospitals.

Accordingly, the government invited the profession to present counter proposals. The Joint Consultants Committee of the British Medical Association set up a joint working party with the Department of Health and Social Security and produced a new procedure which became effective in Scotland in January, 1982. The system is to operate on a trial basis for several years while being carefully monitored by the Department of Health and Social Security.[51]

The new procedure consists of three stages[52] and is based on the well-established medical tradition of second opinions. The first stage is designed to elicit a response from the consultant concerned, whether the complaint is oral or written. An interview or written reply may be sufficient to satisfy the complainant. If the complainant remains dissatisfied the next stage is to put the complaint/...

complaint into writing if that has not already been done. The Chief Administrative Medical Officer (CAMO) of the Health Board must also be informed at this stage by the consultant. The consultant may consider that a further talk with the complainant might resolve the issue but if not the CAMO and consultant should consider the possibility of invoking stage three. Stage three provides for independent professional review by two consultants. They will be chosen by the Scottish Joint Consultants' Committee and one of the consultants will come from outside the original board area. The two independent consultants discuss the case with the staff and the patient. If they consider that the patient's concern is justified they will bring the matter to the attention of the consultant concerned and the CAMO. They will them inform the patient, as far as appropriate, what problems have been identified and what steps have been taken to overcome them.

Although it is too early to say how successful the procedure will be in practice, on the face of it, it does little to meet the criticisms which brought it into being. This convoluted procedure, which one member of the medical profession has described as the "BMA Charter to protect the doctor"[53] does little to inspire public confidence. Patients' associations have said that like other forms of professional self-regulation the new procedure lacks the lay element which reassures/...

reassures complainants of the neutrality of the process.[54]

The new procedure is completely dependent on the co-operation of the consultant concerned, which cannot always be guaranteed.[55] Stages one and two of the procedure are mere duplications and no doubt simply duplicate what the patient has already done to reach the new procedure. It is open-ended and indecisive. No mention is made of what happens if the patient remains dissatisfied after stage three.[56] Health board officials have voiced disquiet over how practical the new procedure will prove to be. The new procedure may have to be aborted if at any stage in an individual case there is a risk of legal action. This may have the unwelcome side-effect of inhibiting doctors in the quantity and detail of their written case-notes.[57]

Two external agencies exist to meet the criticism that complaints agencies in the NHS operate in breach of the rule of natural justice, "nemo iudex in causa sua" viz. no man should sit in his own cause. These are local health councils and the Health Service Commissioner.

5. LOCAL HEALTH COUNCILS (LHCs).

The Farquharson-Lang report was the first to draw attention to the responsibilities of lay members of hospital boards to represent the patient. It introduced the concept of "consumer" councils in the NHS. In the 1970s the government was/...

was pledged to streamline NHS administration and make it more efficient. It hoped to do this by creating a new management structure separating staff, management and patient interests. Specialist committees were set up to represent and advise management on staff views. Consumers were to be represented by Local Health Councils set up in their district[58] consisting of a paid secretary and a committee of Health Board nominees. Salaries, accommodation and expenses were all to be met by the Health Board.

The primary function of the Local Health Councils was to review Health Board policy and suggest improvements but they also have a duty to advise the public on complaints procedures, and in some cases they actually take up cases on behalf of individuals.[59] Local Health Councils had some difficulty in establishing their identity and power base; they have been more successful as an advisory agency than a pressure group.

6. THE HEALTH SERVICE COMMISSIONER.

The Health Service Commissioner is doubly unique in that the office is part of an experiment in British Administrative Law and is also one of the few outside bodies which can investigate complaints in the health service. The following chapters will explore these two themes in more detail.

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55. Information received from Dr. G. Forwell, CAMO, GGHB 20.1.82
56. See footnote 54
57. See footnote 55
58. The National Health Sevrice (Scotland) Act, 1972 Schedule 1
59. S.I. 2177/1974 NHS (Local Health Councils) (Scotland) Regulations

CHAPTER 2

THE ORIGINS OF THE HEALTH SERVICE COMMISSIONER

1. The Origins of the Health Service Commissioner

It is possible to trace the legislative origins of the Health Service Commissioner back to the Parliamentary Commissioner for Administration Act, 1967.[1] The Parliamentary Commissioner Act in turn was inspired by a report "The Citizen and the Administration" undertaken by Sir John Whyatt and sponsored by the group, Justice.[2] The main recommendation of the Whyatt report was to advocate the adoption by Britain of a Scandinavian-style Ombudsman. The Conservative government of the day rejected this recommendation as being irreconcilable with ministerial responsibility to Parliament, and a serious threat to the efficient handling of public business.[3] The Labour party, on the other hand, was favourably disposed towards the idea of a Parliamentary Commissioner as a balancing mechanism to off-set the dangers of centralised bureaucracy. The future Prime Minister, Sir Harold Wilson, made an election speech, committing the incoming government to the proposal[4] and it was finally incorporated into a government White Paper in 1965.[5]

However, the government did not propose that the new Ombudsman, or PCA as he would be known officially, should be allowed to investigate complaints concerning the NHS. The jurisdiction of the PCA was ostensibly based on the criterion that the new office would reinforce existing constitutional/...

constitutional arrangements for protection of individuals viz. the MP as a grievance chaser. Therefore the new PCA would only be able to investigate complaints alleging maladministration arising from the acts or omissions of departments for which a minister was accountable to Parliament.

This proposal allayed the fears of MPs that their traditional function would become redundant but, as Lord Hailsham pointed out, also resulted in an over-specific and almost arbitrary abstraction of certain problem areas to the neglect of others.[6] For example, MPs commonly received complaints about local government and the NHS, both of which were excluded from the Act.

These omissions cannot be attributed to an act of political will since the Parliamentary Act was not really a politically motivated idea. Rather any undue caution arose from an unrealistic expectation of the potential volume of complaints and their gravity. Later, it became apparent that the criterion was not being applied so stringently to other subject-areas.

An amendment was moved at Standing Committee stage to extend the PCA's Act jurisdiction to the NHS but Crossman, then Leader of the House of Commons, opposed it and it was withdrawn.[7] He made it clear, however, that his opposition was not in principle but that he felt the time was not propitious. Only the previous year (1965) the profession had been thrown into a state of turmoil by/...

by the GP's Charter with the consequent crisis in morale.[8] In 1966 the Minister of Health had introduced a new method of dealing with complaints in the form of a circular and it was thought that the Department should wait and see how this was received by the public and the profession.[9]

The result, as MPs pointed out was almost a foregone conclusion. The circular in question was merely advisory and had no legal authority. Even if the circular were implemented the procedure did not provide the element of independence vouchsaved by the office of the Parliamentary Commissioner. Others criticised the secrecy and lack of publicity which surrounded these internal procedures ("In this instance, neither the Minister or anyone else drew the attention of those concerned to the existence of any such circular or any such procedure." - Sir Hugh Lucas-Tooth.[10])

Crossman was also concerned that extending the PCA's jurisdiction would result in him looking at one small sector of medical care. Crossman wanted a complaints system which could examnine any complaint, no matter from which sector of the medical process it arose. His preference was that an independent commissioner should evolve.[11]

Some sections of the press were also surprised that the NHS had not been included. But the Medical Defence Union (MDU) was already sufficiently appalled by the "interference" of MPs in NHS affairs; "The Union deplores the Minister's view, expressed/...

expressed in the House of Commons that it is absolutely vital that any member of Parliament on behalf of his constituent can get up in the House of Commons and ask him why the constituent was not treated properly at such and such a hospital.... If an MP receives a complaint from a constituent he should refer it to the normal investigative machinery without prejudicing the constituent's rights in any way. The MDU is alarmed by the number of cases in which MPs prefer to act instead as 'inquisitors' at large."[12]

Interestingly, the PCA did have jurisdiction over a number of hospitals which were administered directly by the DHSS e.g. Carstairs and Broadmoor and in the years to come proved himself capable of handling these complaints, including ones which involved questions of clinical judgement. But this provision did not attract any publicity at the time. That the issue did not assume greater proportions is perhaps attributable to the fact that the medical staff of prisons and high-security hospitals are not regarded by the rest of the profession as having the same degree of autonomy as their colleagues who work in the NHS. Furthermore, possible criticism was deflected by the fact that the PCA was assisted in his investigations by the advice of the Chief Medical Officer of the DHSS, in the case of special hospitals, the Chief Medical Adviser of the relevant department in pension cases, and the head of the Prison Medical Service in the case of complaints from prisoners. They, in turn, could call on the services of an independent professional adviser/...

adviser if they felt they were too involved in the case themselves to make a truly objective assessment of the complaint.

The Select Committee on the PCA were quick to point out that this arrangement was no guarantee of the neutrality of the advice proferred by the medical advisers, although they were anxious not to impugn the integrity of the officials concerned.[13]

As a result of the Select Committee report, the Parliamentary Commissioner invited the Royal Colleges to nominate a panel of advisers who could be called upon whenever a case involved their speciality arose.

The new procedure was tested in a number of cases which were resolved to the satisfaction of the parties involved without any feeling that the PCA had over-stepped his powers. The PCA experience in handling medical cases convinced the Select Committee that they had a good case for advocating the extension of the PCA's remit to cover all hospitals.

2. The Movement to Create a Health Service Commissioner

(i) Scandals and Inquiries.

Developments took place in Scotland and England which prepared the ground for the Health Service Commissioner and also explained why the time/...

time was particularly ripe in Scotland. In England, Barbara Robb was responsible for revealing the scandal of conditions and treatment in long term carehospitals for the elderly in a book entitled, "Sans Everything".[14]

This resulted in a general enquiry into conditions for the elderly in hospitals and also individual enquiries at a number of hospitals which were named in the Book by Robb. They all reached broadly similar conclusions as to the necessity of establishing a watchdog to over look the system. The enquiry at Cardiff voiced the opinion of other committees when it said: "Consideration should be given to the establishment of an independent body on the lines, as has been suggested in several quarters recently, of the Parliamentary Commissioner.... who could, in the last resort, undertake consideration of complaints and disciplinary matters which had not been handled satisfactorily in some other way."[15]

The "Sans Everything" scandal had assumed even greater proportions when Crossman revealed that the alleged state of affairs did, in fact, exist and had done so with the full knowledge of the DHSS for many years.[16] In order to be seen to take immediate action, Crossman proposed to set up a Hospital Advisory Service (HAS) for the long-term psychiatric and geriatric institutions. It was to take effect from 1st April, 1970 and was simply to delay the introduction of the Health Service Commissioner rather/...

rather than supplant it. In fact it had never been intended otherwise. Sir Harold Wilson said: "We accepted the need for a similar system in the National Health Service over and above the proposals for a new hospital advisory service which Dick Crossman had announced".[17] And in reply to a PQ Crossman said: "I made it clear earlier that I am not pressing ahead as fast as possible with this because I first want to establish the hospital advisory service under its director and see how far that meets one side of the problem.... I myself am convinced that there is a substantial case for a public health commissioner".[18]

In Scotland the situation was slightly different. As MPs were to continue to point out in debate, Scotland benefited from the existence of the Mental Welfare Commission (See Ch. 1). This body, consisting mainly of laymen with a number of medically qualified staff heard complaints from the inmates of mental institutions as well as having a roving commission to seek out abuses. The smaller geographical area also means that the Mental Welfare Commission can visit all the hospitals within its remit at least once in the year. This is something the Health Advisory Service has been unable to do in England. The result has been that scandals have not occurred in Scotland to the same extent as in England. The successful record of the Mental Welfare Commission has also demonstrated to the medical community in Scottish hospitals that they have nothing/...

nothing to fear from laymen looking into their affairs.

(ii) Pressure in the House of Commons.

Although there was no mass populist movement in the House MPs continued to press for appointment of a commissioner, particularly after the publication of "Sans Everything". On 25th July, 1968 Mr. Moonman, MP, asked the Secretary of State for Social Services if he were considering the appointment of a commissioner. The then Secretary, Kenneth Robinson, replied" I have no evidence to suggest that the present arrangements for the handling of complaints in the hospital service are not working satisfactorily."[19] But he did mention that the Green Paper, published only the week before did contain some proposals for possible changes.[20] A Cabinet shake-up resulted in the appointment of a chief minister more sympathetic to the idea of a commissioner. When Mr. Whitaker, MP, asked Mr. Crossman whether he would "now appoint an ombudsman for hospitals" the new Minister gave a less negative response than his predecessor. He said he was still considering the views of interested organisations on the Green Paper which included the tentative proposal that the Health Service Commissioner be established.[21]

A change of government did not result in a lessening of the demand for a Health Service Commission, even although the previous Conservative/...

Conservative administration had declared its opposition to the idea of an ombudsman. Between 2nd February, 1971 and 1st February, 1972 one MP alone asked the Minister for Social Services on six separate occasions whether he was about to announce the establishment of an office of Health Service Commissioner. Sir Keith Joseph's reply was always that he was still considering the proposals. Evidently the government had genuinely not decided what course to take because on 14th August, 1971 the editorial column of the British Medical Journal commented that the government had not yet decided whether it might not be better to extend the PCA's scope of inquiry to cover hospital complaints rather than set up an entirely different body. The British Medical Association preferred this compromise solution to any radical reform but the SC on the PCA in its report on the Act wanted to go further in the powers that the PCA would have regarding clinical complaints although they two wanted the PCA to assume this new role.[22] Sir Edmund Compton had retired in April of 1971 to be replaced by Sir Alan Marre who said he was unperturbed by the difficulty of clinical complaints and would have a panel of experts to assist him.[23]

iii) Government Papers.

In 1966 the Farquharson-Lang Report on the "Administrative Practices of Hospital Boards in Scotland"/...

Scotland" re-assessed the role of voluntary members of hospital boards and called for increased delegation of responsibility. It emphasised that the hospital board not only represented management but the consumer and that the intelligent use of consumer reaction can be an aid to efficient management. The analogies it drew from private industry foreshadowed the 1971 Conservative government reforms but their most immediate recommendation was that a Working Party (WP) should be appointed by the Secretary of State to devise a procedure for the handling of complaints. The Working Party reported as the Elliott-Binns Report in 1969. It was to identify the problems involved more accurately than ever before and so prepare the ground in Scotland, for the establishment of the HSC.

The Working Party had a very wide remit: (1) to devise a procedure that covered all complaints from the most serious to the most trivial, (2) to devise a procedure which covered out and inpatients (3) to publicise the procedure, (4) to suggest ways in which the Health Boards could use the information and (5) to take into account the needs of patients and staff. It was in the emphasis placed on the last pointthat a different slant emerged from that which was to become the dominant theme in the later reports of the PCA, SC and HSC. In fact, the Working Party placed so much importance on guarding staff interests that at one/...

one point in the drafting of the report the Working Party proposed making this issue the subject of a separate chapter. Finally, they decided that it was so important that it had to be in the forefront of their minds throughout but, to indicate their feelings, they changed the order of wording in their report by entitling it, "Suggestions and Complaints" instead of vice-versa. Moreover, the Working Party explicitly said that they felt that the question of an independent body was outside their remit. Nonetheless the results of their research all pointed to the HSC as the solution.

The debates on the PCA Act Bill kept the topic of the HSC in the forefront of government minds. In 1968 two documents appeared which proposed either the extension of the PCAs remit to the NHS or the creation of a separate Health Commissioner. The Ministry of Health published a Green Paper, "The Administrative structure of the Medical and Related Services in England and Wales" (HMSO 1968). This report was devoted, in the main, to the future re-organisation of the health services but also had a section on dealing with complaints. It proposed that the PCA remit be extended, or that the Privy Council appoint a person or persons to investigate complaints or that a National Health Commissioner/...

Commissioner with oversight of a network of local Health Commissioners should assume the responsibility. In Scotland the SHHD published "The Administrative Re-organisation of the Scottish Health Services". It noted the special role in Scotland of the MWC and took account of the Elliott-Binns Working Party which was then still considering the handling of complaints and suggestions in all types of hospitals. But it warned that the "extent to which any procedure could cover complaints on matters involving clinical judgement would require careful definition".[24]

In 1970 the DHSS published a second Green Paper "The Future of the National Health Service". The idea of the commissioner had become sufficiently concrete for it to be retained and modified. It was now acknowledged that the commissioner could not be allowed to investigate matters concerning clinical judgement. He could only ask himself whether the doctor had put himself in a position to make a reasonable judgement and acted upon it. (In short, they had adopted the formula devised by the SC to enable the PCA to look at complaints involving clinical affairs). The government proposals were still hazy as to how the HSC interact with the Health Advisory Service and Mental Welfare Commission. Even so, the profession felt sufficiently threatenedto denounce even these modest suggestions.[25]

More/...

More liberal sections of the profession asked "Is it not time the profession shook itself free of its occupational obscurantism?"[26]

A change of government prevented these ideas coming to fruition. The new Conservative administration in its first publication "National Health Service Reorganisation" put the emphasis on improving management structure rather than improving the complaints procedure.[27] However, the reports of committees of inquiries into scandals uncovered by the press and the publication of "Sans Everything", meant that the government could no longer refuse to consider reform but was not prepared to incur the wrath of the medical profession on whose co-operation any scheme would depend. It therefore took the time-honoured step and set up a committee of enquiry under the chairmanship of Michael Davies to investigate the possibility of devising a new complaints system for hospitals.[28] (In the event it was to be eight years before a divided committee submitted a report which ignored everything which had occurred in the intervening years!)[29]

3. Parliamentary-BMA Negotiations on the Bill

By the end of 1971, the British Medical Association was being sounded out for its opinion but the government itself had no definite proposals to present. It could not decide whether to enlarge the PCA's scope of inquiry to include hospitals, in accordance/...

in accordance with the recommendations of the SC on the PCA and the wishes of the newly appointed Sir Alan Marre, or to create an entirely new institution, perhaps drawing on the experience of the PCA. In the event, the government did opt for a HSC but negated the import of this by appointing the PCA as office-holder. Negotiations proper were entered into by the British Medical Association Council and the Department of Health and Social Security. With hindsight it is obvious that the government did feel constrained to take purposiveaction for the initial discussion document was quite far reaching. This much is obvious from the protracted length of proceedings and the allegations of back-tracking by the government, expressed by the opposition MPs.

One of the main obstacles to commencing negotiations on the creation of the HSC was that the British Medical Association refused to concede that any major reforms were required in the first place. In its annual Report for 1971-72 the British Medical Association Council expressed its anger that investigations into the complaints procedure were being carried out simultaneously by the Davies Committee, which only added to the confused atmosphere and no doubt to the confused results. In its evidence to the Davies Committee the Council said: "The Council takes the view that the existing machinery for dealing with complaints is sufficient in itself, and that improvements in the existing arrangements are needed rather/...

rather than the introduction of an entirely new procedure." But "At the outset the Secretary of State made it clear that he was predisposed towards the appointment of a Health Commissioner of some kind." In turn, the British Medical Association left Sir Keith Joseph "in no doubt" that the case for the need for a Health Service Commissioner had not been made out.[30]

Negotiations with the British Medical Association presumably moved slowly because when the National Health Service (Scotland) Bill was introduced to Parliament it contained no provisions relating to the appointment of a Health Service Commissioner.[31] The Bill, to re-organise the National Health Service in Scotland, was based both on the Green Papers of the previous Labour administration and the current Conservative government and was therefore regarded as a consensus bill.[32] Consequently, it was given its first reading in the House of Lords (by Baroness Tweedsmuir) on 19th January, 1972. Lord Hughes, commenting on the absence of provisions for the Health Service Commissioner said this was for reasons "which I think we all understand",[33] viz. the inability of the Department of Health and Social Security to secure the co-operation of the British Medical Association. But, in the event of the government not resisting British Medical Association pressure Lord Hughes promised that the opposition party would table an amendment to make it possible to introduce the Health Service Commissioner.

On 29th January, 1972 the British Medical Association/...

Association Council considered a memorandum it had received from Sir Keith. As a direct result of their representations the Department of Health and Social Security had modified its earlier proposals expressed in the Green Paper that the Health Service Commissioner should be able to inquire into clinical matters. Sir Keith met again with the Council on 2nd February 1972 and "agreed to continue discussion on points of detail before the the introduction of legislation." Later that day in response to a Parliamentary Question (PQ) the Secretary of State, asked whether the government was yet ready to announce the appointment of a Health Service Commissioner gave a curt reply - "Not yet!".[34] The Secretary of State was not only struggling with the defenders of Parliamentary traditions and the recalcitrance of a professional group, there were financial considerations too. The enquiries of the early 1970s had shown that many of the complaints arose from inadequate facilities and under-staffing. These public expenditure implications also made the government wary of conceding too much. Abel-Smith concluded that this would force the government to search for a formula "which will concede the shadow rather than the substance of the commissioner idea."[35] The main difficulty, other than substantive provisions, was to find the appropriate wording to deal with such sensitive areas as clinical judgement. It is evident from the memorandum that the British Medical Association were concerned by three main issues:[36]

(i) clinical judgement

(ii)/

(ii) cases which could be taken to a court of law

(iii) complaints against independent contractors arising from their contracts with the Health Boards

(i) The government has relinquished its earlier stand that the Health Service Commissioner should be able to investigate all aspects of health care in favour of a purely administrative remit. The difficulty was in how to incorporate this exclusion into the Act. By June of 1972 the situation stood at the form which finally made its way into Schedule 5 of the National Health Service (Scotland) Act, 1972, paragraph 2. Action which could not be made the subject of investigation was to include: "Action taken in connection with the diagnosis or the care or treatment of a patient, being action which, in the opinion of the Commissioner, was taken solely in the exercise of clinical judgement, whether formed by the person taking the action or by any other person".

The British Medical Association fought this draft, right up to the last movement; it was still not prepared to allow the Health Service Commissioner to investigate instances which included clinical judgement however incidentally.

Despite their fears, the last clause of the section ensured that complainants would not be able to reach the heart of clinical decisions/...

decisions on the strength of a technicality where other members of staff were acting on the instructions of a doctor.

The decision as to whether the action taken was taken solely in the exercise of clinical judgement is one which the Commissioner reaches in consultation with medically qualified advisers.[37]

Initially the British Medical Association refused to co-operate with the Health Service Commissioner by providing a list of medical advisers. The main bone of contention was that the British Medical Association insisted that there is no such thing as uniform national standards applicable universally. Really, the British Medical Association was acting in defence of its members' interests, It did not want to have its members judged by top specialists from the Royal College. Finally, the British Medical Association did issue a list of doctors who were prepared to advise the Health Service Commissioner on whether or not a complaint involved clinical judgement.

(ii) The British Medical Association was particularly worried by the problem of double jeopardy i.e. investigations by the Health Service Commissioner might be used by the complainant as a fishing expedition to obtain evidence which could be used later in litigation. It was pointed out that most legal proceedings relate to medical negligence and would/...

would therefore be excluded from the Health Service Commissioner's remit under the terms of the legislation. The government proposed that in these few cases which overlapped the jurisdiction of both the courts and the Health Service Commissioner the complainant would not have a right of recourse to the Health Service Commissioner unless the Health Service Commissioner was satisfied that it would not be reasonable in the circumstances to expect the complainant to have recourse to the courts. The British Medical Association did not believe that the HSC could be expected to exercise this discretion correctly in every case.

Furthermore, this still left a residual number of cases which did not appear to involve negligence at first instance but which emerged as such at a later stage in the investigation and where the complainant did not enter into the HSC investigation intending to go to court but who later changed his mind on the basis of the evidence disclosed.

Not only did this lay doctors open to the danger of being "prosecuted" twice but it gave complainants an advantage in terms of evidence. Under the present law doctors are under no legal duty to reveal medical records to their patients.[38] Where access is opposed the patient would have to resort to the courts, and even there disclosure is often made only to the patient's/...

patient's solicitor and not the patient himself.[39]

But the government was prepared to stand firm on this issue since it had the evidence of the PCA's experience that the discretion was not abused. And where a complainant did uncover a good case through a Health Service Commissioner investigation it seemed unfair to penalise the complainant by barring him from judicial remedies because he had not obtained his evidence in a more conventional manner.

(iii) It is interesting in retrospect that the question of how complaints against General Practitioners should be dealt with was such a burning issue at the time, for now there is no controversy over the fact that different arrangements exist for General Practitioners. The British Medical Association however felt real concern that the government or future governments might try to bring General Practitioners within the ambit of the HSC.

The British Medical Association wanted assurances that the General Practitioners would not have to live in a state of uncertainty as to their disciplinary procedures under future administrations. The British Medical Association Council asked for an explicit confirmation by the government of Crossman's assurance that General Practitioners would not be/...

be included in any new legislation. Sir Keith gave this assurance and, for good measure, included it again in his statement to the House on 22nd February, 1972 when he announced the government's intentions for a HSC.[40]

The nearest thing that the government could offer to a cast-iron guarantee was to provide that these provisions of the Act, alone, could not be amended by Order in Council but could only be altered by the introduction of new legislation which calls for much more concerted time and effort.[41]

On 8th February, 1972 the National Health Service bill received its second reading in the House of Lords, still without the new clauses appended. However, significantly, on 12th February, 1972 the British Medical Journal carried as its leader an article entitled "Ombudsman Imminent?" - a full ten days before the announcement was finally made in the House. It reported that the British Medical Association Council had tried to delay the introduction of the commissioner on the grounds of the upheaval that would already be created by the re-organisation of the National Health Service and a desire not to pre-empt the conclusions of the Davies Committee. But, it alleged "political pressures appear to have convinced the government but it dare not delay".[42]

4. The Passage of the NHS Bill through Parliament

On 22nd February, 1972 the Secretary of State in the House of Commons (and Lord Aberdare in the House of Lords) made statements regarding the introduction of legislation to establish a Health Service Commissioner. The statement was still deliberately vague on certain points which had not yet been settled between the government and the British Medical Association but was padded out with provisions on the mechanics of the office borrowed from the PCA Act, 1967. Two days later Baroness Tweedsmuir announced that the time-factor involved in drafting new provisions meant that the clauses on the Health Service Commissioner were to be introduced into the Bill in the House of Commons, and the National Health Service Bill went into its House of Lords Committee stage without the sections on the Health Service Commissioner. In this slimmer version the Bill received its third reading in the House of Lords on the 23rd March, 1972.

In the House of Commons, the Bill received its second reading having been referred to the Scottish Grand Committee (SGC) under Standing Order No.67 (Public Bills relating exclusively to Scotland) on the 13th April, 1972. Scottish Grand Committee sat twice on the 2nd and 4th May. On the second sitting, Mr. Smith complained that "any discussion of this matter in this committee is greatly inhibited by the fact that the committee has very little idea of what the government actually propose". And he went on to suggest that the government was actually withholding the draft clauses/...

clauses deliberately - he could not believe that it was possible that they did not yet exist.[43] Mr. Millan pointed out that the Ombudsman idea was hardly a new one - even in National Health Service circles. "I warmly welcome the idea of a Health Service Commissioner. Such an appointment should have been contained in the Act which set up the Parliamentary Commissioner. Had it not been for medical, departmental and ministerial obstructions - Ministers were divided on this - it would have been in the original Act."[44] This was an interesting observation since Mr. Millan was in a unique position to know, having been Under-Secretary at the Scottish Office, 1966-1970 and having worked on the Scottish Green Paper.

On 8th May, 1972 the Bill went into its standing committee stage for detailed clause-by-clause examination. The committee was to meet on nine separate occasions between May 16th and June 22nd. At these meetings Mr. Wolrige-Gordon defended his government from charges of dilatoriness or the suppression of information: "As for this tremendous reaction against the way these Clauses have been produced I should point out that the general aims and nature of the Health Commissioner have been known since 22nd February, when my Rt. Hon. friend, the Secretary of State for Scotland made it clear that legislation was going to be drafted with the intention of making it as <u>flexible</u>[45] as possible. I strongly suspect the difficulties which would be involved ...I suspect that they have been practical and not theoretical difficulties."[46]

In/...

In fact, the government succeeded in publishing the new clauses on 12th May, 1972 the Friday before the first standing committee meeting. Mr. Munro, Under Secretary for Health and Education at the Scottish Office, echoed his colleagues's words: "This is not a proposal out of the blue. It was mentioned in the previous government's White Paper in 1968, in paragraph 60. A discussion paper was circulated in July 1970,[47] and it was announced in February in another place that this would be brought into this Bill. There is no question of the matter being rushed in any way. The Clauses could not be tabled until as near agreement as possible with the profession and all who were interested was completed, and this only happened last week."[48]

Mr. Jim Sillars moved an amendment to increase the number of sittings but the chairman refused to countenance these. And so a feature of this Bill, as so many others in Parliament, was the shortage of time to consider its implications, exacerbated in this case by the prolonged negotiations with the British Medical Association.

Clause I (Appointment of Commissioner and Security of Tenure) was given its first and second readings on 20th June, 1972. At this point MPs were aware that the legislative framework laid down by them would probably be the basis for the English situation, too. They were therefore concerned that some of the proposals contained in the legislation seemed to restrict the Health Service Commissioner unduly. But they were aware that the shortage of time and the nature of the extra-Parliamentary negotiations /...

negotiations left them little leeway. "If the Health Commissioner does not operate in the manner some of us would like then again it is not our fault. It is really the government's fault for having bungled their timetable to such an extent that we cannot adequately discuss the issues before us.... Any of the arguments we convey to the Under-Secretary, either now or on the second reading, or on amendments, will be resisted by him, because he has probably fully committed himself in internal negotiations to the profession. Having given the profession that commitment he is likely to resist whatever blandishments we put before him."[49]

Mr. Hughes confirmed these suspicions: "...discussing the clauses in a meaningful way assumes that the government are prepared to think flexibly. This is impossible because the government has done a deal with the medical profession. If anything there has been evidence of attitude, and a bias more towards the medical profession".[50] His evidence of this was that: "It seemed that there had been some backtracking between the issuing of the (discussion) document and the Secretary of State for Social Services making this announcement,"[51] i.e. backtracking between the 1970 discussion paper (see footnote 45) which implied that the Health Service Commissioner would be able to investigate the actions of General Practitioners, and Sir Keith's statement to the House of Commons on 22nd February, 1972.

On 22nd June, 1972 Mr. Munro gave a first and second reading to new clauses on salary, pension, administrative/...

administrative provisions along with clauses on bodies and action subject to investigation. Even at this stage the British Medical Association were pressing for changes. Sir John Gilmour raised a number of points on its behalf. "I was approached by the British Medical Association and asked to raise this matter ..."[52] Even at Scottish Grand Committee stage Sir John asked the government to withdraw the Health Service Commissioner's discretionary power to handle cases where the complainant already had a right of recourse to a tribunal or court but the government refused.

MPs moved amendments on a number of points which interested then, e.g. they wanted to widen the range of bodies and actions subject to investigation. They did succeed in restoring the Health Service Commissioner's power to investigate complaints to the status quo ante of the discussion paper, i.e. that the Health Service Commissioner could investigate complaints arising from an allegation that a patient had been unfairly or unreasonably treated. This particular provision had disappeared during the period between the publication of the discussion document and the new clauses. In addition, the committee succeeded in extending the period for acceptance of complaints from six months to one year but this kind of amendment was easily justifiable in the light of the PCA Act from which the HSC borrowed so heavily in other spheres. More radical amendments, e.g. to permit direct access or include independent contractors in the legislation were mooted but barely discussed for any time before division since it/...

it was acknowledged by all that these suggestions were not politically realistic. Other aspects of the bill were simply altered at the negotiation stage between British Medical Association and Department of Health and Social Security. Sometimes the British Medical Association was not so successful as it might have liked and congratulated itself on non-existent victories as a public relations exercise for its own members: "the Council is happy to report that, as a result of its repeated representations to the Secretary of State, the Health Service Commissioner will not have power to investigate action taken (or action not taken) solely in the exercise of clinical judgement".[53] The government had conceded this from the first, the real battle was over whether the Health Service Commissioner should be allowed to investigate complaints which even involved clinical affairs incidentally.

Although the British Medical Association was unable to resist the tide of opinion in favour of establishing a Health Service Commissioner it could take comfort from the fact that once this decision had been taken professional interests were paramount in determining how it should be given effect.

CHAPTER 2 FOOTNOTES

1. For the more extensive story of the origins of the Ombudsman idea itself, see for example, R. Gregory, P. Hutcheson "The Parliamentary Ombudsman" London 1975
2. Justice, "The Citizen and the Administration", London 1961
3. HC Debates Vol. 666 Col. 1125 1962
4. 20.4.64. Stowmarket reported HC Debates Vol. 279 Col. 1367-1370 1966-67
5. CMND 2767, 1965
6. HC Debates Vol 734 Col 67 18.10.66
7. HC Debates Vol 739 Col 1427 -28 (Crossman) "A. Howard (ed) The Crossman Diaries, London, 1979 pp. 198-199. Crossman reports that Sir Harold Wilson refused to consider dropping the Ombudsman Bill to ease the legislative programme because he wanted to appoint a certain civil servant to the post of C. A-G and could only do this if he could ease out the then holder (Sir Edmund Compton) into the position of Ombudsman.
8. British Medical Association "A Charter for the Family Doctor Service" BMA, 1965
9. DHSS NHS Circular HM (66) 15 "Methods of Dealing with Complaints by Patients"
10. HC Standing Committee (Official Report) Vol 3 Col 445 24.11.66
11. See Footnote 7
12. Medical Defence Union "Annual Report, 1967" p.17
13. HC SC on PCA "Report on the Investigations of the PCA" 2nd Report, HC 513 (Session 1970-71)
14. B. Robb "Sans Everything: A Case to Answer" 1967
15. DHSS "Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Hospital Cardiff" 1969, Cmnd. 3975, p.120 para 480
16. A. Howard (ed) op cit pp.591-94
17. H. Wilson "The Labour Government, 1964-70" London, 1971 p.684
18. HC Debates Vol.784 Col.8-9 19.5.69
19. HC Debates Vol.769 Col.188 25.7.68
20. Ministry of Health "The Administrative Structure of the Medical and Related Services in England and Wales", HMSO, 1968

21./...

This vote is treated as a cash limit.

2. It covers the pay and general administrative costs of the Office of the Parliamentary Commissioner and Health Service Commissioners in connection with the investigation of complaints of maladministration against government departments and National Health Service authorities. The vote does not include the Commissioner's salary which is paid directly from the consolidated fund. At present the offices of the Parliamentary and Health Service Commissioners are held by one person who is only entitled to draw the salary of the Parliamentary Commissioner for Administration.

3. The provision for 1982–83 of £1,216,000 is 0.5 per cent below that for 1981–82. This is a result of a reduction in the number of staff from 92 to 90 and a decision to defer work on the implementation of a computerised information retrieval system.

OTHER SERVICES (OFFICE OF THE PARLIAMENTARY COMMISSIONER AND HEALTH SERVICE COMMISSIONERS)

I **£1,216,000**

Amount required in the year ending 31 March 1983 for the expenditure of the Office of the Parliamentary Commissioner for Administration and the Health Service Commissioners for England, Scotland and Wales, including an international subscription.

The Office of the Parliamentary Commissioner and Health Service Commissioners will account for this vote.

	£
Net total	1,216,000
Allocated in Vote on Account (HC 43)	550,000
Balance to complete	666,000

II

1980–81 Outturn £	1981–82 Total provision £	SUBHEAD DETAIL	1982–83 Provision £
		PROGRAMME 13.6 OTHER SERVICES	
1,020,957	1,222,000	**A1 Office of the Parliamentary Commissioner and Health Service Commissioners**	1,216,000
	1,067,000	(1) Salaries etc of 90 staff at 1 April 1982 and 31 March 1983 (92 staff at 1 April 1981 decreasing by 2), including staff on loan from the National Health Service	1,084,000
	154,955	(2) General expenses including travel, subsistance, telecommunications, agency and contract staff, office machinery, stationery, printing etc.	131,850
	45	(3) Subscription to the International Ombudsman Institute who disseminate material regarding ombudsmen worldwide	150
	Forecast Outturn £'000 1,160		

III **EXTRA RECEIPTS PAYABLE TO THE CONSOLIDATED FUND**

No extra receipts were received in 1980–81 or are expected in 1981–82 and 1982–83

IV **ANALYSIS OF THE VOTE BY PROGRAMME AND TYPE OF EXPENDITURE: 1982–83**

All of the expenditure on this vote is classified as public expenditure (current) on programme 13.6 (Other services).

Symbols are explained in the guide at the front of the volume.

21. HC Debates Vol 781 Col 272 16.4.69
22. See Footnote 13
23. HC SC on PCA and Report HC 513 (Session 1970-71)
24. SHHD "Administrative Reorganisation of the Scottish Health Services" HMSO, Edinburgh 1968 para. 59
25. See BMJ Supplement 4.4.70 p.14
26. Lancet, Editorial 21.4.70 p. 759
27. DHSS "National Health Service Reorganisation" HMSO 1970
28. Cmnd. 4734 HC Debates Vol 830 3.2.71 Written Parliamentary Question to Sir Keith Joseph PQ (223)
29. A. Shearer "End of the Shut Up or Sue Syndrome" The Guardian 2.9.81
30. BMJ 13.5.72 p.86
31. NHS (Sc) Bill HL 109 vol 327 19.172
32. House of Commons Scottish Grand Committee Vol 13 Col 71 Wolrige-Gordon
33. See Footnote 28
34. B. Abel-Smith "A Hospital Ombudsman" New Society 22.4.71
35. HL Debates Vol 327 Col 1085 8.2.72
36. BMJ Supplement 29.1.72 p.30
37. The row which developed over who was to nominate the medical advisers revealed the extent of the split between the BMA and the Royal Colleges, see BMJ 19.5.73 p.599 and BMJ 6.10.73 p.5
38. Boyle v. Glasgow Royal Infirmary, 1969 SC72
39. Administration of Justice (Sc)Act, 1972 s.1
40. HC Debates Vol 831 1104 22.2.72
41. NHS (Sc) Act, 1972 Sch 5(1) and s.45(5) see House of Commons Scottish Grand Committee Vol 13 Col 401 22.6.72, Session 1971-72
42. BMJ Leader Article "Ombudsman Imminent?" 12.2.72 p.393
43. House of Commons Scottish Grand Committee Vol XIII 2.5.72 - 4.7.72 Cols 5-108
44. ibid Col 95
45. Emphasis the author's own

46. House of Commons First Scottish Standing Committee 16.5.72 Cols 14-15
47. Scottish Home and Health Department, "A Health Commissioner in a Reorganised National Health Service". A discussion paper by the SHHD, July 1970

48/...

48. See Footnote 41 Cols 17-18

49. House of Commons First Scottish Standing Committee 20.6.72 Cols 369 and 373, Mr. Jim Sillars.

50. House of Commons Scottish Grand Committee, Vol XIII Cols 373-78, Session 1971-72

51. HC Debates Vol. 841, Col 2009 26.7.72

52. See Footnote 48 Col 398

53. BMJ Supplement "The Annual Report of Council 1972" 31.3.72 p.111

CHAPTER 3

THE HEALTH SERVICE COMMISSIONER FOR SCOTLAND: THE STATUTORY PROVISIONS

(All references to the National Health Service (Sc) Act 1978, an act consolidating inter alia, the National Health Service(Sc) Act, 1972 and the National Health Service Reorganisation(Sc) Act, 1973)

In many respects the Health Service Commissioner was modelled directly on the Parliamentary Commissioner for Administration (PCA) and, at some points, the National Health Service (Sc) Act, 1978 actually incorporates the Parliamentary Commissioner Act, 1967. In turn, the Parliamentary Commissioner was modelled on the Comptroller and Auditor-General (C & A-G).[1] For example, all these share in common their method of appointment, security of tenure and independence in carrying out their functions.[2] Where they differ is in the nature of those functions. Neither the Health Service Commissioner nor the Parliamentary Commissioner were conceived of as auditors, although it could be argued that they do perform an auditing function indirectly in that many complaints arise from management inefficiencies. Nor are the Health Service Commissioner and Parliamentary Commissioner identical, even thought it was envisaged right from the start that in all probability one man would hold both offices.[3] It was accepted that the statutory provisions relating to the Health Service Commissioner would need to take account of the kinds of problems thrown up by the health service.

Appointment/...

Appointment of Commissioner and Tenure of Office

The legislation establishing the Health Service Commissioner is couched in terms of powers, duties and jurisdiction. It does not create patients' rights. Medical ethics recognise to some extent the patients' "rights" to self-determination in experimentation, surgery, consultation etc. Local Health Councils similarly recognise the patients' "rights" as taxpayers but patients have few legal rights. The Health Service Commissioner does not judge staff or administration by rules but by norms which have evolved through time in the case-law, which reflect notions of fairness or good practice.

S.90(1) creates the title of "Health Service Commissioner for Scotland". However, the words of the sponsoring minister - and the terms of the rest of the Act - make it clear that specifically Scottish legislation was passed for technical reasons only. The nomenclature of the Scottish National Health Service administrative structure differed from that of England and Wales and the administrative structure was itself more varied. There were also specifically Scottish rules regulating the conditions of service for General Practitioners and dentists. In addition, special account had to be taken of the position of the MWC.

However, it was made clear that in all other respects there would be the "closest correspondence"/...

correspondence" between the functions of the Health Service Commissioner for Scotland and his counterparts in England and Wales.[4] In this way it would be possible for one person to hold all three posts. Nonetheless, the statutory provisions allow for the appointment of a Health Service Commissioner for Scotland alone if the case load justified it. (As the present rate of complaints runs at 62 p.a. approximately from Scotland the probability of such an appointment seems remote.)[5]

S.90(2) provides for the appointment of the Commissioner by the Crown, by Letters Patent and that he shall hold office during good behaviour, subject to s.90(3) (see infra). The Crown appoints the nominee suggested by the Prime Minister. This method of appointment is traditionally a guarantee of independence. When the Ombudsman idea was first mooted in 1967 it was proposed that one possible method of appointment might be by Privy Council.[6] But, the government finally preferred to appoint the Health Service Commissioner, like the C & A-G, by the more authoritative exercise of the Royal Prerogative and Letters Patent.[7]

In its 1971 review of the Ombudsman, the group Justice criticised appointment by Letters Patent in relation of the Parliamentary Commissioner Act.[8] This method of appointment, it said, made the Ombudsman seem like a servant of the Crown rather than a servant of the House. The real point at issue was not the method of appointment but the way in which the name of the nominee was reached. Justice thought it wrong that the Select Committee on/...

on the Parliamentary Commissioner for Administration should be entirely ignored in the process, not even having the name of the Commissioner before the rest of the House of Commons.

The Select Committee was impressed by this argument and in its report for 1975[9] put forward a number of suggestions for involving the SC on the PCA and the House of Commons in general, in the selection process. The SC asked the government that, at the very least, the SC on the PCA or its chairman should be asked to consider the Prime Minister's list of candidates or ideally that the chairman should, after consultation with the SC, choose the candidate and his decision should be confirmed by resolution of the House.

The government, in its reply,[10] took issue with the description by Justice of the PCA as a "servant of the House". The description was "strictly colloquial" since the Parliamentary Commissioner cannot carry out any instructions of the House unless they are within the scope of the Act. It would be more correct to say that the Ombudsman is an officer of the House.

The government rejected the SC proposals. It said debate in the House on the merits of a candidate was "disagreeable" and "invidious" and that, anyway, any proposals for consultation would limit the sovereign's discretion and prejudice the independent nature of the appointment. But the government/...

government compromised by saying that in future it would be the practice of the Prime Minister to consult the chairman of the SC on the PCA on what qualities might be desirable in a commissioner, and to consider any names the chairman might wish to put forward. In addition, the chairman, but not the whole SC would be shown the short leet, then the name of the commissioner before the official announcement is made.

The present position is that the SC does enjoy a special role in relation to the appointment of commissioners.[11] The SC through the chairman, suggests names and the chairman is consulted at all stages relative to the appointment.

S.90(3) provides for the removal of the commissioner either at his own request, or upon an address by both Houses of Parliament or upon reaching the age of 65.[12] It is this provision which has been responsible for the relatively high turn-over of Ombudsman in the last fifteen years; most office-holders already having reached the end of one career already.

S.90(4) disqualifies any person holding office as commissioner from sitting as an MP in the UK or in Northern Ireland. The relevant present legislation goes further in attempting to avoid possible conflicts of interest by barring these office holders from standing in local government elections/...

elections.[13] The only conflict of interest which seems to have arisen in the UK has been in relation to the civil service background of the first three Ombudsman. In 1976 the SC on the PCA received a letter alleging that Sir Alan Marre, then Parliamentary Commissioner, had displayed unwarranted leniency in handling a complaint against the Department of Health and Social Security of which he had been 2nd Permanent Secretary between 1968-71.[14] The Select Committee concluded that the allegation was unfounded. The House knew of Sir Alan's background on his appointment and thought it an aid to his work.

S.90(5) reduces the possibility of similar complaints being made against the Health Service Commissioner by providing that he cannot be a member of the body subject to investigation. This precludes the commissioner from being a member of a Health Board although he can be a past member.

Salary and Pension of Commissioner

S.91(1) provides that the Commissioner shall be paid the same salary as if he were employed in the Civil Service and at a rank to be determined by resolution of the House. This change was brought about by the 1978 Act. The 1972 Act s.43(1) simply provided that the Commissioner be paid a salary to be determined by the House of Commons. Events have shown that the majority of the Commissioner's staff is drawn from the civil service, presumably to create a career structure, and the Commissioner has now been allotted the civil service rank of Permanent/...

Permanent Secretary (the remaining staff range from Higher Executive level to Under-Secretary).

S.91 ss.2-4 provide that the pension provisions relating to the Parliamentary Commissioner also apply to the Health Service Commissioner and that in computing salary any other pensions or salaries payable to the Health Service Commissioner shall be deducted. The financial provisions of the Act make it clear that the salary is not the main inducement to become Commissioner and that the office holder is actively discouraged from having other interests which might potentially prejudice the independence of the office.

S. 91(5) when Sir Keith Joseph made his statement to the House regarding the establishment of the Health Service Commissioner he announced that he would consult with the SC on the PCA as to the future relationship between the Parliamentary Commissioner for Administration and the Health Service Commissioner.[15] The SC responded by saying that while it recognised that it was inappropriate to extend the Parliamentray Commissioner's remit to the health service nevertheless the Health Service Commissioner was modelled on the PCA and would have the closest association with the Parliamentary Commissioner in his work concerning the Department of Health and Social Security therefore it was appropriate that one man should hold both offices. S.91(5) provides that where this is the case the Commissioner shall receive only the one salary.

While/...

While the financial arrangements acknowledge that in practice only one man is going to hold both offices they do allow for the future possibility of two office-holders, if circumstances warranted it. Paragraph (b) of the same sub-section goes further by providing that where one person is Health Service Commissioner of Scotland, England and Wales, but not the Parliamentary Commissioner too, he shall still receive only one salary. This acknowledges that these three posts are distinct and, again if circumstances warranted it, they could be held by three different people. The conclusion is that the statutory provisions do exist for future development of the Commissioner's office.

S91 ss6-7 deal at greater length with the salary and pension difficulties created by one person holding a number of posts.

S91(8) provides that the salary and pension of the Commissioner shall be met from the Consolidated Fund (like the C & A-G and judges) to emphasise the non-political nature of his position.

Administrative Provisions

S92(1) provides that the Commissioner may appoint officers to assist him (numbers and conditions of service to be approved by the Minister for the Civil Service). The Commissioner presently employs twenty seven staff of whom a number are seconded from the National Health Service.[16] The first Commissioner, Sir Edmund Compton had been C & A-G/...

C & A-G for eight years and he continued the C & A-G tradition of drawing staff from the Civil Service. Successive Commissioners have justified the practice on the basis that the back ground of the staff has been an invaluable aid in their investigations especially on the National Health Service side. In fact, the Health Service Commissioner would have liked a greater balance between civil servants and National Health Service staff on his own unit.[17] National Health Service staff would have experience of the health service and would inspire confidence amongst doctors and nurses but National Health Service staff have been reluctant in the past to apply for posts. National Health Service administrative staff are loathe to give up job security or possibly promotion at a time of administrative upheavel and view experience in the Health Service Commissioner office as irrelevant to their career.[18] Seconded staff allegeddifficulties in being re-absorbed into the National Health Service. Together, the Health Service Commissioner and SC have succeeded in obtaining for National Health Service-seconded staff a guaranteed right of return and it is hoped this will improve the recruitment problem.

There are no plans at the moment to increase the complement of staff so the imbalance remains but is mitigated to some extent by the fact that the Deputy Commissioner and one of the two Investigatory Directors are drawn from the National Health Service.

S92(2) provides for the delegation of functions by/...

by the Commissioner to his staff. There are investigatory units in Edinburgh, London, Liverpool and Cardiff.[19]

S92(3) allows the Commissioner to obtain paid advice from experts. The two most likely areas are legal and medical. The present Commissioner is a QC but in the past Commissioners have sought advice from the government's Treasury Solicitor. In 1978 Sir Idwal Pugh, newly appointed as Commissioner, changed his practice to give the process a more independent air and employed private counsel.[20] Presumably this practice would be revived in the event of a future Commissioner having no legal qualifications.

For medical matters, the Health Service Commissioner relies for his advice on a panel of three doctors in Scotland, nominated by the Presidents of the Scottish Royal Colleges and Chairman of the Scottish Council of the British Medical Association.[21] This arrangement was reached only after some disagreement among the medical profession. The British Medical Association initially objected to the unfair imposition of the elitist standards of the Royal Colleges on hospital doctors but later withdrew their objections.[22]

S92(4) All the expenses incurred by the Commissioner are met by Parliament. In 1982 the combined expenses of the PCA and HSC ran to £154,955[23] of which 39% is attributable to the Health Service Commissioner side.[24]

This/...

This figure is disproportionate to the ratio of Health Service Commissioner to Parliamentray Commissioner staff (27 out of 87) but is easily explained by the more expensive Health Service Commissioner practice of interviewing almost every complainant compared to the Parliamentary Commissioner practice of relying more frequently on correspondence.

Bodies and Action subject to Investigation

S92(1) defines "body subject to investigation" as the Health Boards and the Common Services Agency.

S93(2) is crucial because it defines action subject to investigation. It is worth quoting in full:

> "Subject to the provisions of this section, the Commissioner may investigate -
>
> (a) an alleged failure in a service provided by a body subject to investigation, or
>
> (b) an alleged failure of a body subject to investigation to provide a service which it was the function of the body to provide, or
>
> (c) any other action taken by or on behalf of a body subject to investigation,
>
> in a case where a complaint is duly made by or on behalf of any person that he has sustained injustice or hardship in consequence of the failure or in consequence of maladministration connected with the other action."

The/...

The original definition as laid down in the 1972 Act was one long sentence broken down into clauses but still quite difficult to read and understand.[25] In the following year it was re-written in its present form but a clause relating to unfair or unreasonable treatment was dropped. This has had no discernible effect on the number of cases being rejected and presumably it was thought that the phrase could be subsumed under the broader heading of "maladministration". The Commissioner is on record as saying that he will interpret the legislation as widely as possible.[26]

The Commissioner's remit is drafted in very broad terms. Providing the complainant can show injustice or hardship consequent to alleged maladministration or an alleged failure in the service or any other action connected with the subject of complaint then the Commissioner will investigate. Initially, the government wanted to confine the Commissioner to cases of maladministration. It did not want the Commissioner to be able to look at generalised complaints alleging deficiences in the health services[27] since these so often came down to arguments about public expenditure which are more properly the concern of the C & A-G.

What the government overlooked was that if it extended the Commissioner's remit beyond maladministration it would not open a floodgate of complaints about the level of National Health Service financial provision since each complainant had/...

had to show personal hardship. There was little possibility of the section being used by pressure groups to bring class actions.

The legislation and consequently the Commissioner require two things of the complainant:[28] (a) that a named individual has suffered injustice or hardship and that (b) there is prima facie evidence of a causal link between the hardship suffered and the maladministration, action or failure of service complained of. Where a complainant fails either of these requirements the Commissioner will reject his case in limine. On occasions, the Commissioner has protested that these requirements are a limitation on his jurisdiction which conflict with the public interest. In one case he received, the Patients' Association complained that the Area Health Authority refused to recall patients who had been treated by a butcher masquerading as a surgeon. The Commissioner had to reject the case because there was no individual patient to make the complaint.[29]

In his report for that year the Commissioner asked the SC to consider: "Whether I should be empowered to initiate investigations where in my discretion I think that an investigation would be in the public interest."[30] This would be in line with the powers of the Swedish Ombudsman, the Justice recommendations and the views of the SC on the PCA itself, but the idea has not been mentioned since the 1979-80 report of the Health Service Commissioner and seems unlikely to be revived unless a/...

a similar case appears to prompt it.

The most difficult problem posed by the section is the meaning of the term "maladministration" borrowed from the PCA terminology. Neither the PCA nor the HSC legislation provides a statutory definition or guide to interpretation of this word. Neville Brown[31] has posed the theory that this omission was deliberate. He believes that the Ombudsman idea is essentially extra-legal, and conceived of as a means of avoiding the technicalities of the law. To attempt to provide a legal definition for the word maladministration would only destroy the very simplicity which is supposed to be a major attribute of the Ombudsman.

Marshall has reacted quite differently to the term. He says it is so vague as to be useless; it does not even have the symbolic value Neville Brown claims for it and he would like to see it abolished.[32]

In fact we do have some idea of what it means. During the passage of the PCA Bill, Mr. Crossman MP suggested to the House that maladministration would include "bias, neglect, inattention, ineptitude, perversity, turpitude, arbitrariness and so on."[33] Clearly, this Crossman catalogue is sometimes at variance with the proposals contained in the 1965 White Paper and the Whyatt Report. The government paper proposing the creation of a PCA said the Commissioner was not intended to act as a court of appeal/...

appeal from discretionary decisions but to focus on procedural defects. Similarly the Justice Committee chaired by Whyatt was particularly influenced by the Danish Ombudsman and they interpreted his remit as being concerned with procedural defects.

The Crossman catalogue, with its emphasis on incompetence, ineptitude and perversity implies that the Commissioner can re-examine discretionary decisions. Clearly if the Commissioners permitted themselves to so this they would be stepping outwith the terms of the Act and setting themselves up as a court of higher appeal, which would be completely unacceptable to those working in the Civil Service or National Health Service.

The early experience of the PCA proved that a purely procedural interpretation of maladministration throws up some hard cases. In 1968 the SC on the PCA urged the PCA to review cases which appeared to him to be "Thoroughly bad in quality" and infer maladministration or improper procedure from the quality of the decision itself.[34] The chairman of the Select Committee was to call this "the doctrine of constructive maladministration".[35]

Although the Commissioner adopted this practice it seems to have made little difference to the way he carries out his work. Of course, maladministration is only one of the three main grounds/...

grounds on which an investigation may be based, even if it is the least comprehensible.

Alarmed by the ease with which the Health Service Commissioner and the Commissioner for Local Administration in Scotland can look at confidential medical records, the Executive Committee of the British Medical Association gave the following guidance to its members on the extent of the Commissioners' powers:

> "They are concerned solely with administrative matters ... and they cannot question the merits of a decision made unless that decision was reached as a result of maladministration. Therefore, a professional judgement cannot be questioned... so long as it was properly made in the administrative sense. This means that account was taken of established procedures and that all relevant letters and reports were considered."[36]

Perhaps this interpretation is rather simplistic. The New Zealand Ombudsman, commenting on cases he deals with, has said that despite what doctors think professional judgements do not lie on the one hand and administrative decisions on the other. In any large organisation, particularly in the more senior posts, there is an intermingling of the two.[37]

In 1971, Justice admitted that perhaps the Whyatt report had taken too narrow a view of what remit would be appropriate to the Parliamentary Commissioner Act. No doubt the provisions of the Parliamentary Commissioner Act, 1967 were well-intended but there now seemed to be evidence that they deterred complainants. Therefore, in its report/...

report "Our Fettered Ombudsman", Justice argued that the Commissioner should no longer be limited to investigating complaints about maladministration but should be able to look at acts which were "unreasonable, injust or oppressive". Justice backed up its arguments with evidence of the experience of the New Zealand Ombudsman which had shown that such a wide remit was workable.

The idea did not receive the support of either the Commissioner or the SC. The Commissioner said that if the Justice formula were a device to enable him to look at those kinds of discretionary decisions then it was misguided.[38] He said he already looked at those kinds of decisions providing they contained elements of maladministration. What he did not do was to investigate discretionary decisions taken without maladministration.

In the end, the Commissioner and the SC agreed that the argument was really about semantics. He could do everything his opponents said he could not do under the existing legislation and to change it would make little practical difference.[39]

Unfortunately, the Ombudsman's office has not carried out any in-house research which could support either party's claims. Anecdotal evidence, however, suggests that complainants are completely ignorant of the provisions of the relevant legislation and leave it to the Ombudsman's staff to frame the substance of their complaint around the Act/...

Act thus bearing out the view of the Ombudsman and SC.

There does seem some evidence that successive HSC are gradually crystallising a definition of failure and maladministration through the build up of case law. Unfortunately this is not available to the public to enable them to use the Commissioner's office properly. The case law that exists does help the HSC maintain a consistency in decisions. In 1978 the PCA revealed that his office (and presumably also the HSC) kept a subject index of all decisions and it is possible to speculate that he follows some informal law of precedent.[40] (The following chapter on case law will demonstrate this is in fact what happens). The Supply Estimates reveal that when sufficient funds are available the Commissioner would like to install a computer information retrieval system and it is presumably for this purpose.[41]

S.93(3) "... the Commissioner shall not conduct an investigation in respect of any of the following matters -

(a) any action in respect of which the person aggrieved has or had a right of appeal, reference or review to or before a tribunal constituted by or under any enactment or by virtue of Her Majesty's prerogative;

(b) any action in respect of which the person aggrieved has or had a remedy by way of proceedings in any court of law; but the Commissioner may conduct an investigation notwithstanding that the person aggrieved has or had such a right or remedy, if he is satisfied that in the particular circumstances it is not reasonable to expect that person to resort or have resorted to it."

Paragraphs/...

Paragraphs (a) and (b) deal with the problem of double jeopardy. This means the possibility and harassment of someone being penalised twice for the same failing: in this context, once under the Act and once again either by court or tribunal. The Act attempts to resolve this problem by providing that the Commissioner must not normally investigate a complaint if the complainant has failed to exhaust the remedies available to him in court or before a tribunal. But a discretion is vested in the Commissioner to investigate a complaint if he has ground to think it is not reasonable to expect the complainant to have resort to the court or tribunal. This is in keeping with the established judicial principle that the superior courts retain an original jurisdiction which enables them to determine all alleged illegalities unless statute has clearly expressed otherwise and perhaps even then).[42]

The provision is also an implicit recognition that, while the Commissioner might be seen as a cheap and accessible alternative to the law, he is also a substitute working in the twilight areas of the jurisdiction of the courts. The Commissioner looks both at complaints which can be resolved by the judicial process and those which cannot.

The difficulty of vesting such a discretion in the Commissioner is that he is bound to make mistakes, or the complainants genuinely change their minds so the possibility of double jeopardy remains.[43] The only solution would be a positive statutory/...

statutory bar which might seem unnecessarily harsh to an unsuspecting complainant who forfeits his right in law because he was unaware, possibly due to the difficulty of obtaining evidence, that he had a good case.

When the idea of the HSC was first raised the then Permanent Secretary to the Ministry of Health, Sir Arnold France, objected on precisely these grounds.[44] He said that a very large percentage of complaints relating to the National Health Service might result in court action therefore on a narrow reading of the Act the Commissioner would have to reject them causing more frustration than was realised. This seems a rather fatuous argument. Added to this was the difficulty of telling, at first instance, whether a complaint might result in legal action.

The SC on the PCA ignored these objections since it felt that some improvement was better than none. It also pointed out that since all complaints would have first been filtered through the Health Boards, their legal departments would have screened all those likely to give rise to legal action.

S93(4) The Commissioner cannot investigate the actions detailed in Sch. 14 (see infra).

S93(5) Her Majesty may, by Order in Council, amend Sch. 14 paras. 4 and 5 so as to include these actions in the Commissioner's jurisdiction.[45]

S93(6)/...

S93(6) The Commissioner alone decides whether he is competent to investigate a complaint and if so, enjoys unfettered discretion as to whether to initiate, continue or discontinue an investigation. (The point has not yet been tested in court in relation to the HSC but has been decided in the case of the PCA in his favour).[46]

Provisions relating to Complaints

S94(1) provides that the Commissioner may hear a complaint from any individual or group of people providing they are not a local authority or nationalised industry (for which separate complaints systems exist) nor any body appointed by the Queen or government or funded by Parliament. This has the important effect that the HSC cannot accept complaints from Local Health Councils since they are publicly funded bodies. However, he will accept complaints from LHCs under S94(2).

S94(2) Where a potential complainant had died or is unable to act for himself, someone else, whether an individual or group, may act for him. Under this heading the HSC accepts complaints from LHCs.[47] However, most of the complaints which the HSC receives under this heading are from relatives or MPs acting for elderly people. The HSC has identified these complaints as being amongst his most difficult since the representatives' motives for complaining are so often confused with their own personal/...

personal feelings of guilt regarding the possible neglect of a relative.[48]

S94(3) complaints must be made in writing within 12 months of the matter coming to the complainant's notice. Although complaints must be made in writing, the HSC also handles several hundred telephone enquiries each year. Many of these are general health queries rather than complaints and have to be redirected. The remainder have to be advised as to the correct procedure for making a complaint. The number of telephone calls and their nature seems to show all too clearly that the public is confused about the Ombudsman and prefer an oral to a written procedure. Ombudsmen elsewhere in the world accept complaints by telephone or assist the complainants to draw up their complaint. Although the Commissioner for Local Administration in Scotland[49] would like to see a similar system operating at his level this particular proposal had not been espoused by the HSC.

Complaints must be submitted to the HSC within one year. It was thought that a period any longer than this would make investigation impracticable. Even within the present remit the HSC can find it difficult to contact National Health Service staff because the turnover is so fast. The Commissioner has discretion to waive the time bar which he does only rarely. He used the power most frequently in the first year to take account of cases which had taken place before his office came into/...

into being.

S94(4) stipulates that the Commissioner may consider a complaint only after the body subject to investigation has considered it. This filter is analogous to the role of MPs in relation to the PCA. It was not only designed to minimise the number of complaints but to "recognise the board's responsibility for dealing with complaints as an integral function of management, and... to avoid complaints going to the health commissioner unnecessarily."[50]

S94(4) remained in this form despite the protests of Mrs. Castle, MP that it failed to take account of staff who wanted to complain.[51] Mrs. Castle said this was a grave weakness since the Ely scandal had shown that staff fear of victimisation was a major factor in the scandal remaining unreported for so long. It was important that staff should be able to bring a complaint without first taking it to their employer.[52] The National Health Service reorganisation (Sc) Act, 1973 Sch. 4 para. 145 (2) removed this limitation on the HSC. The HSC still retains a discretion to refuse to accept such a complaint referred in this way if he is not satisfied that the particular circumstances warrant it.

S94(5) provides that a body subject to investigation may itself refer a complaint to the Commissioner subject to the same time limit as other complainants of twelve months. The complaint may be one/...

one against itself or the complaint may be brought on behalf of an aggrieved person. In the former case the Health Board may not have been able to resolve the complaint to the complainant's satisfaction and think that intervention by a more apparently independent body will bring the matter to a satisfactory close.[53]

The process is entirely dependent on the patient complaining. The HSC has no power to initiate his own investgiations. This was negatively commented upon at the time of passing the Act[54] and has also attracted criticism from the HSC and SC (see infra).

Application of Certain Provisions of the Parliamentary Act, 1967 viz. ss.7,8,9,11.

S7 (procedure in respect of investigations) The procedure is not laid down in detail.

The Commissioner has complete discretion as to how to conduct the investigation, what information to obtain and from whom. He must give the person against whom the complaint is made an opportunity to reply and may decide to permit him legal representation. The Commissioner may also pay expenses to the parties involved, if he thinks fit, for loss of time or expenses incurred (e.g. in taking time off and travelling to X for the purposes of an interview). The initiation of an investigation by the Commissioner does not affect actions already taken by the body subject to investigation/...

investigation or which it may take in the future.

The statutory provisions only give a hint of what happens in practice. When the HSC first receives a complaint it is screened by a member of his investigatory unit.[55] They may make informal enquiries of the Health Board. On the basis of this the case is submitted to the HSC with a recommendation for investigation. The HSC contacts the Health Board and requests the name of a liaison officer to handle the Health Board side (e.g. providing interview rooms, arranging appointments for interviews etc.). The HSC sends the liaison officer a proforma for completion with a covering letter explaining HSC procedure. Any individuals named in the complaint also receives a summary of the complaint so that they can present their case in writing. The investigatory unit normally interviews all the staff involved and examines all the records including medical records, ward reports, waiting lists, appointment lists etc. until a dossier of information has been built up.[56]

This very thorough and time consuming method of investigation has earned the Commissioner's investigations the description "Rolls-Royce". But it has also been judged as inefficient use of staff time. Gwyn has said that in this respect the British Ombudsman suffers from the legacy of the C & A-G.[57]

In/...

In keeping with this inquisitorial style of procedure, the HSC draws up a draft report which is sent, without findings, to the Health Board and staff member concerned for comment. The complainant does not receive a copy of the draft report and does not have the opportunity to challenge the evidence from the hospital as he would be able to do before a court or tribunal. These provisions really give the lie to the accusations of the British Medical Association that in these investigations the HSC is a kind of despot.[58]

Bradley makes the point that it is all too obvious that when these provisions were drawn up there was "almost total lack of recourse to legal techniques, the legal profession and judicial process."[59] This remains true despite the appointment of a QC as the most recent Commissioner (although it is significant that in his reports he is more likely than his predecessors to mention the difficulty of weighing up the credibility of a witness; he was the first HSC to use his powers to hold a judicial hearing),[60] and, most recently, published cases are also summarised, rather like the rubric to a case report.

The procedure is designed to be cheap, private, quick, and inquisitorial in nature with all its attendant advantages. But when conflicting facts must be established or witnesses are loathe to give evidence then the Commissioner must fall back on the adversarial style of procedure.

S8/...

S8 (evidence) requires those concerned to furnish information or documents. The Commissioner can hold a hearing, having the same powers as a court to compel witnesses, take evidence on oath and compel the production of documents. No plea of confidentiality will be accepted including Crown Privilege. For a short time, it appears that the HSC could have looked at Cabinet documents, too, but this was removed in 1973.[61] Even so, very wide powers have been conferred on the Commissioner although he uses them rarely.

S9 (Obstruction and Contempt) both punishable by the court on the certificate of the Commissioner.

S11 (Secrecy of Information) The Commissioner and his officers are bound by the Official Secrets Act 1911. It is this provision which compels the Commissioner to publish anonymised reports.

S11(3) The section also provides that notwithstanding the preceding provisions the Commissioner may communicate the contents of documents certified by a Minister of the Crown as containing information or belonging to a class of documents disclosure of which would be contrary to the safety of the state or public interest. As far as we know no such certificates have been issued.

Reports by the HSC

S96(1) This section deals with the Commissioner's/...

Commissioner's reports. It is also an oblique reference to the remedies which the HSC can obtain since it is only through the medium of his reports that the HSC can hope to do anything for the complainant.

There are four recommendations open to the HSC:

(i) an apology
(ii) an apology and an invitation to the offending Health Board to review their practices
(iii) an ex gratia payment
(iv) advise on need for departmental guidance on a particular point

The HSC has no powers of enforcement. He must reply on his own authority, the quality of his reports and the backing of the SC. Health Boards have proved particularly reluctant to grant ex gratia payments. This controversy raised questions as to whether the HSC should have powers of enforcement.

The HSC has said that if the complainants want damages he advises them to seek a legal remedy. But if they want moral satisfaction only, he will proceed with the case.[62] The only element of compulsion open to him is the back up of the SC. Obviously there is a less direct relationship between/...

between SC and HSC than the SC and PCA, since the management of the NHS is in the hands of local boards, not a minister. But the SC has so far always succeeded in using its authority to ensure the implementation of the recommendations.[63] The HSC acknowledges that the system is not perfect but thinks it works well enough especially since the alternative - powers of compulsion in the hands of a non-accountable figure - is unacceptable in a democracy.

At the end of each investigation the HSC sends a copy of his report to the complainant, the Health Board, the person who took the action complained of and the Secretary of State. An omission in the legislation which the HSC has identified is that where someone brings a complaint on behalf of an aggrieved person the former is not entitled to a copy of the report, but only to know that one has been issued.[64] This has caused offence in the past to Local Health Councils acting for individuals.

S96(3) where the HSC decides not to investigate a complaint he must give a statement of his reasons to the complainant and to the Health Board (remembering that the Health Board will have already been contacted during the screening process).

S96(4) where a body subject to investigation refuses to remedy an injustice identified by the HSC/...

HSC he may publish a special report. So far the HSC has not had to publish any special reports mainly because of the success of the SC on the PCA (see ch.6 on SC).

S96(5) the HSC makes an Annual Report to the Secretary of State and may make other reports as he thinks fit, though he has not done so yet. The HSC for Scotland, England and Wales submit a joint report as so far no significant differences have arisen between the complaints from the three countries to justify separate reports.

S96(6) The HSC may also lay occasional reports before Parliament. He has not done so yet because presumably, unlike the PCA no significant cases have turned up.

S96(7) in everything he says and writes the HSC enjoys absolute privilege. Without this dispensation the HSC would find his work impossible.

The reports of the HSC, whether annual or of selected investigations, have attracted some criticism. Their anonymity makes them unattractive to the layman and newspaper reports. This in turn creates the relatively light case load. Although the HSC has become increasingly liberal in providing statistics it is still difficult to relate these to the/...

the investigations. Only a selection of the more interesting are published and they are arranged geographically by country and not by subject matter. The HSC says the main deterrent to a more attractive and coherent presentation is cost.[65] At one time full reports were published quarterly, now only selected reports are published.

There is no provision for the HSC report to be debated in the House, although this is true of other government publications too. It is regrettable in this case because the reports themselves receive so little publicity. The SC recommended that a set time should be set aside for debating HSC reports[66] but, not surprisingly, the government was not prepared to set aside time.[67] To date there has been only one full-scale debate on the Ombudsman and that was brought on a private member's motion by the Chairman of the SC.[68]

Interpretation of Part VI.

S97(1) interprets phrases used throughout the act (but not maladministration.)

S97(2) a final declaration that the HSC cannot question the merits of a decision taken without maladaministration which is in exercise of a discretion vested in a body subject to investigation. This accords with the HSC's own view that he is empowered to look at the merits of a decision if in the exercising of the discretion there/...

there is maladministration. (see infra).

Action not subject to investigation by the Commissioner.

Schedule 14

Schedule 14 concerns subjects which the HSC may not examine, but it should be noted that where a complaint has as its grounds a number of areas of which only some are excluded the HSC will conduct a partial investigation. In a very few difficult cases each year he commences an investigation in the belief that the complaint may be within his jurisdiction only to discontinue the investigation when he discovers that this is not the case.[69]

In his evidence to the SC the HSC admitted that these partial and discontinued investigations are possibly more puzzling and unsettling to the complainants than if he had rejected their cases outright from the start.[70]

The terms of Schedule 14 are stated without ambiguity and have caused, with the possible exception of paragraph 2, little difficulty for the HSC. The HSC has not asked for any changes in the content of Schedule 14, most of the arguments for and against their inclusion having been exhausted in relation to the PCA Act, 1967. If the remit of the PCA were extended to, for example, personnel matters or/...

or contracts, no doubt the remit of the HSC would be brought into line.

Paragraph 1

Services provided by the Executive Councils, e.g. medical, dental, optical and pharmaceutical are excluded from the HSC's remit. These services had their own statutory complaints procedure since the inception of the NHS and this machinery remained unaltered by the decision to establish a health commissioner. This is a good illustration of the rule giving priority to statutory remedies.

The Ministry of Health used this exclusion as a reason for not establishing a commissioner. The Ministry agreed that it would be illogical, in a re-organised health service, to create a commissioner who could only look at one part of a complaint[71] while ignoring the fact that many complaints related solely to the hospital service.

Paragraph 2

The HSC may not investigate complaints relating to the diagnosis of an illness or the care or treatment of a patient if, in the opinion of the HSC, the action was taken solely in the exercise of clinical judgement.

Initially, there was cautious support in Scotland from the medical profession for the inclusion/...

inclusion of clinical judgement in the jurisdiction of the HSC but their English colleagues dissuaded them.[72] Later, in 1977 when the SC on the PCA was reconsidering the HSCs jurisdiction and took evidence from interested parties, the Scottish contribution was marked by its conservatism and vote for the status quo. The SC attributed this change of heart to the superior system of hospital internal review operating in Scotland.[73]

The medical profession was opposed to the inclusion of clinical judgement because it thought that it would harm patient confidence in their doctors, damage the self-respect of doctors, reduce work satisfaction and encourage the slow and expensive practice of defensive medicine. Knowing that the HSC scheme would be totally reliant on co-operation from staff the government was anxious that there should be proposals to make it clear that- "He (the HSC) must not be pictured as a person entitled to say at leisure and with the advantage of hindsight whether the treatment given in a particular case was absolutely right".[74]

Although the HSC may not question clinical judgements per se he may investigate the complaint in order to establish whether the professional person concerned had put himself in a position to make a reasonable judgement and acted upon it. It should be noted that in terms of the Act it is the HSC/...

HSC who decides whether or not something is "clinical".

Doctors are sometimes surprised by the extent to which the HSC does involve himself in the clinical issues of a case. This is particularly so where the HSC and his staff ask to look at the clinical records[75] (this is usually only to establish appointment times etc.)

In contrast, the restriction on clinical judgement does not apply to the PCA when he is investigating complaints about health services provided by central government e.g. in military hospitals or in prison. The SC have tried to use this as an argument in favour of similarly extending the remit of the HSC but the analogy is not accurate; doctors working in the army or civil service are traditionally regarded as enjoying less clinical autonomy than their counterparts in civilian life.

Although the HSC has commented upon the large number of complaints he has to reject because of Paragraph 2 he has never recommended that he is necessarily the best solution to meeting this need. In his Annual Report for Session 1981-82 he reported that he is watching with interest to see whether the new procedure for resolving clinical complaints in hospitals will be successful.[76]

Paragraph 3/...

Paragraph 3

Action taken in relation to the service committee procedure (referred to in comments on paragraph 1) is excluded from the purview of the HSC.

In England, an informal procedure exists for settling complaints between patients and GPs, dentists, etc. without implementing the formal procedure. The HSC is free to investigate complaints at this informal stage. These cases have been among his most difficult, and, on at least one occasion, the SC has had to add its backing to the recommendations of the HSC to obtain a remedy.[77]

Klein has also commented upon the unsatisfactory procedure in operation in his book "Complaints against doctors" where he exhaustively details the weakness of the Services Committee procedure.[78]

Paragraphs 4 and 5

Personnel and contractual matters are excluded from the remit of the HSC. Both have been discussed at length by the SC in relation to the PCA but the government has stood firm in its opposition to any changes in these areas.

Paragraph 6

The/...

Paragraph 6

The HSC may investigate any action which has been or is the subject of an inquiry under the National Health Service (Scotland) Act 1947 s.69 or the NHS (Scotland) Act 1978 s.76 (an inquiry by the Secretary of State for Scotland into a matter of "grave public concern"). This exclusion is in keeping with the general principle of priority accorded statutory remedies and also avoids wasteful duplication of investigative resources. Ss69 and 76 inquiries are intended for generalised, not individual, complaints unsuited for investigation by the HSC.

Paragraph 7

This is intended to avoid any overlap in the functions of the HSC and the MWC.

The MWC exists for quite different purposes from the HSC therefore it was excluded from the remit of the HSC and not abolished. The MWC does examine individual complaints (including clinical judgement) but its protective functions go far wider. Far from abolishing the MWC or minimising its functions to a residual state the NHS (Scotland) Act 1972, S52 strengthened the powers of the MWC to obtain evidence.

The group Justice have made their own attempt to/...

to establish "Principles of Good Administration" and the next chapter will illustrate, through the use of case law what the HSC believes these are.

CHAPTER 3 FOOTNOTES

1. HL Debates Vol. 739 Col. 1373, Lord Chancellor
2. SHHD Ministerial Brief NHS (Sc) Bill, 18.2.72 para 3
3. HC Debates Vol. 831 Col. 1104 Sir Keith Joseph 22.2.72
4. See Footnote 2
5. HC HSC Annual Report 1981-82 HC419 (Session 1981-82) Chapter 2, para 1
6. SHHD "Administrative Reorganisation of the Scottish Health Services " HMSO, Edinburgh 1968 p.24
7. S.A. de Smith "Constitutional and Administratibe Law" Suffolk, 1975 pp.113-114
8. Justice "Our Fettered Ombudsman" London, 1971
9. HC SC on PCA 2nd Report HC 480 (Session 1975-76) paras. 29-32
10. DHSS Departmental Observations by the government on the 2nd Report of the SC on PCA Session 1975-76. Cmnd. 6764 paras. 6 and 7
11. House of Commons Select Committee on Procedure Minutes of Evidence First Report HC 588 (ii) (Session 1977-78) Sir Antony Buck Chairman of SC on PCA 7.11.77 p.216
12. cf. the French Mediateur who was 82 years old ontaking office, quoted L. Neville Brown, P. Lavirotte "The Mediateur: a French Ombudsman" Law Quarterly Review Vol. 90 p. 232
13. ibid p.225
14. House of Commons SC on PCA First Report (Session 1975-76) HC 166
15. House of Commons SC on PCA 2nd Report HC334 (Session 1971-72) para.44
16. Information received Sir Cecil Clother 4.7.83: The Combined HSC, PCA office employs 87 staff currently
17. Information received from Mr. G. Keil, Senior Investigating Officer, HSC in Scotland 1.4.82
18. House of Commons HSC annual Report 1979-80 HC650 (Session 1979-80)

19./...

19. J. Scarlett "The Health Service Commissioner - Nursing Times" 24.1.74 p. 118
20. W. B. Gwyn "The Ombudsman in Britain: A Qualified Success in Government Reform" Public Administration Vol. 60 Summer 1982 p.179
21. House of Commons HSC First Report HC161 (Session 1973-74) para.15
22. See Footnote 35 Ch.2
23. See Insert Photocopy
24. See Footnote 20
25. NHS (Sc) Act, 1972 s.45 (2) "... the Commissioner may investigate any action taken by or on behalf of a body subject to investigation in any case where a complaint is duly made that a person claims to have sustained injustice or hardship in consequence of maladministration in connection with the action so taken, or in consequence of a failure in a service which was or ought to have been provided for him by or on behalf of the body subject to investigation, or in consequence of having been unfairly or unreasonably treated."
26. NHS Reorganisation (Sc)Act, 1973 Sch. 14 para. 144
27. House of Commons SC on PCA 4th Report HC 593 (Session 1979-80) para. 13
28. See Ch. 2 Footnote 45, para 6
29. See Footnote 21
30. Do.
31. L. Neville Brown. P. Lavirotte op cit pp.211.233
32. G. Marshall "Maladministration" Public Law Spring 1973 pp.32-44
33. HC Debates Vol.734 Col. 51 1966
34. HC SC on PCA 1st Report HC 258 (Session 1967-68)
35. HC Debates Vol.959 col. 922 Mr. M. Stewart, MP
36. BMJ Vol.284 p.610 20.2.82
37. G.R. Laking, "The Ombudsman and Medicine" New Zealand Journal, Vol.88(624) p.410, 1978
38. HC PCA 2nd Report HC 157 (Session 1977-78)
39. HC SC on PCA 4th Report HC615/444 (Session 1977-78)
40. HC SC on PCA Annual Report 1978 HC 205 (Session 1978-79) p.6
41. See insert photocopy
42. B. Schwartz, H.W.R. Wade "Legal Control of Government", London 1972 pp.281-282

43./...

43. See Case No. W236/75-76 where the complainant used evidence uncovered by the HSC to commence legal action.
44. HC SC on PCA 2nd Report HC 350 (Session 1967-78) Question 676
45. Sch. 14 para.4 concerns action taken in respect of personnel matters. Para.5 concerns action relating to contractual or commercial transactions
46. In re Fletcher's application (1970) 2 All E.R. 527
47. HC HSC 4th Report 322 (Session 1976-77)
48. C. Clothier op cit
49. Information received from Mr. K. Bratton, Secretary to Commissioner for Local Administration in Scotland 4.8.82
50. SHHD "A Health Service Commissioner in a Reorganised NHS" A discussion paper July 1970
51. HC Debates Vol. 831 Col. 1106 22.2.72 Mrs. Barbara Castle
52. The Economist, Leader "Against Doctor's Orders" 26.2.72 p.27
53. See Footnote 20 The Greater Glasgow Health Board in Scotland is especially keen on this type of referral.
54. The Daily Telepgraph "Hospital Inspectors Needed" 24.2.72
55. See Footnote 20
56. See Footnote 51 pp.199-200
57. See Footnote 23 p.182 Sir Edmund Compton, the first Ombudsman and therefore the one responsible for dictating the pattern of the investigative procedure, was a former C & A-G
58 BMJ Correspondence "A Clinical Competence and the Ombudsman" p.52 7.1.78
59. A. W. Bradley, "The Role of the Ombudsman in relation to the Protection of Citizens' Rights". Cambridge Law Journal Vol. 39(2) p.309
60. Case No. W450/78-79
61. NHS Reorganisation (Sc)Act, 1973 Sch. 4 para. 146
62. HC SC on PCA 1st Report HC 45 (Session 1977-78) Minutes of Evidence p.38
63. cf. the recent experiences of the Local Ombudsmen in England, who favour the creation of a SC-style body to provide back-up "Your Local Ombudsman, Report for the year ended March 31, 1983/...

1983 "London and The Times 20.7.83 Leader p.13
64. HC HSC 2nd Report HC 106 (Session 1979-80)
65. HC HSC 5th Report HC 650 (Session 1979-80)
66. HC SC on PCA 4th Report HC 45 (Session 1977-78)
67. Government observations on 4th Report of the SC on PCA Cmnd.7449
68. HC Debates Vol. 959 Cols 894-986 1.12.78
69. Case No. W236 /75-76
70. HC SC on PCA 1st Report HC282 (Session 1975-76) para. 3
71. HC SC on PCA 2nd Report HC 350 (Session 1967-68) Question 675
72. Information received from Mr. J. Walker, Under-Secretary, SHHD 7.8.81
73. HC SC on PCA 1st Report HC45 (Session 1977-78) Appendix II
74. SHHD HSC (Sc) Bill HL Ministerial Brief 18.2.72 para. 6 (unpublished mimeo)
75. HC SC on PCA 1st Report HC282 (Session 1975-76) paras, 35-37
76. HC HSC Annual Report 1981-82 HC419 (Session 1981-82)
77. HC HSC 2nd Report HC306 (Session 1980-81) p.210 Case No. W279/79-80
78. R. Klein "Complaints against Doctors" London, 1973

CHAPTER 4

THE HEALTH SERVICE COMMISSIONER : INVESTIGATIONS AND REPORTS

INTRODUCTION

The HSC reports quarterly on selected investigations. With time, these reports have become longer and more detailed. They are longer because the total volume of complaints made is greater. They are more detailed because the complaints themselves raise more complex points, and more of them.[1] In addition, it seems to indicate a greater openness on the part of the HSC.

We do not know on what basis the HSC selects investigations to be published. We do know that in the Annual Reports the cases which the HSC chooses to discuss, because they reveal general areas of weakness in the health service, are invariably to be found in these published reports. However, not all cases are chosen for this reason. Other published cases seem to be merely of curiosity value, to arouse public interest. Others again may have been proven to be entirely injustified and are included to illustrate abuses of both the NHS and the office of HSC.

It could be said that this series of published reports now constitutes a body of case law. The term should be used advisedly. It must be stressed that the reports available to the public do not constitute the/...

the entire body of cases available to the HSC. The published reports do not constitute a complete record of HSC activities. There must always be some doubt whether the published cases are modified by those which remain unpublished. Furthermore, until Sir Cecil Clothier took office, the HSC was always a civil servant without legal qualifications. The term "case law" can only be used in the loosest sense as meaning the consistency of one case with another. Writers have characterised the office of the HSC as being essentially "non-legal".[2]

Professor Bradley believes that the process of evolving a system of precedents has already taken place in the office of the Ombudsman though his remarks are specificially directed to the PCA.[3] In support of his assertion he cites the "frequent practice" of the PCA of referring back in his reports on cases to earlier investigations into similar complaints and also the publication of a subject-index of decisions in 1978. Most other observers would suggest that Professor Bradley has exaggerated the frequency of the PCAs referrals, and note that the published index was discontinued after only one year. Furthermore, financial cuts have forced the HSC to defer implementation of a computerised information retrieval system which would make an extensive indexation system possible.

In his report for 1981-82 (HC419) para. 32 the HSC did remark on a group of cases which all came from the same department of one hospital. The HSC has/...

has never published a subject index but in his Annual Report he publishes an analysis of grievances according to subject-matter giving numbers raised in each category, and the number found justified. However, the HSC does hold ad hoc surveys within the office and in addition, staff make informal use of files relating to previous investigations.[4]

The significance of case-law is that it is the major source of information available to us about the HSC (with the exception of the Annual Reports to be discussed in a later chapter). The legislation tells the HSC on what grounds he may conduct an investigation and how to proceed, but only in the broadest terms. For the details we have to look at case law.

The headings under which I have chosen to discuss the case law do not coincide with those of the HSC. I propose to divide the material into three broad categories:

(1) Procedural
(2) Jurisdictional
(3) Substantive

In his Annual Reports, the HSC categorises the cases in six broad headings and, most recently, 23 sub-headings relating to content. In the published reports, each investigation is headed by a distinct title/...

Analysis of separate grievances contained in results reports issued
1 April 1981—31 March 1982—Table III

	Some Justification	*No Justification*	*Unable to Resolve*	*Sub-Total*	*Total*
Administration					
—policy decisions (manner in which reached)	7	4	—	11	
—day-to-day (hospital in-patient)	25	18	—	43	
—day-to-day (hospital out-patient)	1	2	—	3	
—day-to-day (hospital casualty) ...	9	4	—	13	
—day-to-day (family practitioner services)	2	—	—	2	
—day-to-day (community health) ...	1	—	—	1	73 (79)
Failures in service					
—ambulance	1	3	—	4	
—catering	1	4	1	6	
—community	1	—	—	1	
—domestic	2	1	1	4	
—facilities on wards	4	3	—	7	
—paramedical	—	3	—	3	
—portering	—	—	1	1	26 (27)
Medical					
—lack of or incorrect information...	13	26	1	40	
—attitudes	9	35	8	52	
—failure in non-clinical procedures	18	24	2	44	136 (93)
Dental					
—practitioner	—	—	—	—	— (1)
Nursing					
—failures in care	14	43	8	65	
—lack of or incorrect information	2	9	1	12	
—attitudes	6	16	3	25	
—clerical procedures	2	—	1	3	
—maltreatment	—	2	—	2	107 (125)
Handling by Authority	34	31	—	65	65 (74)
Totals	152	228	27		407 (399)

( ) 1980–81 figures

title which is essentially a summary of the major source of grievance raised by the complaint. Given the variety of circumstances under which complaints can arise in the health service this kind of categorisation, according to content, is not particularly helpful. (see page interleaved for table)

Therefore, any discussion of the case law has to be qualitative rather than quantative in nature. The cases are made available to the public in a very selective way and those which are important to the HSC are not necessarily revealing for our purposes.

Part I.[1] Procedural

1. Receipt of Complaints.

The question of who may make a complaint is more properly dealt with under the heading of jurisdictional matters but the HSC has imposed procedural stipulations himself, outwith the Act, and on occasions overlooks the requirements of the Act.

(a) "direct access".

On occasion, the HSC permitted some complainants "direct access" to him.[2] A woman made a number of complaints about the care her mother had received while in hospital. As required by the Act, these were referred to the AHA but their response was unsatisfactory.

During/...

During the course of the HSC investigation, officers interviewed the woman and her mother. During the interviews they raised additional points of complaint which had not previously been put to the relevant AHA. But, in this case the officers of the AHA agreed with the HSC that the HSC should investigate all the points raised.

This is an interesting case if only because it is such an isolated example. Given the type of person who complains, the subjects which concern them and the unstructured way in which they present their complaints it is surprising that there are not many more cases like this.[3] Of course, this approach depends on the co-operation of the AHA officers and if they withhold it, as they are entitled to do, it may be that the HSC persuades the complainant to proceed on the basis of the complaints originally made.

(b) Vicarious application.

In another case, the HSC permitted a case to be brought on behalf of someone who remained unaware of the investigation.[4] The Act permits relatives and friends to make complaints on behalf of patients but in the majority of cases the complaint emanates from the patient. In this case a father made a complaint about his son's treatment while in a psychiatric unit and later in/...

in the psychiatric ward of a hospital. The son was still receiving medical care during the period the investigation took place. The father wished his son to remain ignorant of the complaint for the sake of his peace and stability of mind. The HSC accepted this condition to his investigation and it is a sensible decision for if the Act was designed to enable those who are incapable of articulating their complaints to do so then it is logical to extend it to those who are incapable of judging whether they have been the subject of questionable behaviour.

(c) Potential abuse of the service.

In relation to private patients, the HSC insists that they pay their bill before he undertakes his investigation. In SW44/76-77 a private patient complained that the hospital administration had misled him as to the true rate of charges with the result that the bill was higher than he was led to believe it would be. And, that the high rates levied were not an accurate reflection of the standards of food or accommodation. Consequently, he refused to pay his bill. The HSC undertook to conduct an investigation only if the bill were paid. The bill was paid, the HSC investigated the complaint, upheld it, and the Health Authority repaid the complainant the excess charge.

The/...

The HSC adopted this attitude because he did not want patients using his investigatory procedure as a means of delaying the payment of their bills.

2. The investigation: sources of information.

(a) Witnesses.

During the course of his investigation the officers of the HSC interview the parties named in the complaint and anyone else who can usefully shed light on the incidents. A continual problem has been tracing staff. NHS staff regularly move from department to department, hospital to hospital. Until recently, the emigration rate was high. In most cases the HSC states that he is confident that the omission of one person's evidence is not material but his approach was called into question in WW28/761-77.

In that case a woman, aged 103, was taken to the Accident and Emergency Unit of her local hospital with a suspected fracture, late at night. The Senior House Officer on duty confirmed that the old lady was unhurt, then, despite, the fact that it was late November and 2 a.m. in the morning, he discharged her. She died shortly after arriving back at her home.

Before the complaint was brought, the Senior House Officer left Britain to work abroad. The HSC did not ask him for a written statement because, he said, the complaint was against/...

against the AHA and not the doctor who was not named in the complaint. Certainly the HSC could not have questioned the Senior House Officer since discharge is an occasion for the exercise of clinical judgement but, on the administrative grounds, the HSC condemned the action as "inhuman". This statement resulted in the local medical committee of the hospital in question passing a resolution of no confidence in the HSC. In effect, the HSC had condemned the doctor without hearing his case or giving him the opportunity to comment on the complainant's allegations.

(b) Third Parties.

The HSC sometimes interviews people whom he believes to have relevant information even although they may not work in the health service. In W239/78-79 the complainant's daughter died suddenly at home. The complainant understood that the pathologist had to conduct a post mortem examination but stated that he did not want any further experimental work carried out on the body. In spite of this, the pathologist removed several organs from his daughter's body for further analysis. The HSC said he could not examine the actions of a Coroner nor a pathologist who, though a NHS employee, was acting for the Coroner. But the Act empowers the HSC to take evidence from anyone/...

anyone with relevant information as he did here.

3. Handling of Evidence.

In the published reports, the HSC begins by briefly stating the complaint in numbered clauses and giving the background to the complaint. If necessary he may include a short paragraph on his statutory position and jurisdiction. This is not uncommonly followed by a short paragraph on the nature of the investigation. This usually consists of an examination of all the relevant correspondence, clinical and nursing notes as well as interviewing all the parties named in the complaint.

In W450/78-79 for the first time ever the HSC used his powers to hold a formal hearing and take evidence on oath in a case where there was so much conflicting evidence that he could not reach any satisfactory conclusions.

(a) the burden of proof.

Many incidents take place without other witnesses. Where this happens, the Ombudsman will come down on the staff side. The onus of proof, therefore, rests upon the complainant. The onus is not the more easily discharged because the complainant has expert knowledge. In WW13/75-76 the complainant was a nurse herself and her allegations were very detailed but nonetheless unsuccessful. Patients who are doctors themselves are less likely to bring complaints/...

complaints since they feel bound by the rules of professional etiquette. The problem is that complaints from nurses or doctors contain an amount of detail which lends them an air of veracity they would not otherwise have. In any case, expert knowledge is not essential to a complaint brought under the Ombudsman procedure.

(b) The need for corroboration.

In one case, the HSC was concerned because although medical records existed and were undisputed they were incomplete for the purposes of an investigation.[5] An expectant mother was admitted to hospital and the nursing staff on duty telephoned for the Senior Registrar to attend her. The Senior Registrar was on night duty and, after receiving the call, inadvertently feel asleep. The baby was still born. In this case the lack of written evidence was not an obstacle since the staff freely admitted that the delay in obtaining a doctor was the cause of the baby's death. The HSC expressed surprise that the AHA had no policy on the recording of incidents and recommended that they devise a procedure without delay for dealing with this situation.

Corroborative evidence is therefore particularly important in the HSC investigative procedure.

(c)/...

(c) Attitude towards medical records and case notes.

The HSC emphasises the importance of meticulous record keeping. Like the courts, in cases of doubt, he prefers written contemporaneous statements to oral evidence after the event. Although the HSC does not quote from records, for reasons of confidentiality, he does rely heavily on his reading of them and a clearly written entry in a record will always overcome an allegation. An exception to that general rule must be W450/78-79. A complainant alleged that her baby was still born because staff failed to attend to her. An investigation failed to reach a satisfactory conclusion because staff gave contradictory statements. There was evidence that the medical evidence had been made up after the event, and parts of it fabricated. The HSC had no hesitation in dismissing the medical records as reliable evidence and preferring the evidence of the complainants.

4. Adversarial Influence.

The previous comments may appear over-legalistic especially since the absence of legal i.e. adversarial techniques and legal professional interest has been such a feature of the British Ombudsmen.[6]

This comment remains valid despite the appointment of a QC to the offices of PCA and HSC. Nonetheless/...

Nonetheless it is interesting to see the intrusion of legal concepts and legal terminology. In considering evidence, the present HSC is more likely than his predecessors to say "on balance" or on "the balance of probability".[7]

The HSC is also responsible for introducing the concept of "culpable maladministration", a device he uses to uphold a complaint but propose no remedy because he does not believe that he could alter the outcome in any way.[8]

Exceptionally, he uses his own legal expertise to challenge the advice or interpretations of legislation offered by legal adviser to AHAs. In W414/78-79 the HSC quoted the Institutes of Justinian in English and in the original at some length to support his own contention that medical records belonged to a doctor and not to the Secretary of State. But this departure does not invalidate the statement made before, that the HSC is non-legal in character. In that case the HSC went on to say that for his purposes the uncertainty of the law was not crucial since the technicality of ownership should not affect the higher principle that a patient's records should remain confidential.

No formal system of precedent exists but it has already been pointed out that the creation of a body of case law inevitably gives rise to an informal system.

Conclusion:/...

Conclusion:

A reading of the case law does not make it immediately apparent what precedents have been created. The HSC style of reporting is very spare. The details of the case are meticulously recorded but the interpretation put on the facts is never made explicit. When the HSC has to come done on one side or another he does not say why. The key to understanding HSC decisions is not the seriousness of the allegations made nor the credibility of the complainants but the standards of evidence the HSC requires complainants to meet. Often the only complaint that the HSC upholds is that the AHA failed to handle the complaint competently at first instance and this is because he relies on the written correspondence.[9]

Even where there is sufficient evidence to uphold a complaint the HSC cannot recommend a satisfactory remedy. Perhaps it is this dilemma which has made him evolve the concept of "culpable maladministration". In W11/77-78 a consultant psychiatrist complained that the AHA refused to follow the DHSS guidance on payment of pocket money to long term patients. The HSC upheld the complaint but said he could not suggest an appropriate solution since the AHA was prevented from carrying it out by lack/...

lack of funds. We can increasingly expect this situation to arise.

When the investigation is complete and the report filed the matter is at an end. But in 1981 the HSC re-opened an investigation first conducted in 1977.[10] He did so, prompted by information received from the General Nursing Council. It has set an important precedent although in this case the new information did not affect the outcome. In a later case where new information emerged after the investigation was complete the HSC simply appended an amending note.

As time has advanced, the cases for investigation have become more complex, especially those which overlap the jurisdictions of the different Ombudsmen. When these occur the HSC conducts a joint investigation, but each Ombudsman makes a separate report.[11]

Part II

Jurisdictional Questions

The case law is also illustrative of the way in which the HSC interprets the provisions of the Act relating to jurisdiction. During the preliminary screening process the HSC must address himself to two considerations. Firstly, threshold issues i.e. is the complaint competent under the Act and, secondly, jurisdictional issues arising thereafter in the course/...

course of the investigation.

1. Threshold issues

(a) negation of competency

(b) affirmation of competency

(a) The first and most obvious category of incompetent cases are those whose subject-matter is expressly excluded by the Act in Schedule 14. The main provision of Schedule 14 which is responsible for the majority of rejections (see infra Ch. 5) is Sch. 14(2) dealing with actions taken solely in the exercise of clinical judgement.

(i) If the HSC is satisfied that such action was taken solely in the exercise of clinical judgement then he may not investigate it. The crucial word is "solely" since, if the HSC believes that the basis for action was formed by other factors, he is free to continue his investigation. Generally speaking though, the provision has a broad ambit. The HSC does not abuse this provision in order to allow himself a means of looking at cases of clinical judgement otherwise forbidden him. He is aware of the sensitivity of the medical/...

medical profession to any encroachments on their clinical freedom.[1] Consequently, some of the material which the HSC has judged as constituting clinical judgement has surprised outside observers.

In W265/76-77 the HSC said that a doctor's decision as to whether to allow a patient out of bed is clinical judgement. In W275/77-78 the HSC held that a doctor's decision to discharge a patient from the Accident and Emergency Department of a hospital was a question of clinical judgement (but see WW28/76-77 infra). Case W40/79-80 concerned the care of a psychiatric patient who committed suicide while in hospital. The crux of the case was the adequacy of the supervision but the HSC said that the extent of the surveillance was determined by the doctor and once this had been set the HSC could only investigate whether it had been followed, not its adequacy.

In W124/77-78 the complainant's husband was admitted to hospital and died there. The ground of complaint was that the doctor gave the wife insufficient information on the seriousness/...

seriousness of the husband's condition and failed to explain it adequately. The HSC said the way in which a doctor described a patient's condition is a matter for clinical judgement.

Schedule 14(2) does not say that doctors are the only people who can make clinical judgements. In W269/75-76 a mother, a trained midwife herself, alleged that nurses refused to call a doctor to attend her baby, resulting in its death. The complainant's MP put the matter to the DHSS on her behalf. The DHSS said that the decision to call a doctor or not was a clinical judgement. The HSC accepted this statement. However, the volumes of cases amply demonstrate that the HSC is far less likely to accept that a nurse was making a clinical judgement than a doctor, and in W269/75-76 was no doubt influenced by the prior pronouncements of the DHSS.

The HSC has further limited his jurisdiction by evolving the concept of "professional decision" to meet the dilemma referred to above.[2] He uses this phrase in conjunction with clinical/...

clinical decisions or as an alternative to them, but not a substitute. The commissioner seems to use the phrase to imply a decision which contains clinical elements which is not clinical judgement and which the nurse has taken on her own but with which he is loathe to interfere.

Schedule 4 provisions exclude the possibility of a HSC investigation but they do not preclude the possibility of gathering information on clinical matters if the HSC regards it as a necessary preliminary, consequence or is dissociated from the subject of the complaint itself.

In W25/74-75 (W7/76-77) a widow complained about certain aspects of her deceased husband's treatment. Many of the allegations concerned his medical treatment. The HSC said:

> "Certain of the points raised by her touch on matters of clinical judgement which are outside my jurisdiction. I have, however, had to seek information from the doctors about the patient's condition and treatment in order to arrive at an understanding of the circumstances which gave rise to the complaints."[3]

On/...

On other occasions, according to the circumstances of the case, the HSC may construe the complaints as going beyond the exercise of clinical judgement. In one case, W7/73 (C311/T), this brought the HSC into conflict with the DHSS. A man complained about his late wife's hospital treatment and, in addition, about the way the DHSS handled his complaints. The HSC did not find the complaint substantiated but noted that the reason the complainant was annoyed with the DHSS was because the DHSS refused to deal with his complaints since it considered that all the main complaints related to clinical judgement. The HSC investigated the case on the basis that the complaints of inadequate supervision and poor communications raised matters going wider than the exercise of clinical judgement. This is a decision which, on the facts, seems contrary to other decisions (see supra).

As well as the "wider than" formula the HSC has also taken the view that where a decision could be both clinical and administrative, and is questionable on administrative grounds the complaint will be upheld. In/...

In the infamous Rhyl case (WW28/76-77) a 103 year old patient was admitted to the Accident and Emergency Unit of a hospital late at night. After determining that the patient had not sustained any fractures, the Senior House Officer discharged her. The old lady died shortly after being delivered to her home, The HSC said:

> "No doubt he (SHO) took his decision to discharge her in the exercise of clinical judgement on which I cannot comment. Nevertheless I can only consider a decision to discharge a lady of 103 at 2 a.m. on a cold November morning as inhuman"

The two sentences seem to contradict one another. The SC on the PCA explained it like this; the Senior House Officer made a clinical decision to discharge the patient but then he should have made an administrative decision to detain her until the morning because of her age.[4]

Sometimes the HSC can use other provisions of the Act to give complainants satisfaction where the main body of their complaints relates to/...

to clinical judgement. In W290/75-76 under the heading of "misunderstandings" the HSC investigated a man's complaint about his treatment. The HSC said he could not look at clinical judgement.

> "But, because the complainant clearly felt he had not had a satisfactory explanantion of what had happened to him, I decided to investigate whether this had been due to some failure in communication."

And again in W265/76-77 the HSC investigated a doctor's decision to allow a patient out of bed on the basis that the doctor did not have all the information to hand to make a reasoned decision.

Successive HSCs seem to be increasingly flexible on this matter. This is illustrated particularly well in a case which involved first, Sir Alan Marre, then Sir Idwal Pugh. In W112/74-75 Sir Alan Marre rejected a complaint brought by a widow about her husband's treatment in hospital and in particular the actions of his consultant. The complainant then wrote to her MP and as a result of his intervention the HSC agreed/...

agreed to investigate the complaint on the grounds of the AHA's inept handling of the complaint at first instance.

Even in cases which manifestly concern themselves with complaints about clinical judgement the HSC may find a means of conducting an investigation. In W209/75-76 the HSC examined the actions of doctors taken during the diagnosis and treatment of illness in order to determine whether or not they stemmed solely from the exercise of clinical judgement. In W433/79-80 the HSC initially refused to investigate a complaint about the discharge of a patient with an undiagnosed fracture but in the course of investigating other complaints he discovered the existence of a missing radiologist's report on the fracture and then agreed to take up the case.

In W342/76-77 a patient complained that for three months during 1976 his consultant had refused to treat him. This was a clinical decision taken by the consultant because the patient's medical records were lost. The HSC was thus excluded. But the consultant freely admitted that he had/...

had exploited this patient's dilemma in order to demonstrate to the administration the inefficiency of the medical records services and to protest about the loss of a valued clerk. The HSC said the consultant's motives took him well outside the normal meaning of clinical judgement, and he upheld the complaint.

In W439/79-80 a patient complained about a consultant's refusal to authorise the supply of a breast prosthesis following an operation. On the face of it, this was a clinical decision but the HSC discovered that the consultant had never, thoughout his long career, made such an authorisation. The consultant admitted that his decision was taken on personal not clinical grounds and the HSC investigated the case.

W236/75-76 a woman was sterilised without her consent because, though capable of functioning in the community, she was mentally defective and in the opinion of her parents and consultant was at risk of being sexually exploited. The consultant had taken the advice of the Medical Protection Society and obtained/...

obtained the opinion of the parents. The HSC investigated the case to see if the decision to sterilise the woman stemmed from solely clinical and not social reasons. As a lawyer he was possibly influenced by the gravity of a case which constituted delict but which was unlikely to be pursued through the courts. It is also significant that this practice is condemned by the MDU.[5]

However, in case W414/80-81, the HSC did, in effect, criticise a consultant for a clinical decision. The HSC appeared to think that the consultant was hiding behind the shield of clinical judgement and in the under-stated restrained language of government papers told him so. The case concerned a fatal accident to a patient following discharge from hospital. The complainant (the patient's brother) contended that the consultant in charge had not seen his brother's medical records and therefore did not know of the patient's suicidal history.

The complainant based his contention on the events at the coroner's inquest. The solicitor asked/...

asked the consultant why he had discharged a patient with a record of suicide attempts. The consultant had replied that he had no knowledge of any previous suicide attempts.

In fact, the consultant had read the medical records including a reference to a drug overdose but he said there was a clinical difference between suicide threats and suicide attempts. The drug overdose just referred to was not a suicide attempt, he said, but just an act to draw attention.

Conscious that he could not argue the point, the HSC made this acerbic comment:

> "In his evidence to me the consultant said that he saw the clinical notes and he explained why, in his clinical judgement, which I cannot question, he told the coroner that he had not seen any reference in them to an attempted suicide... But I am not surprised the complainant made this complaint to me because not every layman could reasonablybe expected to appreciate the clinical distinction drawn by the consultantwithout explanation."

(ii) The HSC will also reject cases relating to other matters excluded by Schedule 14. These occur less frequently and the HSC is/...

is more willing to penetrate below the surface of a question which apparently relates to an excluded matter to find something which can be made the subject of an investigation.

Schedule 14(5) prevents the HSC from investigating contractual or commercial transactions between health authorities and outside bodies but the HSC investigated case number Q117/75-76 in which a guest-house sued the hospital for compensation for damage caused by one of their patients.

Scheduled 14(3)(a) prevents the HSC from investigating complaints dealt with under the NHS service regulations. But in WW15/75-76 the HSC investigated the handling of a complaint during the informal stage prior to invoking the regulations. Some FPCs, in England, are unwilling to bear even his slight intrusion into their jurisdiction and in this case the FPC refused to release papers to the HSC or comment on the case until the SC intervened.

Recently,/...

> Recently, the HSC initiated an investigation into the actions of a FPC to compel it to invoke the formal procedure as requested by the complainants.[6]

> Schedule 14/(4) prevents the HSC from investigating personnel matters but in HSC AR HC407(1974-75) the HSC took up a complaint that a hospital staff member had been dismissed for taking complaints to the hospital authority. The HSC acknowledged that personnel matters were excluded from his jurisdiction but that since the subject of his investigation was the way that the AHA had handled the complaint he was also entitled to enquire into the associated allegation of victimisation.

(b) Affirmation of Competency.

The HSC has to satisfy himself that the complaint concerns a failure in the service or a failure to provide a service or some other act arising from maladministration. This can result in the HSC being brought into the area of policy making where political/...

political considerations loom large. In WW11/76-77 he investigated the closure of a hospital, in SW43/76-77 he investigated the change of use of a maternity hospital and in W313/75-76 he investigated the refusal by the AHA to introduce a comprehensive family planning service.

In W11/75-76 the question was whether the inability of a NHS hospital to accept a geriatric patient resulting in her enforced admission into a private nursing home constituted a failure to provide a service as laid down by S93(2)(a) of the 1978 Act. The HSC had regard to the future resources of the NHS and to the infinite number of competing demands made upon it but concluded that there had been a failure.

In W5/55/79-80 (C429/79) the question concerned the refusal of a hospital to release medical records to the patient. The complainants had a legal remedy[7] without doubt, so was it maladministration for the AHA to require the complainants to go to the trouble and expense of taking legal action to secure their rights? The HSC held that it was.

In W246/77-78 the HSC had to decide whether/...

whether the failure of a hospital authority to obtain the consent of both parents to surgery on their child amounted to maladministration. The father possibly had a legal remedy since there is case law on the subject of consent to treatment. However, there was no court decision on this particular point and the doctor's actions were consistent with DHSS guidance so that the HSC concluded that the father had not made out his case.

In comparison in case W414/78-79 the complainant alleged that the hospital authority released her medical records without her consent. The AHA took the view that there was no maladministration since case notes do not belong to the patient because their consent to release is not required. The HSC challenged the legality of this view.

2. The exercise of jurisdiction.

The HSC will only undertake an investigation if he is satisfied that there is prima facie evidence that a failure or act of maladministration took place. He will only uphold the complaint if he finds that the failure or other act resulted in hardship or injustice and that there was a direct causal link between the two.

In/...

In W136/77-78 a boy was found guilty of burglary and committed to a special hospital under the Mental Health Act, 1959. His health region did not have such a hospital and the boy was transferred to another region, causing him to be isolated from his family. The question was whether this amounted to hardship or injustice. The HSC concluded that failure to implement government strategies could not be construed as causing hardship.

Similarly in W334/76-77 an MP complaining about a two year delay in the conversion of a hospital had to show hardship.

In these cases, where the HSC has been drawn into the policy arena, it is difficult to avoid the conclusion that any decision taken by the HSC will be largely subjective. The HSC tries to place his decisions in an objective context in order to divert this kind of criticism. For example, in W324/77 a patient complained of the lengthy waiting times in the out-patient department of the eye clinic. In considering whether or not the complainant had established maladministration the HSC looked at a number of reports and comparative studies of out-patient department management in the NHS before reaching his decision.

As the enclosed photocopied letter of rejection shows/...

shows the HSC requires there to be more than trifling injustice or hardship.

In most cases it is easy to establish the causal link between the act complained of and the hardship or injustice suffered e.g. poor kitchen management leading to cold food in the wards. It is more difficult when patients suffer pain, injury or death and complainants leap to attribute it to some supposed act or omission. Many complainants seem unwilling to accept that the present state of medicine is still unable to deal with all illnesses and the consequent suffering. This is particularly true in maternity cases where the patient expects a happy outcome and will inevitably link an untoward conclusion with any unsatisfactory incident which took place.

In W43/79-80 an expectant mother was admitted to hospital for the delivery of her baby. During the oversight of labour nursing staff only were present but when they thought the baby was about to be born they telephoned the senior registrar. The registrar was asleep in his hospital room while on night duty call. He answered the telephone and then inadvertently fell asleep again. He awakened 40 minutes later and remembering the case rushed to the maternity suite. When he arrived he found the baby had been born dead. Not surprisingly, the parents complained that if the doctor had come promptly the baby would have lived. The nursing staff said they had not thought to telephone again despite the electric monitor readings showing foetal distress because/...

because they did not really expect the doctor to arrive in under fifteen minutes and anyway they thought they were qualified to deliver the baby themselves. The HSC was not able to establish that the presence of a doctor was necessary at a delivery despite the parents' opinion and naturally could not say that the baby would definitely have lived if the doctor had been present.

Part III Substantive Issues.

Introduction

The group "Justice" said in relation to the PCA system that one of its principal advantages was that:

> "The PCA helps to set and maintain standards of good administration for government departments." It qualified this by saying that "he (PCA) does not seek to formulate these standards in any single document or code, and no formal system of precedent exists."[1]

This statement is equally true of the HSC Nowhere are the standards by which NHS staff are judged made explicit. Staff, and the wider public, have little or no idea what constitutes a valid complaint. We can only deduce what the standards of good administration might be from the published reports. This is not always easy. The reports sometimes/...

sometimes give the impression that the conclusions have been plucked from the air, as if the HSCwere trying to attain justice without reference to objective standards. Yet gradually, inevitably, the HSC has developed standards since otherwise no concept of "maladministration" or "failure" could have emerged. This is a well-recorded legal phenomenon. Robson described it thus (in the context of tribunals):

> "What appeared at first as an arbitrary discretion wielded by an irresponsible official, gradually crystallised into a body of known, ascertainable and consistently applied law.[2]

One of the difficulties for the HSC in 'formulating' standards is the wide variety of problems thrown up by the NHS.

In 1971, Justice tried to circumvent some of these problems by proposing the formulation of principles of good administration to be of universal application.[3] Justice agreed with the later comments of the HSC that the main difficulty would be in formulating principles which would be wide enough to meet all the circumstances, but not so vague as to be meaningless.

Further controversy surrounded the question of whether such a code would be advisory or mandatory. If the code were merely advisory then what sanctions could/...

could be imposed for non-compliance? On the other hand, if the code were mandatory there would be all the attendant difficulties in drafting legislation, already touched on, as well as the difficulty of raising support in the House.

In the end, Justice recommended the publication of a code of "guiding principles". If one were flouted this would constitute prima facie evidence of a breach but would not give rise to any automatic right of resort to the Ombudsman.

We do not seem to be any nearer to the implementation of the Justice proposals. Meanwhile, we rely on the HSC as a kind of mediator between officials who are required to meet certain standards and individuals who might be prejudiced by a failure to meet those standards. It is therefore possible to discern a process by which administrators may deduce what is expected of them, and the public benefits from this. The HSC has publicly regretted the high cost of his reports which prevent their free circulation throughout the NHS administrative staff circles.[4]

The process of evolving standards has been a slow and low-key one. Perhaps for this reason the HSC's work has not always been fully appreciated.[5] The SC reports have not been as scathing in their criticism as observers would like. Critics assume that because the reports are mild in tone they are ineffective/...

ineffective but any Ombudsman-watcher can discern just how strong the HSC views are, if not the words. In W535/80-81 the HSC investigated another complaint from a hospital previously investigated by him. He said "I sincerely hope that their (hospital staff) efforts this time will mean I do not have again to investigate a complaint about communications with relatives at this particular hospital."

The remedies obtained by the HSC are not always concrete or substantial. The office of HSC helps redress the balance between vulnerable individuals and a large bureaucratic organisation. It does this by upholding their rights established in law but not fully enjoyed because of other obstacles e.g. the unlawful detention of patients in homes for the mentally ill, and by extending their rights beyond the law into other areas, e.g. the right to be treated kindly.[6]

In his Annual Report, the HSC analyses complaints according to their subject matter. The six main headings are:-

I. Administration
II. Failures in service
III. Medical
IV. Dental
V. Nursing
VI. Handling by authority

Each/...

Each of these headings is then further sub-divided into more specific subject headings e.g. under I you might find "outpatients". The process of subdivision could be a long one, so it is best to follow the more general headings. Some headings throw up rules which are applicable only to the subject matter at hand e.g. I might throw up very detailed rules for handling of waiting lists whereas under III and V we expect to find certain rules being universally applicable e.g. need for considerate treatment of patients.

The following are some of the areas which the HSC has considered in the past, and criticised.

I. Administration.

(a) Manner in which policy decisions reached.

Both in the closures of surgeries (W17/73) and the closures of hospitals (WW11/76/77) (SW19/78-79) the HSC stressed the need for full and speedy consultation with local groups; the importance of acting on full and accurate data; and the necessity of considering the hardships which might be imposed upon local residents. A DHSS circular already exists incorporating these principles but its status is merely advisory. The fact that where the Health authority concerned flouts the consultation procedure the HSC is/...

is likely to hold this as maladministration means that the HSC has given the DHSS circular mandatory status. But, in W255/78-79 where there was a proven failure in the consultation procedure the HSC held that, in the circumstances of the case, this did not amount to maladministration. The case is an interesting practical illustration of the difficulties which Justice have already considered, in theory, in relation to codes of good administration. The case shows the inflexibility of a mandatory code and the weakness of an advisory code because it will only become public knowledge when a determined and well-organised pressure group make efforts to uncover it.

(b) Need for Procedures.

The HSC has been particularly successful in highlighting areas of NHS administration where there are no standard administrative procedures in practice. In the early days, many complaints related to the inadequacy of administrative arrangements for investigating and taking action on complaints, despite earlier government reports on the subject. The HSC found that some health authorities and some individual hospitals had not taken action to implement/...

the government's recommendations. There was confusion at every level of hospital administration.

The impact of the HSC on the NHS has been such that he no longer receives so many complaints about complaint-handling at ward or hospital level, which suggest that he has been responsible for hospitals formulating and adhering to new procedures. But he is still concerned by the way in which health authorities tackle complaints. so much so, that this forms a separate category (VI) in his analysis of grievances.

The HSC has also held that the lack of procedures for handling patients' property constitutes maladministration.[7] In some of these cases he has been successful in obtaining compensation for lost articles from health authorities in the form of ex gratia payments. (W310/75/76) (W149/74-75).

The public is concerned by the more public scandals of surgical waiting lists and waiting times in out-patient departments. The HSC accepts the need for both but says that where they exist a more efficient and imaginative system of management would, at least, make them more acceptable/...

acceptable to patients.[8]

In W6/73 the HSC sympathised with the difficulties of administering admissions to an intensive care unit and showed appreciation of some of the finer points of inaccurate statistics for patient turnover with the resultant difficulty in compiling balanced operating lists. But, he then went on to criticise poor and incomplete record keeping which perpetuated an inefficient system. And, he accused staff of all levels of insensitivity to patients' anxiety caused by delays and postponements. He said that a provision for information and regular review of waiting lists was an important component of any efficient management system.

Of course, waiting lists are not entirely within the administrative domain. Consultants are responsible for determining priorities within waiting lists. This is an exercise of their clinical judgement with which the HSC cannot interfere. In W204/78-79 a consultant carried out no operations at all because she considered the accommodation to be unsuitable. The HSC called this a "professional decision" (a recognition that it was not entirely a clinical matter but certainly had a bearing on clinical affairs) and refused to comment/...

comment on it.

In Scotland the HSC was responsible for highlighting a gap in the complaints procedure and having it remedied. In SW18/78-79 the complainant found that neither the principal doctor nor the Health Board (acting through its service committee) was responsible for a GP's locum. The HSC found that there was a responsibility gap in the legislation and succeeded in securing from the Scottish Office a new reading of the NHS service regulations which resolved the problem.[9] It is indicative of the power of attention the HSC commands because the Scottish Office of the British Medical Association had already raised the matter in Parliament through Scottish MPs without success.

(c) Detention in mental hospitals.

The HSC has encountered some of his most difficult and controversial cases in mental hospitals. The Annual Report for 1981-82 concentrates on the need for adequate supervision of patients but in the past he has had notable success in cases of unlawful detention.[10] The HSC's vigilance has nudged health authorities into an increased awareness of mental patients' rights./...

rights. The HSC made the health authorities realise that breaches of the Mental Health Act, 1959 are not merely technicalities. In W329/75-76 the HSC was successful in obtaining a substantial ex gratia payment for a patient unlawfully detained in hospital.

II. Failure in Service.
e.g. Ambulance.

The majority of complaints in this category relate to the delay in obtaining an ambulance either from home, or from the hospital itself. However, occasionally there are complaints about the total unavailability of ambulances. Most members of the public are unaware that where an ambulance is medically indicated, the patient is entitled to the use of a private taxi. But misunderstandings between patients and administrators do occur. In W282/75-76 the HSC was successful in obtaining compensation from a health authority for a patient who had been required to take a taxi to hospital.

III. Medical

(a) lack of or incorrect information.

Complaints about the low level of communications between patients and doctors are now an accepted public response to alleged medical arrogance. This is a matter of/...

of some importance since effective communication is believed to be a crucial element in patient compliance with treatment.[11] It is also important since it may result in an infringement of patients' rights. There may be a patient's right to dignified treatment: e.g. in W309/77-78 a patient was not told that she had a right to object to the presence of students during treatment.

Complete and accurate information is also the basis of informed consent to treatment, the lack of which constitutes maladministration.[12] The HSC has had to exercise special caution in cases of consent to the administration of electro-convulsive therapy (E.C.T.) Wherever mental patients are concerned it is difficult to prove the absence of consent or otherwise. In two cases (W397/76-77) (W249/75-76) the HSC went beyond the minimum legal requirements in instituting safeguards for the interests of patients e.g. obtaining the consent of two doctors to treatment rather than just one.

(b) Attitudes.

The HSC has said: "... there is an underlying consideration which seems to me to be present in most if not all the cases. That/...

That is the problem of communication."[13] This is a problem common to doctors (category 3) and nurses (category 5). It underlines much of what has been said already in section (a) (supra) and contributes to some of the complaints which arise in section (b).

In W48/77-78 a woman complained about staff rudeness when she attended a dental hospital for treatment. The staff there did not think that the woman had an appointment and mistakenly ordered her to leave. The HSC concluded that the whole affair should be dismissed as a misunderstanding.

In W19/79-80 a pregnant woman who had a miscarriage complained of the doctor's callousness. The HSC concluded that the woman had mistaken clinical detachment for a lack of sensitivity. Whereas in W181/77-78 the HSC condemned staff for the abrupt manner in which they had told a mother that her baby had Down's Syndrome.

In most cases of this kind the HSC is unable to come to a firm conclusion. Even where witnesses are present to an altercation, they are usually unwilling to go as far as saying that a colleague was rude or insulting. In W38/79-80 a complainant said that a consultant had been rude and insulting. The consultant/...

consultant himself admitted that he had been "short" in his dealings with the patient. The HSC held that this was by itself insufficient and that there was no other evidence to support the complainant's allegations.

IV. Dental.

The HSC receives very few complaints about the provision of dental services. There is no empiric evidence to explain why this should be so but it is interesting to speculate on the significance of the patient's right to choose his dentist at will. In W387/80-81 the HSC investigated a case which typified a widespread but unknown practice; dentists were providing treatment, charging the patient private fees and then belatedly pointing out that the patient had not made it clear that they wished to be treated under the NHS. In this case, Mrs. A. had assumed that she would be treated under the NHS unless she expressly asked for private treatment. She complained to the FPC who refused to handle her complaint because it was out of time. She then referred the matter to her MP who asked the FPC Administrator if he would, nevertheless, give the matter some consideration since it gave rise to public concern. The Administrator refused. The HSC investigated the case and made his displeasure clear but the Administrator refused to apologise to either the/...

the MP or the complainant. The Administrator in question was called before the SC and the apology demanded was made.[14]

V. Nursing.

Failures in care.

The HSC cannot investigate nurses' actions which are in exercise of their professional judgement or that of a doctor but he does investigate allegations of neglect, dilatoriness or abuse. Such complaints can arise from the public's natural ignorance of modern nursing procedures. Some patients' relatives are shocked by the very business-like approach which hospital staff adopt towards their charges. For example, in X3/74-75 allegations of cruelty were made against the staff of a hospital for the mentally handicapped. The HSC found that a degree of physical restraint used in the wards was typical of that used elsewhere in the country. It may have upset visitors but it was in accordance with standard nursing practice, and as such the HSC could not criticise it.

In another case (W7/77-78) a complainant found that her elderly mother's body had developed bruises, and accused the nursing staff of cruelty. The HSC commented that he heard so many cases of this kind that he might be forgiven for suspecting widespread abuses in the NHS. Only experience had proved conclusively that elderly people, especially inactive and/...

and prone ones, were all too easily susceptible to bruising and anxious relatives often misinterpreted this.

But, in a similar case, (W153/80-81; death from infection caused by pressure areas) the HSC criticised the prevailing nursing philosophy that bed sores are a fact of life in a geriatric ward. No doubt he was influenced by the seriousness of the case but he was able to go as far as this supported by the report of the area nursing officer that conditions were superior in other geriatric wards.

VI. Handling by Authority.

This category deals exclusively with complaints about the way Health Boards and AHAs handle the complaint at first instance. Case W140/75-76 is typical of many which the HSC receives. The complainant said that the AHA's replies to his letters were unsympathetic to the point of callousness and totally inadequate: they did not answer the questions he had put. The HSC concluded that AHAs wrote letters so as to discourage complainants from pursuing the matter because they were overly concerned with the comparatively remote possibility that litigation was pending. The HSC has said that authorities must adopt a less secretive manner. Specifically, they should answer the question put to them and make some sympathetic reference to a bereavement, or other tragedy, without legally compromising themselves.

But/...

But in WW40/80-81 the HSC praised the authority for the way thay had handled a complaint. The authority in question had admitted the error, apologised for it and proceeded to remedy it.

Where a complaint made to a health authority reflects on the competence of staff the authority may hold an internal inquiry. As these inquiries are prompted by complainants' allegations they may find it difficult to understand why they are excluded from the process or finding out its conclusions.

In W14/77-78 the HSC criticised an authority for failing to report to a complainant the findings of an inquiry. In W19/76-77 the HSC condemned an authority which had suppressed and misrepresented an inquiry's findings of negligence to a complainant because they had feared the threat of legal action. But the HSC has not said that complainants have a right to be present throughout inquiries.

Conclusion:

Usually the HSC is content to uphold a complaint without further comment. He saves his worst for the people who bring complaints and those against whom they complain. The HSC performs a delicate balancing act between not wishing to deter complainants but condemning those who use his services frivolously. It is important that from the point of view of NHS/...

NHS staff, the HSC should not just be seen as a critical, negative institution. In a case which was to receive nationwide publicity the HSC condemned the complaints brought as "trivial", "unreasonable" and fatuous." In another case, involving the forcible administration of electroconvulsive therapy the HSC was unable to find evidence of maladministration but this did not prevent him from accusing the clinical assistant involved of being "less than frank" in his interview.[16]

Doctors and AHAs are in a very powerfull position and the HSC is particularly quick to condemn if they seem to be abusing it. In W122/74-75 the HSC deplored the consultant's decision to withdraw from a case because his patient had complained to the HSC and allegedly forfeited his trust. The HSC used the strongest terms possible to condemn this action which he thought jeopardised and undermined the entire complaints procedure system in the NHS. But in W134/74-75 the HSC accepted that a consultant had a right to withdraw from the case where the patient had complained to the HSC about an administrative matter connected with her treatment simply because the terms of the complainant's letter could be construed as implying that the patient was questioning her consultant's treatment of her.

It must be obvious from the examples cited above that in some cases the principles enunciated by the Commissioner/...

Commissioner are too specific to be of general interest. But, through all of them runs a theme, uniting them:

> "The public have a right to expect that it will be provided with a full sense of service to them. This goes well beyond efficiency...
> People... want to feel... they have been treated with understanding, courtesy and consideration."[17]

CHAPTER 4 FOOTNOTES

1. HC HSC Annual Report 1981-82 HC 419 (Session 1981-82) p.10 4.03 grievances per complaint on average.
2. H. Wade, "The British Ombudsman: A Lawyer's view" Administrative Law Review, 24(a) p.137 1972
3. A.W. Bradley "The Role of the Ombudsman in relation to the Protection of Citizens' Rights", Cambridge Law Journal 39(2) pp 304-342, November, 1980
4. Information received from Mr. G. Keil, Office of HSC

PART I.

1. References to cases follow the notation provided by the HSC. Initial letter refers to the geographical source: W - England; WW - Wales; SW or SX - Scotland. Subsequent number refers to the number of case in that year, last four numbers refer to the session in which complaint was first lodged.
2. W260/76-77
3. cf. the Portugese Ombudsman who asks complainants to complete a questionnaire
4. SW40/76-77
5. W43/79-80
6. A.W. Bradley, op cit
7. see WW13/75-76
8. HC PCA 4th Report HC 351 (Session 1979-80) p.48
9. W255/78-79
10. W271/77-78
11. see for example, the HSC and PCA W111/75-76 HSC and CLG W219/76-77

Part II.

1. C. Clothier op cit
2. W204/78-79
3. W25/74-75 para. 5
4. D. L. Williams "The Health Service commissioner and the Rhyl Case" BMJ p.1090 14.10.73
5. Shortly after, Heilbron, J. held that sterilisation for non-therapeutic purposes was not within a doctor's clinical judgement. RE "D" (A Minor) High Court of Justice, Family Division September 1975
6. W541/81-82
7. Administration of Justice Act, 1970 s31, McIvor v. Southern Health and Social Services Board, (1978) 2 A11 E.R. 625

Part III./...

Part III.

1. Justice "Review of Administrative Law in the U.K." A Discussion Paper p.35 para.106 (ii) April 1981
2. W.A. Robson "Justice and Administrative Law" p.35 London 147
3. Justice "Administration under the Law", 1971
4. HSC in evidence to the SC on PCA, HC 23.11.82
5. cf Views of Dr. D. Buchanan (Secretary to the Scottish B.M.A.) that the abolition of HSC would make no difference at all 22.9.11
6. A. Marre "Thoughts and Experiences of the first HSC" Royal Society for Health Journal Vol. 96(4) p.150 August 1976
7. HC HSC 3rd Report HC417 (Session 1977-78) paras. 49-56
8. HC HSC 1st Report HC407 (Session 1974-75) para. 7
9. BMJ Vol.284 23.1.82 p.287
10. HC HSC Annual Report 1981-82 GC419 (Session 1981-82) paras. 59-67
11. BMJ Correspondence "General Practice Compliance Study" Vol. 282 p.1470 2.5.81
12. HC HSC 4th Report HC322 (Session 1976-77) para. 28 and e.g. WW6/77-78
13. ibid para. 4
14. W. Russell, "Letter from Westminster" BMJ p.1131 10.4.82. W198/79-80 and L. Saunders op cit
15. W198/79-80 and L. Saunders op cit
16. W397/76-77
17. A. Marre op cit

CHAPTER 5

THE ANNUAL REPORTS OF THE HEALTH SERVICE COMMISSIONER (1973-1982)

Introduction

The HSC is required to report on the performance of his functions to the Secretary of State for Scotland.[1] And similarly, as HSC in England and Wales he is required to submit reports to the Secretary of State for Social Services and Secretary of State for Wales, respectively.[2] To date, the HSC has submitted a single report annually commenting on all three countries to the three Secretaries of State.

Since the creation of the office of the HSC in 1973, the Health Service commissioner has published an annual report the first of which, however, covered only a six month period. The annual reports are our major source of information about the HSC. The published reports of investigations tells us what he does, but the annual reports tell us why he does it and how. It is all the more lamentable then for Ombudsman-watchers, and the public in general, that the reports are so uncompromisingly bureaucratic in tone, unattractive in presentation and expensively packaged.[3] One could say that this is true of all Parliamentary papers but one might have hoped for some concessions from the Ombudsman in acknowledgement/...

acknowledgement of his role vis a vis the consumer.

Structure and Form

The reports do not form a single homogeneous group. The most marked difference is between the first three reports and the following six. The first three reports, as well as being annual reports, are also the first of a series of reports made in the year by the HSC reporting on investigations.

In 1976 it was decided that investigated cases should be published separately and the annual report became thereafter a distinct document with its own cover and title differentiating it from all other publications from the HSC Office.

1. A most important influence on the content of the annual report is the form which the published investigations take. For example, in 1973 the HSC had only been in existence for six months and had issued only 23 reports of investigations. In the appendix to the 1973 annual report the HSC gave summaries of 19 of the cases and this necessarily confined his Annual Report to only three pages of comment. Of course, in those early days the HSC had very little to comment on, and he did not use the Annual Report as a means of explaining his function or publicising his existence; he had separately published leaflets for that.

In/...

In the Annual Reports for 1974 and 1975 the HSC had many more reports of investigations to summarise and because the complaints were becoming more complex and raising more points of grievance each summary became longer. The Annual Reports for these years are much longer than the 1973 Annual Report but the amount of space devoted to the Annual Report proper remained practically the same.

In 1976 reports of investigations were first published separately. This gave the HSC more room to expand the Annual Report. Previously he had written the Annual Report in the form of a series of short paragraphs with sub-headings. Now, he retained the sub-headings but expanded on them, for sometimes two pages at a time. But the result was still a slim leaflet which read like a short address.

In 1977, the HSC introduced chapters and in 1979, an index of contents. In 1983 the HSC introduced a separate section summarising the facts and findings in each case. He hoped National Health Service staff would use this to identify those cases which they would like to read in full, rather than dismissing the whole document because it was too long.[4] With each succeeding year the Annual Report became fatter, relying more and more on tables and statistics to make sense of the investigations. As long as the investigations are reported in a manner which makes the volume incomprehensible, i.e. lack of subject not content index then a major function of the/...

the Annual Report will be to reorganise the material on investigations in a thematic way as well as commenting on the significance of whatever themes now became apparent.

2. Naturally, what happens in the previous year affects the form of the Annual Report which emerges at the end of it. As the HSC has said "the nature of my workload, depending as it does to such an extent on unrelated and unpredictable events, means that some fluctuation from one year to another will be inevitable.[5]

Although there is a common core of subjects which are dealt with every year, some subjects which emerge as full-blown chapters are omitted in succeeding years. For example, in 1973, when the office of the HSC was still an unknown quantity, the HSC included sections on the background to the creation of the office, the procedure which he followed during the investigation of a case, and the role of medical advisers, none of which he ever mentioned again presumably because they have remained unchanged.

Similarly, in 1979 the HSC took space to deal exhaustively with a topic to which he had previously only referred, "complaints which are not investigated".[6] He described, in the form of a verbal flow chart, the process by which complaints are screened to determine whether or not they are within the HSC's jurisdiction. He demonstrated amply the lengths to which he and his officers go to ensure that/...

that cases are only rejected as a last resort. The complainant is given every opportunity, through further correspondence and interview if necessary, to show that his complaint or part of it is within the HSC's jurisdiction. If the HSC does reject a complaint, as well as giving reasons for doing so, he tries to suggest alternative remedies so that complainants are not left feeling too dissatisfied.

Nevertheless, as the HSC himself recognises, the very high rate of rejection[7] does mean that there will be many disappointed complainants.[8] At the moment the HSC is more concerned with trying to educate the public as to his true role than with compaigning to amend the restrictive sections of the legislation which give rise to the problem in the first place.

3. A third consideration which affects the Annual Reports is the personality of the HSC. Obviously this is a factor which affects style more than content but it is interesting to note that the publication of the first Annual Report proper coincides with the replacement of Sir Alan Marre by Sir Idwal Pugh as Ombudsman. With the appointment of Sir Cecil Clothier as HSC in 1979, the Annual Reports settled down into a more predictable style but this may be due to the fact that Sir Cecil has now held the post longer than anyone else as much as to hisown personality.

4. Recently, the expense of producing the report has become a consideration.[9] By this I do not mean the publishing costs which are inevitably entailed but the cost to the staff of compiling and drawing up tables/...

tables and statistics. This has not involved employing additional staff but diverting existing staff resources from investigative work. The HSC dropped a table from the 1981-82 Annual Report because he thought that the time and expense involved in preparing it was disproportionate to the value of the table. It is rather hard for a layman to understand this economic argument since most of the information which the HSC publishes in the Annual Reports is information which the HSC acquires anyway by virtue of his work. It is difficult to see what savings are made by simply not publishing it.

CONTENT

Introductions

The introductions to the annual reports are an excellent example of the changing style of the annual reports themselves. Increasingly, discursive and lengthier with every passing year the Health Service Commissioner draws together:

(i) conclusions about his year's work
(ii) comments on trends
(iii) highlights of his work which do not fall into any other category

(i) In the early years the introduction seemed to be simply the first paragraph. Nor is it a genuine introduction; a preliminary discussion of themes which are to be discussed in/...

in more detail later in the report.

The HSC has reached two main conclusions, both of which he reiterates constantly. Firstly, that despite great efforts on his part the public remains ignorant of the existence of the HSC, and those who do know of him misunderstand his function. Secondly, that the major factor underlying the majority of complaints is bad communication between staff and patients.

Neither of these conclusions is particularly helpful to those who would like to improve relations between NHS staff and the public. The HSC is partly at fault, as we shall see, because he spends so little on publicity and he spends it on the wrong things. There are no figures to indicate advertising costs but total expenditure by the 90 members of the combined PCA and HSC staff on travel, telephone, machinery, stationery, printing and advertising only comes to £155,000.[10] Even if one were to accept that in today's economic climate it would be unrealistic to expect that more money should be made available for publicity work, it will become obvious when we look at publicity in more detail that the HSC does not always dispense his funds effectively. Of course there will always be those who argue that as long/...

long as the HSC remains in his present state i.e. hedged about with restrictions and exclusions there will never be more than a minority of people who understand him properly, regardless of the level of publicity.

The HSC's conclusion that the major cause of complaints is bad communication will not surprise those already working in the health field. As early as 1966, Vera Carstairs working in Scottish hospitals highlighted communications as a problem.[11] The difficulties result from expert talking to layman, the psychologically strong talking to the psychologically vulnerable, the socially superior to the socially inferior.[12] It exists between staff and patients but can also exist in a modified form between various levels of staff.

Perhaps this may be putting the case too strongly, in so far as the general public are so much better educated about health and less in awe of professionals nowadays. But the problem does exist. The HSC does not make any positive suggestions as to how the problem could be resolved. He shies away from the solution that health professionals' training should be altered to take account of these human problems. Glasgow University Medical Faculty is hoping to implement plans for courses/...

courses on behavioural science in doctors' and nurses' curricula.[13] As with publicity, the HSC is very careful not to antagonise NHS staff and so adopts a studied, neutral pose. How at odds this is with the media image of the Ombudsman as consumer protector.

(ii) As more superfluous people have come to know about the HSC the rate of complaints has risen although the total made in any one year is still well below a thousand. As more complaints are being made, they are becoming more complex.

It is likely that one of the reasons is that most complainants undergo a series of experiences within the National Health Service rather than just a one-off happening. It may begin in their own home with a GP visit followed by a journey in an ambulance, delivery to an Accident and Emergency Unit, then a transfer to a hospital ward. Only then do their experiences in the hospital begin. This is capable of giving rise to multiple complaints which would be bound to complicate otherwise straightforward problems simply by virtue of the numbers of staff involved.

The significance of this for the complainant is that investigations may take more time than he imagined they would. It is to/...

to the credit of the HSC office that he has succeeded in slightly reducing the average length of time taken for an investigation despite the increasing workload.

Another significant trend has been the number of general enquiries which the HSC office receives, many by telephone. In 1977 the HSC mentioned these for the first time. Although they were not within his jurisdiction, strictly speaking, they were occupying an increasingly large amount of his staff's time.

It is appropriate that the HSC should report on how his publicly funded office is spending its time. He does not encourage enquiries, and does not advertise his office as an enquiry service but he thinks it right that people should be re-directed to the correct agencies or given advice if it is within his power to do so. This demonstrates the confusion in the minds of the public, the need for such a service and certain weaknesses in existing services, e.g. CABx.

This experience raises the questions whether the HSC should be doing a job which is not his and diverting resources from the more immediate problem of how to reduce the times for length of investigations. It is disappointing/...

disappointing that the SC on the PCA have not commented on this new self-acquired function, particularly in view of their own pre-occupation with the problem of publicity.

Another interesting trend, or lack of it, from the Scottish viewpoint are the Scottish statistics which have remained virtually static while those of England and Wales have risen substantially. That is until 1982, when the HSC came up to Scotland in February and March and spoke to the press, radio and T.V. By the end of the year, Scottish complaints had risen by almost 27% but almost half of this increase came in the months of February and March themselves. This suggests the increase is almost wholly attributable to the publicity created by the HSC Scottish visit - or to the HCS taunt that Scotland was an uncomplaining nation![14]

Reasons for the comparatively low level of complaining in Scotland are the greater concentration of the kinds of poeple who are the least likely to complain.

(iii) The HSC has taken the opportunity in his introductions to answer criticisms levelled at him and to redress the balance by emphasising the constructive aspects of his office.

It/...

is only natural that NHS staff should be on the defensive although the HSC is at pains to emphasise that he is a neutral investigative officer and not a consumer officer. Perhaps he is adopting an unrealistic stance for in the event he is doing precisely what NHS staff accuse him of; taking up patients' complaints against staff. NHS staff are notoriously suspicious of all forms of external accountability and there is probably nothing that the HSC could do to appease them short of recommending his own abolition.

Members of the SC on the PCA are confused in their thinking about the role of the Ombudsman. These MPs prefer to emphasise the Commissioner's Parliamentary links, and, by association, the idea of people's representative.[15]

What the HSC does do is to remind NHS staff that both he and they are working towards the same end, namely to inspire public confidence in the National Health Service.[16] It is rather hard to evaluate the degree of success of this plea to disinterestedness.

In the Annual report for 1981-82 the HSC went so far as to pinpoint 2 Area Health Authorities who had acted well in excess of what the complainants had the right to deserve./...

deserve. But it was rather an empty gesture for, of course, the AHAs were not named and so no credit accrued to them.

In the introduction to the 1979-80 Annual Report, the HSC publicly justified his recent decision to publish only summaries of the more important cases. This does make it difficult to talk about the cases in a meaningful way since we no longer have access to them all but it is an instant guide to those cases which the HSC thinks are significant. The Health Service Commissioner said that one of the main reasons why he decided to publish only a selection of the investigations was to make it easier for those working in the NHS to isolate those areas which are likely to give rise to similar problems. It is questionable whether this is true since the HSC still drafts cases in such a way as to obscure the general theme. The recent introduction of epitomes or abstracts is more likely to meet this need.

Another major concern of the HSC has been the question of clinical judgements made by medical and nursing staff. These have always been the main reason why he has been forced to reject complaints and the SC on the PCA took this up. In its report on hospital complaints the SC recommended that, as one way of reducing the high rejection rate,/...

rate, the HSC jurisdiction should be extended to enable him to investigate clinical judgements.[17] The HSC has given advice to the SC on the implications for his office of such an extension but did not participate in the decision of the SC to recommend extension.

The HSC refused to comment on the recommendation but probably still felt that he was too closely allied with the SC on the PCA in the eyes of National Health Service staff. In his Annual Report for 1981-82 he attempted to dissociate himself from the SC recommendation:

> "I have never suggested that complaints about clinical judgement should be brought within the remit of the Health Service Commissioner, but I have expressed the view that some recognised procedure for investigating complaints of this type was needed."[18]

This statement is perfectly true as an expression of the HSC's own intentions but it was well-known to doctors and nurses through the pages of their professional journals that the government fully intended to implement the SC recommendation unless the profession came up/...

up with an alternative.

Background, Procedure and Medical Advice

In his first Annual Report the HSC discussed these three topics because the office was so new that no-one really knew what his function was or his methods. One unanswered question then was how the HSC would fit in with existing complaints handling machinery such as the MWC in Scotland and the HAS in England. Experience has shown that the HSC has had no real problems in co-existing with other agencies. The problems have all been on the part of the patient who has to make sense of them all.

For that reason the HSC described what he would do with a complaint when he received it. He had his experience as PCA to fall back on and described exactly the same procedure. What he could not have foreseen then perhaps was how reliant the HSC would become on interviews. On the PCA side, staff investigate on the basis of civil servant files, but doctors' notes do not serve the same function and are much less informative. Also, complainants find it more difficult to articulate precisely what their grievances are.

There/

There have been few complaints about HSC procedure since it is so obviously fair to all parties involved. The only criticism that might be made is that the degree of fairness involved is at the expense of a speedy resolution.

In that first report, the HSC also thought it expedient to comment on the role of medical advisers. It will be recalled from Chapter 2 that this was a controversial item during the passage of the bill.

It seems now that the British Medical Association was over-reacting to an apparent threat to their members. The HSC has declared confidently that he finds no difficulty in deciding whether or not cases involve clinical judgement and very rarely calls upon his medical adviser. (But we are not given any statistics). No doubt the situation would change rapidly if a HSC took a less stringent view of his own jursidiction.

Appendices

The HSC has used an appendix to reproduce a letter which he sent to all the Chairman of Local Health Councils on their creation clarifying his position vis a vis the Councils. /...

Councils. The effect of it was to encourage LHC to become a "patients' friend" and advise them of their rights. Most LHCs now actively participate in the complaint-making process since they feel many patients are incapable of doing so for themselves. The HSC is happy to accept complaints from them in this capacity. The real difficulty is in restraining LHC who would like to take an even more active role even though it meant exceeding the terms of the legislation.

The early appendices were the means by which the HSC published summaries of some of the cases he had investigated. After 1973, when the cases were reported separately, the HSC expanded his section on the investigations. Now that the cases were no longer at hand the HSC had to summarise the details of the cases before he could comment on them. To a certain extent this defeated the point of separate publication since a great deal of space was still spent outlining the details of the cases and too little on identifying common themes.

Investigations

The HSC dealt with the investigations by identifying those subjects which had given rise to several cases of interest. It is interesting/...

interesting that over the years, despite the efforts of the HSC it is still the same types which crop up year after year but, as with statistics, the HSC is usually unwilling to commit himself in print by speculating why certain problems occur. This can have the effect of trivialising certain types of complaints which are all put down to clashes of personality for want of a better reason.

The most satisfying cases are those where the HSC identifies what has gone wrong and is in a position to recommend a course of action to prevent it from happening again. The HSC does not have a follow up procedure to see if AHAs or Health Boards have acted on his recommendations but occasionally they write to him to tell him that they have done so.

Certain groups of patients recur in the HSC investigations viz., the old, the pregnant and the mentally ill. Many complaints investigated by the Commissioner concern elderly patients. The course of the problem is that governments, both central and local have not yet faced up to the problem of what to do about our increasing geriatric population and so the old clog up the hospital system. No previous generation has ever had so many elderly relatives in hospital and their/...

their impression of the NHS is not a happy one.

Few of the complaints made relate to nursing care. In fact, many old people are not acutely ill. They just have the chronic illness of old age which require a little nursing care. Relatives expect elderly patients to be treated for their illness just like other patients but they also expect that treatment to be dispensed in a special way because the patients are old. Nurses are one of the last paid groups of people who are in a position to provide T.L.C. - tender, loving care.

The HSC tries to impress upon complainants that geriatric patients will not be cared for in hospital in the same way or manner as at home, but this does not necessarily give rise to a complaint.[19] Geriatric patients may seem depressed or under the weather. This is natural - they have just been moved into a strange disturbing atmosphere.

In this category of complaints, perhaps more than any other, the HSC must continuously explain and justify staff action. He takes the time to do so because, as he says elsewhere, the complainants are so obviously acting/...

with the best intentions.

Another group of patients who complain vociferously are expectant mothers. The problem here is not one of unexpected demand on the NHS because the birth rate has fallen and the slack in resources has been used to improve existing facilities so that they are now fully equipped. The problem is rather that mothers themselves now have a totally different attitude to childbirth. The majority of women control their own fertility, they decide when to have their baby, they practise regimes designed to make them healthier and they are not prepared to relinquish control to doctors at the moment of the birth itself. All this is at odds with the attitudes of staff who have been trained to "manage" childbirth without allowing the mother any say in the process. Gradually, hospital staff are beginning to recognise that mothers can be given a voice, which increases their satisfaction but which does not endanger the unborn baby. The HSC becomes involved in these cases where the staff are still set in the old, authoritarian ways.

A third group of patients who are frequently involved in complaints are the mentally ill and the mentally handicapped. One question concerns the competence of the mentally ill to consent to treatment especially/...

especially if it is treatment to which their relatives object e.g. E.C.T. Or the treatment may be one sought after by the relatives but to which the patient objects e.g. sterilisation. In this area, the HSC has been concerned by the casual standards followed by doctors. It is true that the legal and ethical situation is not always clearcut. The medical defence societies and professional bodies simply caution their members to err on the side of prudence but offer no guidelines.[20] The HSC stresses that mentally ill patients have the same rights as other, sane patients and these must be respected just as strictly because of, and not despite their mental affliction.

The HSC has also found that the staff of hospitals are rather lax about fulfilling the technical aspects of certification, the effect of which is to deprive someone of his liberty wrongfully. As with the question of consent to treatment the HSC is here meeting examples of what the voluntary organisations in the field of mental health have been complaining about for years.[21]

On the positive side, mentally ill patients enjoy a much more pleasant and freer regime than formerly. They may be free to leave their ward, even the hospital itself, to mix with other people, including people of the opposite/...

opposite sex. The price to be paid for this freedom is in suicides, accidents, illicit relationships and unexplained disappearances. Admittedly these are exceptional occurences but they are so serious that the HSC has dwelt on them at length in his Annual Reports. He considers that it is appropriate to interpret his function to justify existing mental health policies to relatives rather than to condemn staff outright for deficient supervision.

While the HSC was being established the Davies Committee was looking at the way hospitals handle complaints and they recommended a hospitals complaints procedure. The situation was much more stable in Scotland, but in England and Wales there was little uniformity or certainty about hospitals complaints procedures. It is not surprising then that in the first few years the HSC has some strong things to say about the way AHAs handled complaints. We have seen from Chapter 4, Part III the way AHAs mishandled complaints. The HSC believes that one reason, initially, was that hospitals did not have proper complaints procedures. That is less likely to be the case nowadays but the figures are still high. Why? The HSC believes that one reason is that AHAs are misled by their legal advisers who act very cautiously to protect/...

protect the AHA in the drafting of replies.[22] The HSC does not criticise legal advisers for doing their job. What he does say is that they act on this basis without a single shred of evidence that the complainant is considering legal action. The net result is to antagonise complainants who would not otherwise have taken their complaints any further.[23]

The view has also been expressed that some members of AHAs and Health Boards who used to be on the old Boards of Governors and Hospital Management Committees prior to reorganisation are much more autocratic and less committed to the ideal of a board of people representing community interests.[24] Certainly, the figures formerly published by the HSC breaking down the number of complaints by regional health authority area showed some disparities.

Each year, in writing investigations the HSC has gradually focussed fewer issues and at greater length. The usual form is still no use two or three cases to illustrate the heading which may be "events following deaths in hospitals" or "disclosures of medical records" but he usually prefaces these with a few sentences on why he receives complaints under this heading and what could be done to avoid/...

avoid them. He never does more than indicate a few generalities. By confining himself to this level of comment, he avoids controversy but still says enough to NHS administrators to let them know what standards are expected.

Publicity

One of the problems is that the HSC cannot assume that the public or NHS administrators know a great deal about him. The HSC hopes that NHS staff read his annual reports and cases of selected investigations but one would imagine that the cost and length of the reports are deterrents. Could the HSC not publish some of his main findings in circular form? It would be worthwhile if only to attract the attention of every member of the administrative staff and not just those who sit on the board.

Right from the beginning the HSC set out to present himself to the public in a simplified form. He did so, at first by printing leaflets (see enclosures). These are very uninspired items, with their dense, fine print and extensive quotations from and allusions to the legislation. It might be the kind of leaflet which is sufficiently informative and detailed to be of use to someone/...

someone working in an advisory capacity but it probably would not tell a member of the public much.

This form of publicity did not have a great effect on the numbers of people complaining nor the rejection rate. In 1975 the Department of Health and Social Security agreed to refer complainants to the HSC if they so desired and in 1976 the HSC recorded one of his highest rates of complaint ever.

In 1976 the HSC took a more positive and active approach in publicity campaigning by speaking to the press, radio and T.V. In 1977 the HSC stated in his Annual Report that he had employed the professional services of the Central Office of Information and had also published papers.

The HSC has said in his early Annual Reports that the success of his office depended on the public knowing about and understanding his office but he is prevented from embarking on a fullblown publicity campaign because it would lay him open to the charge of encouraging complainants, rather than simply making it easier for people to express existing complaints. In his Annual Report for 1977-78 the HSC tried to lay this ghost to rest. "But once I am satisfied that/...

that I am taking all reasonable measures to make my services known to the public I do not look upon it as my duty to stimulate complaints about the health service."[25]

The HSC started to talk to local press and local radio. The HSC's Scottish tour suggests this is a fruitful form of publicity campaigning. Before 1980 the HSC had confined his attention to the national radio network and the heavyweight national daily newspapers. He could probably achieve much more by gaining exposure in one of the daily tabloids or speaking on popular radio. One cannot imagine that this would seriously detract from his authority.

Even if the HSC were prepared to take such a radical step by stepping into the popular arena he would still have the problem of presenting material which cannot be readily simplified. In his 1981-82 Annual Report the HSC announced his intention of uniting with the PCA and local ombudsman to issue jointpublicity material explaining the role of the Ombudsmen (see enclosures). And, in a far sighted decision, the HSC announced the issue of a video on the work of the Ombudsmen for distribution to schools, colleges and interested groups.

External Relations/...

External Relations

The HSC has used his Annual Reports to clarify the nature of his relationship to the other Ombudsmen. This has always been a subject of confusion in the public mind. The problem for the HSC himself was cross-jurisdictional complaints.

In his Annual Report, 1973-74, the Commissioner said that the HSC office began well because it could rely on the experience staff had gained under the PCA. At this point the HSC said that having a combined PCA-HSC staff was an advantage in dealing with overlapping complaints. This was certainly true but the full advantages could not be taken because of the problems attributable to the legislation which created the fiction of two separate offices while allowing for the reality of one operational office. Thus, complaints containing PCA elements had to be routed through an MP while the HSC complaints came direct from the complainant. Fortunately, in a minority of HSC complaints they are also directed via an MP.

Additionally, if complaints combined HSC-PCA elements copies of the final report had to be issued to parties who would not normally/...

normally be allowed one if the complaint related to the Health Service Commissioner alone, viz. the MP. Furthermore, if the complaint combined HSC and local government complaints the HSC and local Ombudsman had to publish separate reports. One can imagine the chaos caused by a tripartite investigation.

In his 1977-78 Annual Report the HSC created a new separate chapter in his Annual Report entitled "External Relations" to explain the relationship of the HSC to the other Ombudsmen as well as voluntary and statutory organisations. This was explicit recognition by the HSC that he was just one agency in the complaints handling system. This was also the first year in which he started publishing statistics on general enquiries handled in the office.

In 1977 the HSC also announced that he had formalised arrangements with the other Ombudsmen in the event of joint investigations but did not make public their exact nature. When one considers that one man holds two posts, and that the PCA and HSC share staff it becomes harder to understand that justification remains for failing to unify the Ombudsman system in Great Britain.

The/...

The complaints handling system in the National Health Service has been allowed to grow in such a haphazard manner that it seems to throw up anomalies. For example, the HSC may investigate the way FPCs handle informal complaints, but not formal complaints. In Scotland, the HSC cannot investigate complaints against service committees at all. The HSC will not accept complaints from LHCs because they are not aggrieved individuals but will accept complaints from them if they are acting on behalf of a patient who is unable to act for himself.

It was not until the publication of the 1978-79 Annual Report that the HSC announced that he would actually notify the LHC that he had completed his investigation but still would not tell them the result of his report nor issue them with a copy of it. Not surprisingly, Local Health Councils were not very happy with the way they were being treated by the HSC. They thought that the HSC was not doing the public a service by insisting on such an independent approach e.g. in his publicity the HSC refused to allow himself to be connected with any other organisations. The Local Health Centres want to expand and link with other complaints handling/...

handling agencies in the interests of providing a unified service for the public. The HSC wants to remain strictly within the letter of the legislation and says he is not responsible for providing the public with a comprehensive statement about how to make a complaint about the National Health Services.

The HSC no longer includes a chapter on external relations in his Annual Report. Presumably he now believes that the Ombudsman's relationships are settled.

Staff

The HSC has good relations with the health authorities even after he comments upon them adversely in his reports. Some people would say that this is because he is not powerful enough so that the health authorities have nothing to fear from him, or even that his reports are so colourless that the press never pick them up and publicise the anonymous authority involved.

The HSC himself pays tribute to the tact of his staff in dealing with National Health Service administrators. One other reason must be that the HSC employs staff in his investigative work on secondment from the NHS. This/...

This means that they have friends and contacts in the NHS and know NHS methods and problems.

There are those who question whether the HSC can be really independent if he employs NHS staff as well as civil servants. This is probably the complainant's view but one which is not shared by NHS staff who are very unlikely to believe that the HSC is compromised in any way. Ultimately, the HSC is right in saying that he gets the advantage of NHS expertise.

Jurisdiction

In the first Annual Report, the HSC was only able to define his jurisdiction in a very general way by indicating who was entitled to submit a complaint and on what grounds. In the 1974-75 Annual Report the HSC had by then had 18 months experience and encountered his first major jurisdictional obstacle, clinical judgement. Contrary to the expectations of doctors the HSC had not found this difficult to determine and had only occasionally called on the help of his medical advisers. What had surprised doctors was the extent to which the HSC immersed himself in clinical details and the HSC attempted to justify this.

It was apparent to the HSC that other complaints handling agencies were either failing/...

failing in their jobs or did not exist to handle the number of complaints he received about clinical judgement. Initially, the HSC seemed to be hopeful that the Davies Committee which was then considering the subject would formulate some helpful proposals. The Davies Committee did report but the government failed to implement its proposals on "investigative panels" to look into complaints about clinical judgement.[26]

Like others, the HSC realised that the government was not going to act on the Davies Committee proposals which left him with an embarrassingly obvious problem.[27] Year after year, clinical judgement was the main reason why he had to reject complaints. The SC investigated the problem, and, perhaps not entirely to the satisfaction of the HSC recommended that the HSC be allowed to look into such cases. The HSC as office-holder, was only too acutely aware that in making this recommendation the CS had flown in the face of medical opinion. The scheme was doomed before it even started. Fortunately, the BMA introduced a new scheme of its own which it hoped would resolve the problem.[28]

In 1976 the jurisdiction of the HSC was extended by the Health Services Act to cover private patients treated in NHS facilities. Although it was an important extension politically, it has not given rise to any cases/...

cases.

Other interesting jurisdictional problems are discussed in the Annual Report 1979-80 paras. 22-29. In 1979 the HSC encountered a potential problem caused by the proposal to dismiss Lambeth, Southwark and Lewisham AHA for overspending and replace them with Special Commissioners. While the AHA was subject to the jursidiction of the HSC the Special Commissioners who would be assuming the same functions as the AHA would have been immune from his jurisdiction. Of course, the patients within the area would have recourse to the PCA so the anomaly was bound to be confusing, and really depended only on a technical omission in the legislation. The HSC requested that the department draw up amending legislation but none was ever produced and the situation is hardly likely to recur.

The HSC also encountered a real, not theoretical problem, over the status of Community Physicians.

This is a comparatively new post. Such doctors are employed by the Health Board or AHA but as community doctors working closely with many social services provided for by the local authority they are frequently involved with local government affairs. A typical complaint would relate to a housing waiting list maintained by the council. Community Physicians could determine priorities within the/...

list by recommending rehousing on medical grounds. However, because these doctors are employed by the AHA or Health Board the HSC and local Ombudsman are required to carry out dual investigations. This is just another example of the absurdities thrown up by such divisive legislation.

Even the HSC is driven to say that the legislation is worded too restrictively when it prevents him from investigating a complaint about a layman masquerading as a surgeon (see footnotes to chapter 3 fn. 18).

When the HSC encounters such jursidictional problems he does not automatically assume that the correct solution would be to amend the legislation to allow him to investigate the case. He does this only when the case is excluded from his jurisdiction by an apparent oversight on the part of the draftsman or involves a situation which the draftsman could not have foreseen or considered. For example, in relation to clinical judgement the HSC has not been wholeheartedly behind the SC proposals to extend his jurisdiction to include clinical judgement. The HSC has serious reservations, and not just about the need for medical co-operation. The HSC is also concerned about how such a scheme would affect his relationships with the courts. If his reports were used by unscrupulous complainants as a basis for legal action would this not endanger his/...

his frank relationship with NHS staff in future investigations? And how would judicial decisions rebound on the HSC if the judge disagreed with HSC findings? The obvious means of overcoming this difficulty is to introduce an exclusion rule whereby parties who come to the HSC are barred from then going to the courts. A statutory rule of this kind is distasteful to all the parties involved and may not even be sufficient in every case to usurp the jurisdiction of the courts.

Despite the HSC own doubts about tackling clinical cases himself he remains convinced it is still a problem and seems unimpressed by the first year's operation of the BMA clinical complaints procedure.[29] It seems certain that the HSC will take up this problem again.

Statistics

This chapter is the most important source of information about the HSC Office contained in the Annual Report. It has grown each year to reflect this status and, no doubt, in response to calls from the SC on the PCA for more information. It is the only chapter which presents hard facts although these are somewhat limited. However, comparative work is made more difficult because of the changing contents of this chapter. Generally speaking, it has expanded but at the expense of consistency. It is difficult to say whether this/...

this has occurred in response to changing circumstances or the differing views of the officeholder. The result is that we do not have a nine year run on most tables. Even tables which are repeated annually may change internally, making them useless for HSC comparative purposes e.g. in 1977 the HSC first published his analysis of reports issued indicating which aspects of health care were most complained against. The category (such as "ambulance") which appears one year, perhaps in response to industrial action might disappear the next to be subsumed under a new category the following year.

Recently, the HSC has hinted that one major factor which determines the content of this chapter is the time and effort involved in preparing a table weighed against its statistical value.[30] A recent casualty to this line of thought was the table breaking down complaints into the English Regional Health Authority areas. It is not an argument which bears up to examination since it could be validly argued that none of the information contained in the chapter is of real statistical value and presumably all the information required is to hand, anyway. On the other hand, surely if the Annual Report is to be as informative as possible for the public and a precautionary tale to NHS administrators then not enough information can be published.

1. The volume of cases with which the HSC is/...

is dealing yields a database too small to be reliable for analytical purposes, e.g. in the Annual Report 1978-79 para. 21 p.8 the HSC reported that in the Mersey Regional Health Authority area the total number of population per complaint has risen from 1 in 225,000 to 1 in 83,000. On the face of it, this seemed a serious deterioration in health care. But, as the HSC noted the actual number of complaints made in the Mersey Region had merely risen from 11 to 30, of which only 8 were capable of being investigated and of these only 6 found to be justified.

The HSC recognises the dangers of trying to deduce from insufficient data and this leads on to the second criticism.

2. The HSC tends, as elsewhere in the Annual Report, to present information baldly without commenting on its possible significance. No doubt he is influenced by the fact just referred to but he is the person best placed to comment on the significance of statistics related to his office and the SC and public are entitled to look to the HSC for that information.

The written sections in the chapter usually repeat verbally the information contained in the tables simply highlighting the/...

the main trend, if there is one, and allowing the rest of the material to pass unremarked. Recently, the HSC has included in his written sections useful conversions of the main figures as percentages. While it is essential to retain the absolute figures as a reminder of the dimensions of the problem it would probably be more helpful if the HSC converted many more of the figures into percentages for comparative purposes.

3. The HSC publishes the Annual Report because he is under a statutory duty to do so. At least one member of the SC on the PCA to whom I spoke questioned whether it had any value as a medium for disseminating information.[31] He was concerned that those who work for the NHS only became aware of the HSC when they became involved in an investigation. The public only become aware of the HSC when the press and T.V. draw attention to his work so in writing a chapter on statistics the HSC does not really know who he is writing for - other than the members of the SC on the PCA who are already privy to this information,

One of the difficulties of using the statistics is that the HSC has not set them against any background or in any particular context./...

context. When he does do so, it is against the general population. It would be more meaningful if the HSC discussed his own work in relation to hospital in-patient figures or National Health Service contact rates than just the world in general.

Similarly, when the HSC discusses his own statistical rates he does so in relation to the total figures of complaints received and not the much smaller figures of those where the complaint was wholly or partially justified. It gives the impression of a very busy office (which is no doubt accurate) but glosses over the rather small, hard core of justified complaints. In fact the early Annual Reports did include statistics which were more biased towards justifying the office than in explaining how it spent its time.

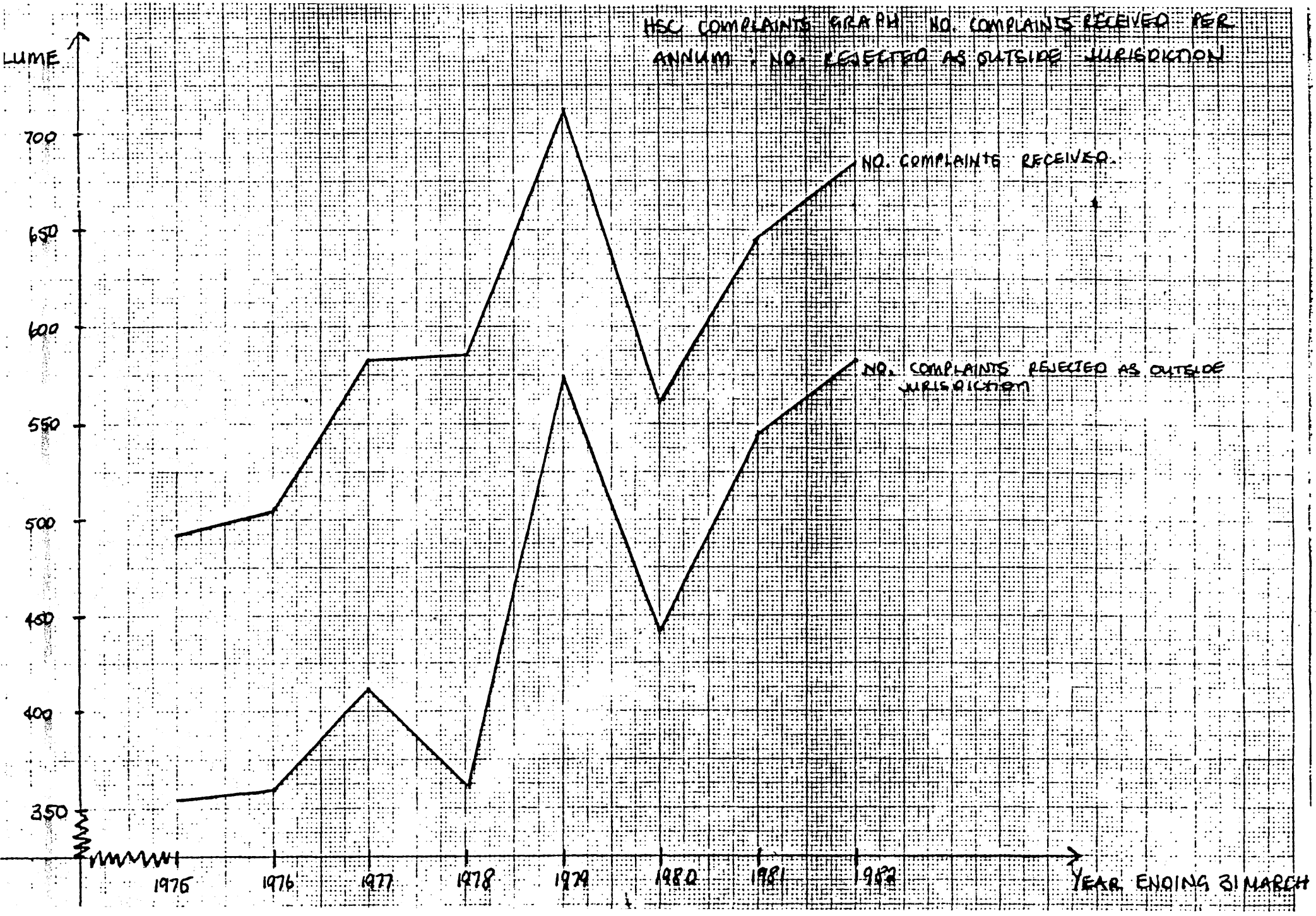
For example, in the very first Annual Report the HSC published statistics on the number of complaints received, the number of cases closed or cases screened and rejected/investigated, the number rejected as being outside jurisdiction, the number discontinued or withdrawn, the number of reports issued as well as a note of whether complaints were against the then Regional Health Boards, Boards of Governors, Boards of Management, Hospital Management Committees and Executive/...

Executive Councils (the last two being Scottish terms). All the figures mentioned were also broken down in English, Scottish and Welsh totals.

In the 1974-75 Annual Report the HSC had to include a new category to take account of the length of time his office was taking to complete investigations viz. "complaints brought forward". In that first year the figure was 119. It is now almost double that, and hovers around the 200 mark, although it has exceeded this.[32] As a proportion of the complaints received, however, it has remained the same despite an increase in the complexity of the cases.[33] This has been part of a deliberate campaign by the HSC to keep the lengths of investigations down to a minimum.

In 1976, the first year in which Sir Idwal Pugh had a free hand to write the Annual Report without taking into account the views of his immediate predecessor, Sir Alan Marre, and also the first year in which the summarised investigations were published separately, the HSC introduced a much strengthened section on statistics. The HSC introduced new tables of information and presented the year's figures alongside the previous year's in brackets, for instant comparison.

The/...


HSC COMPLAINTS GRAPH NO. COMPLAINTS RECEIVED PER ANNUM : NO. REJECTED AS OUTSIDE JURISDICTION
LUME
700
650
600
550
500
450
400
350
NO. COMPLAINTS RECEIVED.
NO. COMPLAINTS REJECTED AS OUTSIDE JURISDICTION
1975
1976
1977
1978
1979
1980
1981
1982
YEAR ENDING 31 MARCH

The HSC introduced 2 new categories in his 1976-77 report. The first gave the total number of complaints examined in the year. This figure exceeds the total number of complaints received in the year because it includes complaints brought forward from the previous year. This would enable us, if we thought it were a valid exercise, to analyse the HSC office efficiency and costs by relating the number of staff and office expenditure to the number of reports issued.[34]

This was also the first year in which the HSC commented on the published tables and converted the main figures into percentages e.g. HSC says that in that year 72% of all complaints received were rejected as being outside his jursidiction (i.e. 423 out of 582). The HSC has continued to give his percentage each year and attaches great significance to it since, in his opinion, it reflects how well the public understands his powers and function. (see table).

This is perhaps misguided since this figure of rejected complaints also includes cases which have been discontinued after a partial investigations or withdrawn by the complainant.[35] The percentage then suggests a higher rejection rate than is actually justified. There are all sorts of reasons for cases/...

cases being discontinued or withdrawn e.g. the health authority or staff complained against may resolve the complaint to the satisfaction of the HSC or complainant, the complainant may decide that an alternative service such as the courts or Local Health Councils will be more useful to him than the HSC. But the Health Service Commissioner does not distinguish these cases from those which the HSC rejected because they fall outside his jurisdiction.

The HSC admits that the rejection rate is high, no matter on what basis it is calculated. To give some indication of what the main stumbling blocks are the HSC provides a breakdown of the reasons for rejection into 13 headings. The main reason in 1976, and now, for rejection is that the complaint concerns the clinical judgement of a doctor.[36]

The emphasis on the high rejection rate detracts attention from a much more significant aspect of the HSC work. Each year of the hundreds of complaints received and investigated, only a tiny minority are found to be justified. This is a much more telling basis for criticism of the value of the Health Service Commissioner office.

In/...

In the Annual Report, 1977-78 and with the agreement of the chairman of the SC on the PCA, the HSC published an analysis of cases according to frequency of occurrence in the English Health Regions. The HSC did not breakdown the Scottish and Welsh figures because, he said, they did not have an equivalent to the regional health authority. Strictly speaking, this is not true. The AHAs in Wales and the Health Boards in Scotland are the equivalent of RHA. The argument used against breaking the Scottish and Welsh figures down further is that it would enable one to identify the hospitals referred to in the cases since the areas are so much smaller.[37] But it probably would be possible to do exactly the same in the case of the Regional Health Authorities. Since then, the HSC has decided to drop the table entirely.

In 1977, the HSC first discussed the source of complaints. Surprisingly, considering the fact that complainants have direct access, only 50% of complaints come direct from the complainant. Another 31% are raised by relatives. This equates with information the HSC has previously released about the numbers of cases concerning geriatric and mentally ill patients. 19% of complaints come from a third party e.g. MPs, LHCs,/...

LHCs, CABx. Significantly, in all cases brought by someone other than the patient himself 24% of the patients had died.

In the Annual Report, 1981-82, the HSC published an analysis of the results reports issued showing which aspects of health care were involved. There were 10 main headings and also an indication of whether the complaints had been found justified or not, or remained unresolved. The largest number of grievances were about nursing care (111), closely followed by complaints about the lack of information to patients' relatives from the doctors (99). The third largest group of complaints were made against the way that health authorities handled complaints at first instance (61) but this was also the category with the highest number of complaints that were justified. The category in which there was the highest number of complaints without justification was that of lack of information from nurses and this was the same category in which there was the highest number of cases which could not be resolved.[38]

In the 1978-79 Annual Report the HSC considered the number of cases which he received which were out of time. Contrary to expectations these did not disappear after the first few years and currently run at 20-30 a year./...

year. The HSC has had to accept that thanks to the dilatory correspondence that frequently occurs between complainant and health authority, some complaints will be out of time. The HSC also accepts complaints from complainants who were dissatisfied with the way their complaint was handled but who were not made aware of the HSC's existence.

The most basic criticism which can be levelled against the Annual Reports is that they are short term. At the most they compare one year with another. The HSC never tries to take a long term view, looking back or forward.

Remedies

The raison d'etre of the HSC is not the attainment of remedies for complainants but he has included chapters on this subject in his Annual Reports. In the 1980-81 Annual Report the HSC devoted a chapter to discussing the nature of remedies which he obtained. They may seem nebulous to some but the value of the HSC is not necessarily to be found in the remedy obtained. Rather it is in the independent investigation leading up to it. The thoroughness of these investigations can seem disproportionate to the seriousness of the cases. This is especially so for those working in the National Health Service but it appears/...

appears from what the HSC says that he maintains cordial relationships with the AHAs.

It is easy to undervalue the Annual Reports because they have so little impact on the public mind but it is essential to remember that the Annual Reports are Parliamentary papers and not exercises in public relations. The HSC could probably make the Annual Reports more interesting to the news media without compromising his duty to Parliament.

CHAPTER 5 FOOTNOTES

1. NHS (Sc) Act, 1978. s96(5) (formerly the NHS (Sc) Act, 1972 s.48(4))
2. NHS Act, 1977 s.119(4) (formerly NHS Re-organisation Act, 1973 s.37(4))
3. In 1982, £3.55 for a 38 page document!
4. Information received from Sir Cecil Clothier 6.7.83
5. HC HSC Annual Report, 1979-80 HC650 (Session 1979-80) p.5 para. 9
6. ibid p.15
7. HC HSC Annual Report, 1981-82 HC 419 (Session 1981-82) the rejection rate was 81.8%
8. ibid p.4 para. 6
9. Oral communication of HSC to SC on PCA, HC 23.11.82
10. see insert photocopy p.
11. V. Carstairs op cit
12. A. Kelly "Family Background, Subject Specialisation and Occupation Recruitment of Scottish University Students" Higher Education (5) pp. 177-188, 1976
13. Annual Report, 1981-82 op cit p.7 para. 12
14. Annual Report 1981-82 op cit p.7 para. 12
15. Information received from Mr. D. Lambie, MP 23.11.82 and Mr. W. Walker, MP 4.8.82
16. HC HSC Annual Report, 1976-77 HC 322 (Session 1976-77) p.4 para. 10
17. HC SC on PCA "Independent Review of Hospital Complaints in the NHS" 1st Special Report HC45 (Session 1977-78)
18. Annual Report, 1981-82 op cit p.5 para.9
19. HC HSC Annual Report, 1975-76 HC 528 p.5 para. 12
20. BMJ editorial "Consent to Treatment" Vol.83 p.926 10.10.81 and The London Council for Science and Society "Treating the Troublesome" Report of a Working Party, 1981
21. see for example newspaper outburst after showing of ATV documentary "Silent Minority" Guardian June 1981 passim
22. Annual Report, 1975-76 op cit p.6 para. 14
23. HC HSC Annual Report, 1978-79 HC 106 (Session 1978-79) p.30 para.85
24. Information received from Mr. D. Crawford, Secretary, Western District (GGHB) Local Health Council/...

Council 16.3.81

25. HC HSC Annual Report, 1977-78 HC 417 (Session 1977-78) p.4 para.6
26. DHSS, Welsh Office "Report of the Committee on hospital complaints procedure" HMSO, London 1973
27. A. Ballantyne "Ombudsman seeks remedy on clinical judgement" The Guardian 1.8.80
28. See chapter 1 infra
29. Oral communication of HSC to SC on PCA, 23.11.82
30. ibid
31. Mr. David Lambie, MP op cit
32. Annual Report, 1979-80 225 complaints brought forward
33. Approximately one third of all cases received are carried forward into the next year
34. Combined PCA and HSC staff to number of reports issued per year is 1:6, information received from Sir Cecil Clothier quoted BBC "Election Call" 9 a.m. 30th May, 1983
35. Annual Report, 1981-82 15 cases either withdrawn or discontinued
36. Reasons for rejection, Annual Report 1981-82 p.8:

body complained of outside jurisdiction	5.9%
complaint against FP, dentist etc	12.5%
FPC Service Committes and Tribunal Regulations	1.3%
Clinical/Judgement	25.9%
Legal remedy available	5.5%
Personnel matter	5.9%
Out of Time	3.8%
Authority not given prior chance to answer	20.3%
Right of appeal to tribunal	0.3%
no prima facie failure/malaministration	5.4%
Contractual/commercial transaction	none
General discretion	3.6%
Complainant not aggrieved or acceptable a complainant	1.6%
Complaint from local authority, other public body or nationalised industry	0.29%
Functions of MWC (Scotland)	0.29%

37. Information received from Mr. G. Keil op cit
38. see Chapter 4 Part III

CHAPTER 6
THE SELECT COMMITTEE ON THE PARLIAMENTARY COMMISSIONER FOR ADMINISTRATION

Origin and Constitution

The SC on the PCA was set up in 1967 with the following order of reference: "To examine the Reports laid before the House by the Parliamentary Commissioner for Administration, and matters in connection therewith." In 1973 this order was extended to include the Reports of the Health Service Commissioners for England, Scotland and Wales.

Reference has already been made to its supportive role in obtaining remedies for aggrieved citizens who bring their complaints to the HSC or PCA. In addition, like other specialised committees in the House of Commons, the SC on the PCA exercised inquisitive and information-gathering powers, but, as will become apparent, the SC on the PCA is not entirely similar to other select committees.

An initial difficulty in discussing the work of the SC on PCA is the confusion which arises from its dual role. As will be obvious from its name, the SC on PCA is responsible for supporting the work of both the PCA and the HSC although the former occupier most of its time. However, it will sometimes be relevant to refer to the PCA only.

The/...

The 1968 Government White Paper which recommended the creation of a "Health Commissioner" suggested that he might be on the analogy of the PCA. It did not go so far as to suggest that one man should hold both posts and, perhaps influenced by the degree of autonomy enjoyed by health authorities over day to day matters, proposed that the Parliamentary link should perhaps be through a minister.[1]

In 1972, Sir Keith Joseph as Secretary for Social Services announced the appointment of a HSC in the House. When asked by Mr. Michael Stewart, MP, "What would be the relationship between the proposed commissioner and the Select Committee of this House to which the present Ombudsman reports?" Sir Keith replied that this needed further consideration.[2] Yet the government had already decided that one man should hold both posts of PCA and HSC subject to the view of the SC on PCA.[3]

In its report, the SC pronounced itself firmly in favour of the HSC also being the PCA. It also "expressed the hope that as far as possible the relationship established between the Parliamentary Commissioner and themselves would be continued with the HSC."[4]

To/...

To a very limited extent then the SC may be credited with extending the Ombudsman principle to the National Health Service and determining the form it took. But the government was clearly executing its own wishes anyway and where it disagreed with the SC, as over the question of access the SC's recommendations were ignored.[5]

MPs then, as now, were concerned that the Ombudsman should not usurp their traditional role as grievance chasers. It was this factor which had undoubtedly led them to propose strengthening the parliamentary links by the imposition of an MP filter into the HSC scheme. It also led them, at the committee stage of the PCA Bill 1967 to reject the suggestion that the H.L. should also have a Committee on the PCA.[6] This is confirmation of the view that MPs saw the Ombudsman as an extension of their own grievance handling powers.

Since it will be argued that this fundamental misconception of the role of the SC is still prevalent in the minds of some MPs it is not surprising that the SC's existence has been threatened twice. It happened in 1970 when the newly-elected Conservative government launched its review of the SC structure.[7] On that occasion, the PCA, Sir Edmund Compton, convinced the government of the value of the SC.[8] Secondly, and more seriously, in 1978 the SC on Procedure conducted an evaluation of the effectiveness of the select committee system. It/...

It concluded that the imbalance of power between Parliament and the Executive could be corrected by strengthening the committee system. Specifically, it proposed increasing the powers of SCs, increasing their secretarial and technical assistance and re-organising them on a departmental based system which would encompass expenditure, administration and policy. The SC on Procedure proposed the abolition of the SC on the PCA, distributing its cases among the departmental committee to which they related and assigning any residual functions to the Treasury Committee.[9]

The HSC submitted a strongly worded memorandum to the SC on Procedure arguing in favour of the retention of the SC on PCA.[10] The HSC pointed out that the SC on PCA was not like other specialised committees; it was more like the Public Accounts Committee (which the SC on Procedure intended to retain). Together, the SC on the PCA and the PAC were responsible for the "general supervision of the quality of administration by Government departments". Perhaps the Health Service Commissioner is exaggerating here in implying that the SC on the PCA is of the same stature as the PAC. The HSC concedes as much himself when he says later, in the same memorandum, that the SC on the PCA "though of recent origin is <u>growing</u> into a formidable instrument" (my own emphasis).

The/...

The HSC argues that the worth of the SC is to be measured by its effectiveness in obtaining remedies. He also commends the value of considering cases in a particular as well as general context. He questions whether departmental committees could build up the background or experience to do this. Also, who would be responsible for giving general guidance on jurisdictional issues, publicity and so forth? The HSC thought it unlikely that the Treasury Committee, whose main responsibilities would be elsewhere would be in a position to do so.

The HSC concluded by saying that even if it were possible to distribute the PCA workload amongst a number of committees it would be impossible to do so in the case of the Health Service Commissioner workload which, in the main, centres on one specific subject which is outwith the normal system of Parliamentary accountability:- "In view of the nature of my work and functions as HSC I consider it even more important that there should be only one single Committee dealing with that."

The SC at least in theory, is very valuable to his work. In the memorandum which the Chairman of the SC on PCA, Sir Antony Buck, submitted to the SC on Procedure, the Chairman seemed to echo these views.[11] He described the SC as a "valuable ally" of the PCA and HSC as well as a successful means of bringing maladministration and failures in the civil service and National Health Service to the attention of the House. But in his evidence before the SC on Procedure/...

Procedure he proved to be more equivocal in his views. He seemed to imply that the SC on the PCA has had to develop its own role to justify its existence. It appears that Sir Antony, though a founder member of the SC on PCA as well as chairman, is not completely convinced of its value. In his evidence, he said: "I was a little sceptical about the need for this Committee (SC on PCA) when I sat on the committee which considered the original legislation which created the Parliamentary commissioner ... I have been frankly sceptical about our need from the point of view of the Committee, but we have strengthened the need for it by successive Ombudsmen ... You will find that they have thought it very important to have this back up which, indeed, other Ombudsmen do not have in the Scandinavian situation or indeed in Germany or France."[12]

But the majority opinion of the House in debate[13], and the SC itself was in favour of the status quo.[14] The government took note of the SC's views[15] and it was decided to retain the SC on PCA.[16]

Membership

The SC has eight members, of whom any three constitute a quorum. Initially, its chairman was drawn from the Opposition benches. This is no longer the case and the present incumbent, as well as being a Conservative MP, has also held a Ministerial post.

Four/...

Four members of the SC are Conservative, three are Labour and one is SDP. None of the members has a specialist interest in the National Health Service. In fact, their interests are fairly evenly divided between business and trade unions.[17]

The presence of a Conservative chairman suggests that the SC is not seen as being politically controversial (or perhaps that its findings are not politically significant?). This is in contrast to the PAC whose chairman is always drawn from the opposition benches. It is perhaps more surprising that none of the members of the SC has a declared interest in the health service. If it is at all possible to characterise the members it would be to say that they are committee "types" who sit on lots of other benches. This makes their commitment to the SC on PCA somewhat questionable e.g. Mr. Tony Durant, MP, is a member of eight committees and associations and chairman of four of these.

The SC has power (conferred on all the new departmental committees):
(a) "to send for persons, papers and records. to sit notwithstanding any adjournment of the House, to adjourn from place to place and to report from time to time.
(b) to appoint persons with technical knowledge either to supply information which is not readily available or to elucidate matters of complexity within the committee's order of reference."

In/...

In fact, the SC on the PCA does not have a research officer, but obtained the services of one on ad hoc basis for its review of hospital complaints in the National Health Service.[18]

Standing Order 83A permits the SC to meet the public. The SC found that civil servants were concerned to maintain the anonymity of the PCA/ HSC reports but the SC noted that in the past no witnesses had ever asked for their evidence to be heard in private. Consequently, the SC meets in public in cases relating to the PCA but in camera for HSC cases because of the sensitive and sometimes confidential aspects of these.[19] And, although since April 1978 SC proceedings are liable to be broadcast on radio this does not apply to the SC on the PCA.[20]

It is difficult to define the nature of the constitutional relationship between the SC and the HSC. There is plenty of evidence to support the view that the PCA is a Parliamentary servant but it is more difficult in the case of the HSC whose links with Parliament are much more attentuated.[21] The HSC looks to the SC as a final sanction and for guidance but he does not act at their bidding or accept complaints from MPs in the House.

At least one member of the SC says that the HSC is a public not a Parliamentary servant.[22] But this is not a meaningful statement in practice.

Function/...

Function

In general, select committees are intended to investigate, scrutinise and report on government activities with the purpose of obtaining information, stimulating debate and keeping civil servants on their toes.[23] But the SC on the PCA is not like the other SCs, the main difference being that it is a passive or reactive body whose actions spring from the reports submitted by the HSC/PCA. It cannot initiate major inquiries into subjects in the same way as departmental committees because its brief confines it to examining the HSC reports and therefore it has little scope for positive action. The SC has little option but to accept this limited role. The only time the SC has launched a major inquiry was at the invitation of the government.

When the SC was established to deal solely with the PCA it was envisaged that its function would be to examine the PCA's reports, follow them up by questioning witnesses, if necessary, and making recommendations for future legislation.[24] In other words, the SC on the PCA was to have a supportive and disciplinary role. Lord Shackleton described it as a "management instrument" for the PCA ... "so far as there is one."[25]

As expected the SC on the PCA has been largely a Steering Committee. It is not an overseer of the PCA or HSC nor will it look into complaints about the Ombudsman.[26] In his evidence to the SC on Procedure, the chairman of the SC on the PCA summarised the Committee's/...

Committee's role.[27]

1. "To concern itself particularly with any report of the Commissioner where maladministration has been held to have been present resulting in injustice and where that injustice has not been, or is not proposed to be, remedied and where appropriate to press for further action by the department concerned;

2. To examine a department's procedures where there has been a finding of maladministration with a view to ensuring that appropriate steps have been taken, or will be taken to minimise any possible repetition of the maladministration complained of;[28]

3. To concern itself with the adequacy of the Commissioner's powers to perform his functions and matters concerned therewith."

This is indeed a very limited definition of the function of the SC with emphasis being put on its reactive role to HSC reports. As the brief (quoted at the beginning of this chapter) indicates, this limitation is largely self-imposed and the responsibility rests with the members of the SC, the chairman especially.

The first task of the SC is to examine the Ombudsman's reports. It may be observed that the SC only examines and scrutinises, it does not re-investigate the case. Where the SC interviews witnesses/...

witnesses it does so with a view to ascertaining their objections to providing a remedy and not a re-trial of the case to confirm or overturn the Ombudsman's decision. The SC is not a higher court of appeal to which disgruntled complainants can turn if the Ombudsman does not find in their favour.

To date, the SC has always been successful in obtaining the remedy recommended by the HSC. Successive Ombudsmen have highlighted this aspect of the SC as the most significant. Describing his period in office, Sir Idwal Pugh said: "... while I recognise that the position of the Ombudsman rests on the statute I came to believe that his authority rested pretty fundamentally on Parliamentary sanction."[29]

When the SC on Procedure considered whether or not the SC on the PCA should continue in existence, Mr. Alan Beith, MP, questioned Sir Antony Buck closely on this point. Mr. Beith asked "But how does it add to the weight of the Commissioner who, after all, can make his report public and the response to that report must itself of necessity be public...? Do you believe that the appearance of the Permanent Secretary before the committee adds some new dimension or threat which is not present from the exchange between the Commissioner and the Department in the initial stages?" Sir Antony Buck replied yes, without specifying what dimension he had in mind, but described a SC cross-examination as having a "terrifying effect."[30]

Mr./...

Mr. David Lambie, MP, a member of the SC on the PCA, has said that he believes the SC is successful in HSC cases because doctors are so jealous of their reputations and fear the slightest taint, despite the fact that the SC proceedings may be held in private.

The Second task of the SC is to identify general areas of weakness and find out what steps have been taken to remedy the situation. An HSC investigation in the past has resulted in the past in the Department of Health and Social Security issuing departmental circulars. Where the HSC highlights a precise and specific problem the health authorities and central government have demonstrated a willingness to accommodate him.[31] Action is less forthcoming where the problems are more diffuse e.g. consent to treatment by mentally ill patients or the supervision of minors.[32]

The third task of the SC is to consider whether or not the legislation establishing the Ombudsman is sufficiently flexible to meet current needs and to meet any gaps which might emerge by re-interpreting the Act in the light of new problems or making recommendations for amending legislation. In respect of the HSC the SC has not been at all active in issuing new guidelines or suggesting amendments. This is partly because many of the initial problems were ironed out in the PCA pre HSC days, partly because successive Ombudsmen have interpreted the Act to the limits of credibility[33] and partly because the/

the major problems have been posed by what is excluded from the Act rather than what is in it.

The SC has a fourth informal function which the chairman did not describe to the SC on Procedure but which is an accepted part of its role as a steering committee. The Ombudsman liaises with the SC and attains their approval before changing adopted procedures e.g. the decision to publish only a selection of investigative reports or to change the format of the annual report. The Ombudsman acts with the encouragement of the SC and they have possibly contributed to the "opening out" of the office. The SC has been much less successful in its proposals to amend legislation. Its major report on the hospitals complaints system which recommended giving the HSC power to investigate cases concerning clinical judgement and the power to initiate investigations lies unimplemented. The existing SC is not powerful enough to persuade any government to act on its proposals but this is probably true of most other select committees.

The work of the SC

When the House is in session, the SC on the PCA meets with the Commissioner fortnightly, totalling about 20 meetings a year. Each meeting lasts approximately an hour to an hour and a half so, one could say, that the total workload is about 30 hours a year. Average attendance at the meetings is somewhere between four or five.[34]

The/...

The SC output is usually two reports each session, one on the PCA and one on the Health Service Commissioner. In a supplementary memorandum submitted to the SC on Procedure the Chairman of the SC on PCA gave some indication of how the SC spends its time between PCA and HSC matters. In 1975-76, the SC considered 17 PCA cases and 19 HSC cases. In the following year, it considered 8 PCA cases and 10 HSC cases. Quite apart from the fact that these figures are very low, they can also be misleading. While in both years, the SC examined the report of each PCA case individually they only looked at the HSC cases under sub-headings (5 in 1975-76 and 6 in 1976-77).

The SC on Procedure was unimpressed by these figures. Mr. Nigel Spearing, MP, commented: "From your answer it would seem that the residual responsibilities for matters relating to Parliamentary Commissioners in general, as distinct from cases in particular, are relatively small."[35]

Mr. Alan Beith, MP, said: "I have the feeling that part of the purpose of setting up the Select Committee was to demonstrate that this new creature, the Parliamentary Commissioner, was the servant of Parliament and not some constitutional hybrid for whom no place could be found. I feel that, that purpose has probably been served and that the justification for the Committee's existence must be elsewhere."

The/...

The SC examines the reports on the basis of a list submitted by the HSC. It does not read them all so tends to act on the HSC list though it is free to add to it. One could go so far as to say that the SC is too dependent on the HSC for determining its agenda. The SC does not ask to look at cases which the HSC has rejected, and it is reported by reliable sources that when the HSC lays his reports before the SC it asks questions from a brief prepared by the HSC office.

Select Committee Reports

SC reports focus on three main areas:
a) to follow up procedural defects revealed by the HSC investigative reports;
b) to clarify jurisdictional issues, and
c) to conduct an inquiry into a subject independent of the reports.

Almost all reports fall into categories (a) and (b). The SC on the PCA has only conducted one inquiry of type (c) and that was at the government's behest.

Type (a) reports

It is hardly surprising that one of the first reports concerned itself with how the Department of Health and Social Security was tackling waiting lists since these were a traditional subject of criticism in the National Health Service. The HSC had identified this as an area of weak management. His concern/...

was with the actual management of the lists, determination of priorities and the dissemination of information, not reduction in length. The Permanent Secretary of the Department of Health and Social Security appeared before the SC to announce that as a result of the HSC's comments his department had issued a circular. The SHHD had also issued a circular to Health Boards in Scotland which gave general guidance, reinforced by several points which the Commissioner had made. In addition, the SHHD had asked the Health Boards to report back on progress being made to implement the circular.

The SC concluded that these types of improvements, arising directly from HSC investigations, were one of the most important results of establishing the office. The Permanent Secretary to the Department of Health and Social Security said that it was clear that the existence of the HSC put the health authorities "on their mettle" and that the office of the HSC had had an invigorating effect on the National Health Service.[36]

The SC has been accused of being complacent and self-congratulatory.[37] The SC's experience with individual health authorities perhaps bears it out.

For example, in 1975-76 the SC expressed disapproval of a consultant who withdrew from treating a complainant who had taken her case to the HSC.[38] The consultant said that his relationship with/...

with his patient had been vitiated by the HSC investigation. The SC was very concerned why a consultant should feel that his patient had lost confidence in him when none of the complaints had been connected with clinical services. Secondly, it deplored the way the consultant had withdrawn from the case without providing for anyone to take over.

The consultant was very defensive. He had been alarmed by the legalistic tone of the letter of notification he had received from the SC in particular by the reference to bringing a "friend", possibly a MDU representative. The SC had to reassure the consultant Mr. A. B. "We are not re-trying this matter. This is not a court of appeal." But the SC could not persuade the consultant to admit that his action had been wrong or over-sensitive. Eventually, the consultant was able to evade this charge by attributing his withdrawal from the case to an accumulation of administrative and other pressures, and not solely to the HSC investigation.

In another case, concerning unjust detention in a mental hospital, the SC could not conduct a proper investigation because the MDU had forbidden the psychiatrist in charge of the case to talk to anyone and the AHA's own legal advisers had told it to grant an ex gratia payment.[39]

A woman had been detained for 29 days in a mental hospital after her status had been changed by the consultant from formal to informal (which meant she/...

she was free to leave). The HSC called on the AHA to grant the woman an ex gratia payment commensurate with her period of detention. The AHA initially refused but, after receiving a request to appear before the SC it then sent a cheque for £150 for only one day's illegal detention. (The AHA had argued that the other 28 days detention had been due to errors but were not illegal).

During its meeting with the AHA the SC congratulated itself that in calling the AHA as a witness it had been instrumental in bringing about a remedy. The AHA denied that this was the case. It conceded that an error had been made but denied that it was their responsibility. The AHA claimed that the consultant's decision to change the patient's status from formal to informal was clearly clinical and as such was entirely his responsibility. Therefore, in accordance with departmental guidelines the AHA had refused to grant an ex gratia payment until the consultant's medical protection society had agreed to contribute, and the society'e refusal to do so until much later, and not the invitation to appear before the SC had been the reason why the payment was delayed and then finally made.

On one occasion, the SC was called upon to defend the HSC's handling of a complaint against Clwyd AHA[40] and in doing so effectively held a re-trial.[41] The complaint concerned the death of a 103 year old woman following her discharge from the A & EU of Rhyl Hospital in the early hours of a winter's/...

winter's morning.

The local medical committee criticised the HSC for his apparent breach of the rules of natural justice by failing to give the doctor a right of reply. And they took exception to the HSC 's description of the doctor's decision as "inhuman" and passed a resolution of no confidence.[42]

The SC felt it necessary to express its confidence in the HSC and also confirm his competency to handle such cases. The SC rejected the local medical committee's argument that a clincial judgement was "Total" and could not admit of administrative elements. Recalling earlier statements in relation to the PCA the SC said that the decision to discharge the old woman was "obviously bad" and went to some lengths to justify the HSC's conclusions, particularly in the light of the procedural defects that had been revealed.

The SC felt that the HSC had failed in his moral duty, though not legal, in failing to contact the doctor concerned. Certainly, the AHA had not contacted the doctor either, when he still living in this country and they were dealing with the complaint at first instance, but they did send copies of the HSC report to him along with some questions and this revealed new evidence.

Finally the SC reached the same conclusion as the HSC that the decision to discharge was wrong. But/...

But the SC's decision was based partly on a technicality which overlooked the substance of a complaint, namely the failure to "name" the doctor and partly on the fresh evidence uncovered by the AHA which confirmed the SC's view that the decision to discharge was administrative as well as clinical. In order to reach the same verdict as the HSC the SC had to indulge in some ex post facto rationalisation and the fact that it did so was an implicit recognition that certain aspects of this investigation were open to criticism.

The case attracted some notoriety and the Secretary of State for Wales wrote to the chairman of the SC as well as speaking personally to the chairman of Clwyd AHA.[43] As a result of the case, the area reviewed and improved its information system and complaints procedures.

Type (b) Reports

In its report for Session (1978-79) the SC commented on the difficulties which successive commissioners had encountered in dealing with complaints which involved FPCs in England and Wales.[44] The SC presented this problem as if it were a jurisdictional dispute as much as a lack of co-operation from FPC administrators, no doubt in the hope of obtaining an authoritative government ruling on the matter.

The HSC cannot investigate complaints about services provided by General Practitioners or other independent contractors or about the way FPCs investigate/...

investigate complaints. But complaints to a FPC which have not been the subject of the formal procedure are within his jurisdiction, although some FPCs are totally opposed to this. In September 1978, Sir Idwal Pugh met a deputation from the British Medical Association on this issue.

The SC seemed to imply that the government should consider amending legislation to permit the HSC to look at all the actions of FPCs or to exclude FPCs from the HSC remit entirely. The existing compromise solution was not to the satisfaction of either party. The government emphatically denied that there was any unresolved dispute about the scope of the commissioner's jurisdiction.[45] It re-stated the HSC position that he could look at any of the FPC operating the recognised informal procedure, or any preliminary effort at a reconciliation between doctor and patient providing none of the actions complained of were covered by the Service Committee and Tribunal Regulations. The government did hint that it was considering some amendments to the committee complaints procedure at a later stage but, that, whatever these were, it was more likely that they would curtail the HSC's powers to look into the actions of FPCs than extend them.

In 1979, the SC issued a report recommending a significant extension of the HSC powers.[46] The National Health Service Act, 1978 s.93(2) lays down that the HSC may investigate a complaint from someone claiming/...

claiming to have suffered injustice or hardship as a result of alleged failures in service or maladministration on the part of a health service authority. The two main requirements are that the complainant must have suffered injustice or hardship or is acting on behalf of someone who has, and, there must be prima facie evidence that the alleged failure or maladministration resulted in the injustice or hardship which forms the basis of the complaint.

The HSC received a case which he thought it was in the public interest to investigate but which he was forced to reject because it failed to meet the above two requirements.[47] An AHA had, accidentally, employed a butcher masquerading as a doctor. The "doctor" performed operations during his period of employment with the AHA. Eventually, his real identity was disclosed and he was convicted. The AHA decided not to tell all these patients who had been treated by the bogus doctor. The Patients' Association heard of this, but were not able to find any patients who had been victims of the bogus doctor to bring a complaint. The HSC had to reject the complaint from the Patients' Association because they were not bringing it on behalf of anyone. Also, even if the Patients' Association had been able to trace former patients there was no indication that they had necessarily been harmed by being treated by an unqualified person. Perhaps the HSC has interpreted the terms injustice or hardship too narrowly if he always insists on discernible and permanent consequences./...

consequences. In this case the injustice was surely the risk to which patients were exposed.

The SC thought that the facts of this case highlighted a very severe restriction on the HSC which was at odds with the public interest. The HSC called upon the SC to consider whether or not he should have the power to initiate investigations where he considered it would be in the public interest to do so. The SC seemed to endorse this request but so far no government has taken any action to give effect to the recommendation.

In 1977 the SC showed how far it was prepared to interpret the legislative provisions on jurisdiction extending to alleged failures of service.[48] The HSC had considered a case where a General Practitioner had been unable to obtain an emergency bed for an acutely ill, elderly patient. Believing that her life was in danger and that she required medical care, the General Practitioner had the patient admitted into a private nursing home. Later the woman's son attempted to recover the fees from the AHA on the grounds of its failure to provide a service which it was under a duty to provide. Acting on legal advice, the AHA refused to make an ex gratia payment as directed by the HSC on the grounds that by so doing it would be laying itself open to claims from all the residents of private geriatric homes.

The SC stressed that it was concerned with the AHAs/...

AHAs public duties, not legal ones. In this case, the SC concluded that the AHA had failed in its duty to provide an adequate accident and emergency unit to meet the needs of its population. But, it could not be held liable for a failure in service merely because it did not have a sufficient number of beds for geriatric patients. On the facts of the case, the hospital ought to have admitted the patient because she was acutely ill, but the fact that she was also old was irrelevant.

This SC decision was probably the most sensible one in view of competing priorities and is also in accordance with prevailing medical opinion that longterm plans for future geriatric services in the UK will centre on the social services, not health services.

Type (c) Reports

In 1973, the Davies committee reported on hospital complaints procedures in England and Wales, following a series of well-publicised scandals. The Committee had been formed prior to the creation of the HSC and had not taken his office into account when making proposals to improve complaints procedures in hospitals. The Davies Committee's most controversial recommendation was the creation of a system of investigating panels, to consider complaints which might become the subject of litigation, for every England and Welsh AHA. The SC realised/...

The SC realised that such complaints are outwith the jurisdiction of the HSC but there was the possible danger of some overlap in jurisdiction as well as certain confusion in the minds of the public. The SC urged the government to aim for a coherent system.[49] The SC probably feared that the implementation of the competing Davies committee proposals would put a blight on the growth of the newly-created HSC. However, the SC did express itself in favour of issuing a code of practice for handling complaints, as recommended by the Davies Committee. The SC believed that the publication of such a code would clear up any confusion there might be as to the respective roles of the various complaints-handling agencies and hoped that the Department of Health and Social Security would not delay publication until the outcome of the SC's own enquiry into the jurisdiction of the HSC.[50]

The Department of Health and Social Security agreed with the SC and circulated a draft code amongst interested parties[51] but the initial comments of the medical profession were critical and it was some time before all the parties could agree on a common procedure.

The SC reported in the following year on its own inquiry into the jurisdiction of the HSC, taking into account the Davies Committee proposals on investigating panels. The SC was mainly concerned with complaints about clinical judgement. It found that/...

that approximately half of all complaints received (1,700 in Scotland by Health Boards) involved clinical judgement but that the vast majority of serious cases concerned clinical judgement.[52] Even although this was a very low rate of complaint per in-patient cases per year it still gave the SC cause for concern.[53]

Even taking into account the Davies Committee proposals, the SC felt that the existing arrangements for handling complaints about clinical judgement were unsatisfactory. Firstly, they seemed too complicated and too slow. Staff especially were worried by the time consuming bureaucratic procedures and thought that they contained an element of solicitation of complaints. This viewpoint was not borne out by the SC's own findings. Secondly, the SC thought that the ad hoc committees of inquiry appointed to investigate specific cases tended to act in a non-judicial way. The Davies committee had proposed that where a member of staff, but not the complainant, was dissatisfied with an inquiry verdict, he would have the right to refer the case to an investigating panel. The SC disapproved of turning the panels into courts of appeal particularly where the same right was denied to the complainant. Thirdly, complainants were still dissatisfied with the composition of the committees of inquiry and their reluctance to release information. This criticism would still hold true of the investigating panels since they would be composed largely of medical professionals and, unlike the HSC, they/...

they would have no power to compel the attendance of witnesses or the production of notes.

The SC considered whether clinical judgement, by its very nature, should be excluded from independent review. But, even taking into account the opposition of doctors and the dangers of defensive medicine, the SC concluded that clinical judgement should be open to some form of independent, though not lay, review. The Mental Welfare Commission for Scotland gave evidence of the experience of reviewing clinical judgement and said that it thought that clinical judgement was often used as an excuse. Nurses and midwives, too, gave evidence that they wanted clinical judgement to be open to review. It is no longer true to say that doctors bear the prime responsibility for clinical judgements since so much health care is administered by "teams" of doctors and nurses. The SC was not persuaded that independent review would adversely affect the doctor-patient relationship since the relationship had already been undermined by the patient complaining.

The SC concluded that what was needed was a form of inquiry characterised by authority, confidentiality, speed and flexibility. It believed that the HSC along with expert advisers, could supply all these.

The HSC agreed that there was a gap in the existing/...

existing mechanisms but "The medical profession will have to be convinced of this since they have not universally accepted the need for even the limited investigations that my office can at present undertake."[54]

In addition to this problem, the SC was also concerned how the decision to extend the HSC remit would be reconcilable with the other provisions of the Act. The terms of the Act forbid the HSC from accepting cases if the complainant intends going to court but even when such assurances have been given there have been cases where the complainant has subsequently litigated.[55]

Even if the problem of double jeopardy could be overcome there is still the statutory requirement that the injustice or hardship complained of must have flowed from maladministration. It was suggested to the HSC that removing clinical judgement from the schedule of exclusions would not have a great effect since it would be difficult to show that clinical judgement had been exercised with maladministration and even if this could be established it would not be an advantage in the great bulk of complaints which were purely concerned with the nature of the clinical decision taken. The HSC disagreed. He said that obviously some complainants would want a review of the clinical judgement per se but "I think many complainants would be satisfied if it were possible to give them an assurance from an independent source that/...

that the doctor took the steps, that, bearing his experience in mind, he should have taken to enable him to reach an informed conclusion".[56]

This statement obviously does not go so far as it might first appear from the SCs bold proposal to remove clinical judgement from the list of exclusions, and it is interesting to note, from the case law, that the HSC has implemented it informally in a very few cases where he could clearly identify an administrative element in a clinical judgement.

But the representatives of the British Medical Association were totally opposed to the SC's suggestion, even if the alternative were an increase in litigation. The British Medical Association thought that the HSC was in addition and not an alternative to the increase in mal-practice litigation. No doubt their opposition has been the major factor in the government's refusal to implement this report or to take action on the recommendations of the Pearson Report which examined associated topics.[57]

In the House of Commons, the Secretary of State for Social Services answered, in reply to a Parliamentary question on the future of the SC report, that he doubted whether the recommendation (to extend the HSC jurisdiction to include complaints concerning clinical judgement) carried with it the consent of the medical professional which the committee/...

committee considered necessary for it to be successfully implemented. Instead, the government was awaiting alternative proposals from the British Medical Association Joint Consultants' Committee, which were eventually adopted on a trial basis in 1981.[58]

Criticisms

It is difficult to evaluate the effectiveness of the SC on the PCA. Though valued highly by all commentators its value as a deterrent is difficult to measure. The SC has little opportunity to show its power, though this is not necessarily the only criterion for effectiveness, since so few subjects of complaint ever refuse to grant the remedy recommended by the HSC. The SC's role is largely confined to confirming the Commissioner's reports and noting satisfactorily the outcome of his investigations. In these cases, the SC has played no direct part in obtaining the remedy but its mere existence is probably of some significance since few people would relish the prospect of being called before a select committee. As it has been said of the Swedish experience: "The importance of the office cannot be measured by the scandals it has revealed but rather by the absence of any major scandals."[59]

It may well be then that the SC has achieved some successes which would not otherwise have been brought about but which cannot be proved. Although each successive commissioner has been a prestigious/...

prestigious and influential appointee in his own right, the SC by virtue of its status in the House has been responsible for reinforcing his personal authority.

Professor Gregory has stated that the success of the SC is not due to the calibre of its members but to the institutional status enjoyed by a SC of the House of Commons.[60] According to the evidence given by the chairman of the SC to the SC on Procedure only a minority of members are hard-working and some are not committed at all. It is not unknown for a meeting to delay commencement or lapse because of the inability to sustain a quorum of 3.[61] The Minutes of Evidence of SC meetings bear out that the members are not particularly knowledgeable about health service affairs and the HSC's office confirm that MPs are not keen to obtain places on the SC. My own personal experience as an observer of SC meetings confirms that most of the SC MPs are lamentably ignorant about the workings of the National Health Service and the HSC and either because of this or other factors have the greatest difficulty in asking relevant questions or making cogent or perceptive comments on the evidence presented to them.[62]

The SC has been effective in its relations vis a vis Parliament. As a means of identifying abuse and correcting it, it has been successful. It is helped in this by the provision of reports of investigations submitted/...

submitted by the HSC which form the basis for SC action. Flowing from this, the SC can make very precise recommendations to fit specific circumstances which individual health authorities are in a position to control.[63] In this role, the SC enjoys a close working relationship with the HSC. He suggests what cases might justify further inquiry, gives expert advice, suggest a possible brief of questions and is present at SC meetings with health authority officials to assist in the questioning.

In other aspects of its work, the SC has been less successful as a means of informing Parliament. As already mentioned it does not have a research department. Like other SCs although it has the means to investigate and report on matters, it has no means of bringing its reports to the attention of the rest of the House. Very few SC reports, in general, are debated. The SC on Procedure thought that this reflected the uncontroversial nature of many SC reports.[64]

SC reports do not attract public interest generally, and the reports of the SC on the PCA do not arouse much interest on the floor of the House. When the government responds positively to SC recommendations it appears to do so for its own convenience and not because of pressure from the House. For example, in 1975 the SC criticised the government's method of selecting and naming the Ombudsman without reference to the SC or even its chairman/...

chairman. The government agreed to consult the chairman of the SC and consider any candidates he might care to nominate.[65] However, it denied that the question of who should appoint the Ombudsman, the House of Commons or the Queen, was even open to debate and refused to give an undertaking that the Ombudsman would be drawn from the ranks of independent nominees as well as ex civil servants. In other words, the government was only prepared to consider adopting the SC's views when they would not restrict its own discretion.

Former Ombudsman, Sir Idwal Pugh, was under no illusions about the influence of the SC. In an address to the Royal Society for Arts he said: "The government has hitherto accepted only one of the committee's recommendations and that a relatively minor one. It is, I suppose, the lot of select committees, to make wide-ranging recommendations across the board and to have only a few of them accepted for implementation. But I think it is enormously dispiriting that after a careful review by a select committee... the government should have declined to take any significant action.[66]

The lack of interest shown by the government has not dissuaded outside commentators from trying to bring about reform in their own way, by stimulating debate and public argument about the future of the Ombudsman. The group Justice has been especially active in maintaining a continuous debate on the Ombudsman's/...

Ombudsman's record and there are now signs from within the Ombudsman's office that he too is not wholly satisfied that the SC in its present form or with its present composition is as effective as it might be.[67]

CHAPTER 6 FOOTNOTES

1. Ministry of Health: The Administrative Structure of the Medical and Related Services in England and Wales, HMSO para. 80, London 1968
2. Sir Keith Joseph op cit
3. ibid
4. HC SC on PCA 2nd Report HC334 (Session 1971-72). The SC went further and asked the government to consider whether the MP filter should also apply to the HSC. The government refused on the grounds that it would deter complainants; an argument that was manifestly not persuasive in the case of the PCA.
5. R. Gregory "The Select Committee on the Parliamentary Commissioner for Administration, 1967-1980" Public Law Spring 1982 p.73
6. HC SC on Procedure 1st Report HC588 (Session 1977-78) Vol. II Minutes of Evidence, question 720
7. Select Committees of the House of Commons Cmnd 4507, 1970
8. Gregory, op cit
9. see Footnote 6 op cit Vol. I p.534
10. ibid, Vol. II, Appendix 33
11. ibid, Memorandum 7.11.77
12. ibid, question 694
13. HC Debates, Vol. 963, Cols. 102/107 Sir Antony Buck, 19.2.79, Vol. 959, cols. 894-896, Sir Antony Buck 1.12.78
14. HC SC on PCA 4th Report HC 615/444 (Session 1977-78)
15. HC SC on PCA 4th Report (Review of Access and Jurisdiction) Observations by the Government CMND 7449, 1979
16. HC Debates Vol. 969 Col. 34, Mr. N. St. John Stevas 25.6.79
17. See Dod's Parliamentary Companion, 1982 East Sussex 1982
18. HC SC on PCA "Independent Review of Hospital Complaints in the HS" 1st Special Report HC 45 (Session 1977-78)
19. HC SC on PCA 2nd Report HC524 (Session 1976-77): this is no longer the general rule but the SC retains the discretion to exclude the public
20. see Footnote 6, Vol.1, para.5.12
21. I. Pugh "The Ombudsman - a restrospect". Royal Society/...

21. Society for the Arts 7.4.82 (unpublished) and HC SC on PCA 2nd Report HC480 (Session 1975-76)
22. Mr. D. Lambie, MP. and member of SC on PCA 23.11.82
23. A.H. Hanson, B. Crick "The Commons in Transition", (1970)
24. The Parliamentary Commissioner for Administration, CMND 2767, 1965
25. HL Debates Vol.280 col.686 Lord Shackleton 21.2.67
26. see Footnote 6, Vol. II, question 683
27. ibid
28. Presumably this can also be interpreted to include, in the light of the National Health Service (Sc) Act, 1978 a failure in a service or a failure to provide a service which ought to have been provided
29. see Footnote 21
30. see Footnote 6, Vol. II question 697, 698
31. For example West Midlands RHA in evidence to the SC on PCA (meeting attended 8.2.83) showed that in response to HSC criticisms it had done no less than:
    1. replaced hospital trolleys with safer, more comfortable ones
    2. redecorated fracture clinic
    3. renovated fracture clinic fittings so as to ensure greater privacy for patients
    4. increased patient flow in fracture clinic
    5. Regional ambulance liaison officer reviewed ordering and response procedure from which new arrangements emerged and were implemented
    6. hospital and ambulance staff held 2 joint meetings to review whole transport policy and reports circulated amongst staff
    7. hospital-ambulance liaison monitoring initiated
    8. hospital complaints procedure reviewed and changed
    9. ambulance complaints procedure reviewed and not changed
    10. all the documents and reports relating to above points made available to the SC
32. HC SC on PCA Meeting attended 8.2.83. complaint re inadequate supervision by Norwich Health Authority staff of a minor undergoing psychiatric treatment resulting in her disappearance. SC declined/...

declined to actively pursue anomaly identified by Sir Cecil i.e. that 16 year old is old enough to consent to or refuse treatment but is still not so old that she cannot be in care

33. HC SC on PCA 4th Report HC593 (Session 1979-80) p.13
34. Information received from Mr. M. Hanson P.S. to Sir Cecil Clothier
35. See footnote 6, Vol.II, questions 693-716 passim
36. HC SC on PCA 1st Report HC282 (Session 1975-76)
37. P. Burgess "Whose Side is the Ombudsman Really On?" New Society 13.1.83 p.56
38. see Footnote 36, para. 35-37
39. HC SC on PCA 2nd Report HC372 (Session 1977-78), Case No. W329/75-76
40. Case No. W28/76-77
41. HC SC on PCA 5th Report HC616 (Session 1977-78)
42. D.L. Williams "The Health Service Commissioner and the Rhyl Case" BMJ 14.10.73 p.1090
43. HC SC on PCA 2nd Special Report (Departmental Observations) HC246 (Session 1978-79)
44. HC SC on PCA 2nd Report HC311 (Session 1978-79)
45. HC SC on PCA 1st Special Report (Departmental Observations) HC405 (Session 1979-80)
46. HC SC on PCA 5th Report HC650 (Session 1979-80)
47. ibid
48. se Footnote 39
49. HC SC on PCA 1st Report HC268 (Session 1974), 1st Report HC282 (Session 1975-76)
50. Undertaken at the invitation of the Secretary of State for Social Services, HC Debates 6.2.76 Col.85 (Parliamentary Question - written)
51. HC SC on PCA 1st Special Report (Departmental Observations) HC107 (Session 1976-77)
52. see Footnote 18, Minutes of Evidence, Memorandum submitted by the SHHD
53. Less than 0.3%
54. see Footnote 18, Minute of Evidence. p.38
55. W236/75-76
56. see Footnote 18, Minutes of Evidence, p.37
57. Royal Commission on Civil Liability and Compensation for Personal Injury, CMND 7054-1. 1978
58. HC Debates Vol. 972 Cols. 158-159 (PQW)
59. N. Andren "The Swedish Ombudsman" Anglo-Swedish Review (5) p.7, 1962

60./...

60. see Footnote 5 pp 49-88
61. Witness the events of 8.2.83
62. SC meeting 2.2.83. The Chairman of the SC publicly but tactfully had to restrain some of his colleagues who had wandered from their brief. He took pains to correct the misleading impression they may have made on the witnesses.
63. For example, W553 80-81 AHA accepted HSC criticism that heating in a ward was inadequate but HSC recognised their argument that other projects took priority over replacement of the heating system and therefore remedy was to increase level of heating using old system, as far as possible. 64. see Footnote 6, Vol. I, para. 6.2
65. Observations by the Government on 2nd Report from SC on PCA, Session 1975-76 CMND 6764
66. see Footnote 21. Col.12
67. see Footnote 35

CHAPTER 7

EXTERNAL AGENCIES

Introduction

It would be misleading to present the HSC as the only, or major, complaints-handling agency of the National Health Service. On the contrary, many others handle a far larger case-load and maintain a more public profile. Unfortunately, few meet the criteria enunciated by the Franks Committee (1957) as guaranteeing the impartial execution of investigatory functions. It is this which distinguishes the HSC's office.

For example, in composition the majority of external agencies fall severely on one side or the other of the professional/patient borderline. This has been a factor in shaking public confidence in the service committee procedure. Even where professionals sit in a minority, their influence is disproportionate to their numbers. Laymen have shown themselves all too ready to assimilate without question professional values at the expense of patient interests. This is a common phenomenon, observed in other types of tribunal where laymen and professionals sit together.

Health authorities are single-purpose authorities, without the responsibility of revenue-raising, dominated by professionals and insulated from party politics.[1] Lacking medical expertise/...

expertise, laymen are unable to challenge the medical assumptions implicit in current policies yet have failed to define adequately other areas, such as financial or administrative, where they might be on an equal footing with doctors. The general standing of party politics is also no encouragement to those concerned about the public accountability of the National Health Service since it deters suitable people from accepting appointments on health boards.

This situation has given rise to the comment: "external bodies or authorities are ineffective or even counter-productive; they may either provide a focus of largely irrelevant conflict or seem to absolve doctors ..."[2] This is best exemplified by the experiences of local health councils at one end of the spectrum and the service committee procedure at the other.

The external agencies cannot be the subject of neat categorisation. They are confused as to primary function, many carrying out more than one, whether formally or informally. My concern has been to consider those which have the quasi-judicial function of inquiring into grievances and which are independent of the National Health Service. It may also be necessary to take into account that these agencies have certain characteristics which might compromise their impartial performance of their quasi-judicial function but this is not a factor in determining whether or not they are to be excluded from this note.

There/...

There are four heads to consider:

(a) the resolution of grievances on a collective level

(b) the resolution of individual grievances

(c) the resolution of grievances by referrals

(d) the resolution of grievances by the courts

(a) <u>The resolution of grievances on a collective level</u>

i. The Scottish Hospital Advisory Service (SHAS)

The SHAS is the Scottish counterpart of the English Hospital Advisory Service. The SHAS was established in April 1970 at the instigation of Mr. R. Crossman, Secretary of State for Social Services as an immediate response to the disclosure of scandals in Britain's long-stay hospitals (ref. infra to Ely, Whittinghame reports etc.). Therefore, not surprisingly, its remit is confined to hospitals which provide long term care i.e. for the chronic sick, geriatric, mentally ill and handicapped patients. Within this sphere, the role of the Scottish Hospital Advisory Service is to visit hospitals, report on them and advise management on patient and staff needs with a view to promoting standards of care.[3]

The SHAS consists of medical, nursing and social work staff seconded from their parent/...

parent departments by the Common Services Agency. Its professional composition is one reason why it commands the support of hospital staffs who welcome SHAS visits as an opportunity to express their frustrations.

The SHAS is unique amongst the agencies under consideration as being the only body to have visited nearly all of Scotland's long term institutions at least twice. In the course of these visits, the SHAS has had specific problems brought to its attention and has recommended specific solutions in its reports.

The SHAS is a form of inspectorate which is acceptable to the medical profession. It commands respect because it consists of fellow-professionals. It offers peer review to doctors in isolated positions, it focuses much-needed attention on the "Cinderella" specialities and operates in specialities renowned for their undogmatic approach to medical treatment.

The SHAS would not wish to compromise its position by undertaking to investigate individual complaints but it has shown itself willing to put questions to individual hospital authorities where it reaches/...

reaches the conclusion that an individual complaint is indicative of a more generalised problem. While such a discreet approach may placate medical staff it does not satisfy the complainant's need for explanation and information, quite apart from a remedy.

The SHAS is similar to the MWC for Scotland and the same criticisms can be directed against both.[4] Both are essentially passive, reacting to staff/patient criticism and failing to act on their own initiative. It is questionable whether either was conceived of as being anything else but they may have to adopt a more positive stance to counter the criticisms of such groups as MIND that a gross imbalance exists within the National Health Service between professional and patient representation. While consultative committees within the National Health Service are openly centred on professional interests, which are likely to be clearly distinguishable from patients' interests, confusion may result when this distinction is overlooked.

ii. Committee of Enquiry into Maternal Deaths in Scotland

The Committee exists to conduct an investigation into maternal deaths in Scotland, and to report on each individual case/...

case in turn in volumes published quinquenially.[5] The Committee does not act at the instigation of bereaved husbands and families but on information provided by the Registrar General for Scotland. Thus, the committee investigates every case of maternal death occurring and not just those where mismanagement is suspected.

The enquiry itself is confidential, no witnesses from the deceased's family are present. Evidence is taken of the medical management of the case and the strictest standards of medical practice apply.[6] However, the completion of the enquiry is entirely dependent on the co-operation of the consultant involved and this cannot always be obtained.

Each report points out all avoidable factors in the mismanagement of the case and identifies cases where the provision of care fell below current practice. This information is immediately available to the hospital but the deceased's family are not notified. The report may only be published years later and is intended for general circulation amongst health professionals, not concerning members of the public. Perhaps because of this, the reports are very frank and full. They are very technical but contain all the information which, translated, would appease the bereaved/..

bereaved family.

(b) The Resolution of Individual Grievances

The Committee of Enquiry is an example of how the medical profession shoulders its responsibility of self-regulation when it considers that a serious error has taken place. Self-regulation as a means of protecting the public interest is less successful when patient and doctor differ as to the significance of an event. This is illustrated by the activities of the General Medical Council.

i. The General Medical Council (GMC)

The Medical Act, 1858 gave the GMC responsibility for maintaining a register of doctors licensed to practise. The GMC uses it power of temporary or permnanent erasure from the register to discipline its members. The council hears cases where a doctor is thought unfit to practise by reason of mental or physical illness or "serious professional misconduct."[7]

Like the other agencies already considered the GMC's concern with the resolution of individual grievances is almost incidental. As Sir Alec Merrison has said: "It (the General Medical Council) is not a patient's ombudsman, obliged to look into every aspect of doctor's professional dealings... The crucial role of/...

of the GMC in this field (is) looking at the doctor who is a public risk."[8] The GMC does not get involved in the less serious cases because it would involve scrutinising the day-to-day running of the National Health Service and other schemes exist for handling complaints of that nature.

A particular problem, in fact, are those members of the public who do complain directly to the GMC and are likely to be frustrated when they are told to lodge their complaint with the competent health authority. But it is explained that if, upon investigation, the complaint is established and serious. the GMC will consider the matter.[9]

The 93-man GMC appoints one person as a preliminary screener who sifts through all the cases received[10] and weeds out those in which the doctor concerned is sick. Providing he accepts treatment and sick leave the matter will proceed no further. If he refuses, the case wil be heard by a Health Committee which has the power to erase a name from the Medical Register, temporarily, in the hope of persuading a sick doctor to accept treatment. The majority of cases involve drugs and alcohol/...

alcohol.

The Preliminary Proceedings Committee considers all other cases. It may refer to the Health Committee, too or to the Professional Conduct Committee in the case of serious professional misconduct. Alternatively, the Preliminary Proceedings Committee may inquire into the case itself and, if appropriate, issue a warning letter. A typical case would be a first criminal offence involving alcohol.

The Professional Conduct Committee considers criminal convictions which indicate that a doctor is no longer fit to practise e.g. possession of drugs, non bona fide prescribing, abuse of alcohol, indecent assault etc. The ultimate sanction is for a doctor's name to be erased from the register.

Other than in the case of criminal convictions which are automatically referred by the courts to the GMC these procedures are not activated unless the GMC is informed about an offending doctor. The GMC relies on information being relayed to it by doctors and members of the public; this tends to be very little and of poor quality. Doctors may have a misplaced sense of loyalty to their colleagues; patients/...

patients know very little about the GMC. In evidence to the Merrison Committee (1975) the group MIND said: "while it is proper that disciplinary action should be taken on different levels by different bodies, this situation is confusing for the public, and much greater initiative could be shown by (the General Medical Council) in making clear its disciplinary role."[11]

Few individual complainants understand that their complaint must relate to a doctor's fitness to practise, and that their complaint must be in the form of the statutory declaration.

Sir Denis Hill, the first Preliminary Screener, was disappointed that the Medical Act, 1978 which created the Health Committee and named the other two committees had done little to relax the formality or punitive nature of General Medical proceedings.[12] For example, the profession had demanded that the Health Committee include legal as well as medical representatives although this runs directly counter to the spirit which prompted the creation of the Health Committee. Despite these legal safeguards, some members of the GMC were still concerned that the Health Committee was nothing but a "trial jury".[13]

Sir/...

Sir Denis Hill had hoped that the new Health Committee scheme would evoke a greater response from doctors both individually and collectively, but, to date, only two specialities have introduced sick doctors' schemes which would enable sick doctors to seek help and obviate the necessity of invoking the GMC formal procedure.[14]

It must be obvious that the primary function of the GMC is to protect the public from doctors who are no longer fit to practise. The role of the individual is peripheral. An individual complainant's statutory declaration may prompt a General Medical inquiry but the complainant will not be called as a witness in informal cases. Even in formal inquiries, the Professional Conduct Committee might rely on other evidence. Furthermore, as the Professional Conduct Committee does not give reasons for its decision the complainant may never get a satisfactory explanation of his own case although he may have the satisfaction of knowing that the doctor concerned is no longer practising.

ii. Action for the Victims of Medical Accidents (AVMA)

AVMA is a charitable organisation established in July 1982 following the transmission/...

transmission of the play "Minor Complications" on television.[15] It portrays the enormous difficulties encountered by a woman seeking compensation after an operation goes wrong, and was based on a real case. The author, Mr. Peter Ransley, received so much mail from the public that he became convinced of the need for such an organisation as AVMA.

Action for the Victims of Medical Accidents is a referral and advice centre, confined to the greater London area and funded by the GLC and the Rowntree Charitable Trust; it was refused a grant by the Department of Health and Social Security. Its function is to help medical accident victims assess what has happened to them, and if negligence is a possibility, put victims in touch with solicitors and solicitors with medical experts.[16] AVMA is insistent that it does not seek to promote unnecessary litigation but to make it easier for ordinary people to pursue remedies to which they have a right.

AVMA itself will not investigate complaints but hopes to be active in assisting victims to obtain information from the hospital and Department of Health and/...

and Social Security relevant to their case, including medical accident statistics and details of out of court settlements. The AVMA is supported by the Association of Community Health Councils for England and Wales and accepts referrals from them.[17]

Already, the advice centre has handled more than 600 cases.[18] This experience has confirmed the view of AVMA that ultimately no-fault compensation is probably the answer but to campaign for such would endanger their charitable status.[19]

Although the AVMA Steering Committee consists of both doctors and lawyers, as well as nurses and laypeople, the medical profession has reacted adversely to it, and in one case is sceptical of its value. A committee member resigned after only three meetings because she was made uneasy by the attitudes of other committee members who appeared to want confrontation with doctors.[20] AVMA itself is having "great difficulty" in building up panels of medical experts.[21] On the other hand, the group has attracted so much attention from the legal profession that it has set up a lawyers' Support Group. But, as a correspondent of the British Medical Journal/...

Journal asked of the AVMA : "Does it really believe that it can make important improvements within the present negligence system, especially if opposed by the might of the defence unions?"[22]

(c) Resolution of Grievance by referrals - the Local Health Councils (LHC)[23]

Strictly speaking, Local Health Councils have no role in investigating and reporting on individual complaints which remains the direct responsibility of health service management and, where appropriate, the HSC, MWC or other outside agencies. However, since their inception Local Health Councils[24] have increasingly devoted their time and efforts to this area. They do so because they perceive an unmet consumer need which they are in a position to meet. Their view is borne out by the fact that their aggrandisement does not appear to have been at the expense of other agencies. No doubt, Local Health Councils have been unconsciously propelled along this route by their singular failure to make an impact on health authorities in any other area.

As originally conceived, Local Health Councils were intended to voice consumer opinion to Health Boards on the delivery of health care in their area.[25] They bore some resemblance in theory to the consultative councils for the nationalised/...

nationalised industries but in operation they were intended to be quite different. Earlier, the House of Commons Select Committee on Nationalised Industries had reported disparagingly on the consultative councils because they were so weak, so limited in scope and so little-known.[26] The new Local Health Councils were to be so structured as to give nationwide coverage at district level and guarantee consumer access to district and area administration. In determining their function, however, the government was less clear-cut as to the aims of Local Health Councils.

Health Councils were advised that their role was "(to) review the operation of the health services and make recommendations for improvements and will otherwise advise the Health Board on any matters relating to the operation of the health service."[27] However, Local Health Councils were given a great deal of latitude in interpreting what this meant. They were told that each Local Health Council could make up its own mind on how best to fulfil its statutory role. This discretion has remained unfettered by the formation of an Association of Scottish Local Health Councils which does not attempt to lay down national policy.[28]

Although the Local Health Council is the most consumer-orientated of all the agencies so far considered, its ostensible independence from the National Health Service has been compromised in/...

in a number of ways.

1. Health Boards have a psychological advantage in that they were responsible, initially, for creating the schemes to set up Local Health Councils. They determine their form, location, accommodation and staffing. To a lesser extent by their unco-operative stance they have determined the extent of the powers and spheres of interest of the Local Health Councils.[29]

2. In particular, Health Boards have a large say in determining the composition of the councils. Health Boards are reponsible for appointing two-thirds of the members of a 15-30 member council thus guaranteeing that their nominees will always hold a majority. The nominees' names are all drawn from voluntary organisations and Health Board members cannot become Local Health Council members. A survey of Health Board nominees in Local Health Councils reveals that Health Boards favour trade union representatives from NUPE and COHSE, retired medical personnel who devote their time to voluntary work, and charitable associations working in the fields of mental health, children and terminal illnesses. Local authorities are responsible for selecting the remaining one-third members. They too are attracted by candidates who have prior knowledge of the health service. The Local Health Councils appear to represent the public but in fact the members are drawn from a closed circle of people who/...

who are quite unrepresentative of the average patient. It would make little difference if the members were nominated by the local authorities or Secretary of State since they, too, in all probability, would have to rely on the same kinds of people. The position is unlikely to change until it ceases to be dependent on people already active in the field and urges ordinary members of the public to volunteer.[30]

Fortunately, Local Health Councils have found that this arrangement can work to their advantage. The National Health Service is a complex organisation and lay members of the council can be overwhelmed by their task or find it difficult to make relevant and appropriate recommendations. Retired medical professionals, on the other hand, are already very familiar with the system and are very active in council meetings.

3. Each Local Health Council has a full-time secretary and supporting staff. However, although Local Health Councils may select their own secretary, their choice is subject to any objections raised by the Health Board via the Secretary of State for Scotland. Clerical staff are seconded from National Health Service Health Board staff. Thus, although ultimately the Local Health Council scheme is regulated by the Secretary of State for Scotland, the parameters of daily work are controlled by the Health Board.

The/...

The Health Board bears the entire cost of salaries and expenses incurred by Local Health Councils and grants them a small annual budget. This renders the SHHD injunction to Local Health Council staff to regard themselves as "in the service of the local health council and accountable to it for the performance of their duties" rather hollow.[31]

4. Even as regards accommodation, responsibility has devolved from the Scottish Office to the Health Boards. Health Boards are responsible for finding vacant offices from existing National Health Service properties which would be suitable as offices and meeting places. This unfortunate decision may result in Local Health Councils being seen by the public as being too closely associated with the Health Boards. Much of the accommodation is inconveniently located from the public viewpoint preventing the development of the Local Health Council offices as advice centres or public information offices.

At least one Local Health Council in Greater Glasgow Health Board is actually located in a hospital itself.[32] Rather than deterring complainants, the Local Health Council finds that the close links with hospital staff, patients and visitors resulting from its physical proximity mean that the Local Health Committee receives some complaints of which it might never otherwise know. The value of this relationship/...

relationship must be weighed against the danger that the Local Health Council might be seen as an extension of the staff and the success of the Local Health Council above is largely attributable, in my opinion, to the personal attributes of the Secretary, the nature of the hospital (geriatric) and the very limited goals the Local Health Council has set out for itself.

5. The discretion permitted Local Health Councils to determine their own role in local circumstances has not served the Local Health Council movement well. There was a great deal of discussion about the role of the Local Health Councils in the early days but members have not been able to define, with any accuracy, what their function actually is. The rejection of the consultative council model seemed to throw Local Health Councils towards attempting to influence management decisions. Health Boards are required to consult Local Health Councils on changes in health service provision in their district i.e. closures, changes of use, developments. In order to make informed judgements, the Local Health Councils need information, policy papers and access to Health Board meetings. Few Health Boards have such a close relationship with their Local Health Councils, despite the duty imposed upon them. Health Boards are lax about providing Local Health Councils with the information they require and when they do consult them they only do so after they have already taken a decision and/....

and not in the formative stages.[33]

Local Health Council members have no right to attend Health Board meetings or demand minutes of papers. In the Greater Glasgow Health Board area, it is known that only one Local Health Council has succeeded in obtaining access to district administration Executive Group minutes.[34] Unlike their English counterparts, the Scottish members of Local Health Councils have no right to be represented on Health Boards.[35] But this trend towards participation in Health Board matters confused Local Health Council members as to whether they are becoming part of the management structure and not just participating in it.[36] There is some conflict as to whether it is possible to reconcile decision-making with consumer representation.

Local Health Councils in Scotland are not seeking a generalised power base within health authorities. They recognise that current consultation procedures between Local Health Councils and Health Boards are inadequate. In particular, Local Health Councils are fighting to obtain observer status at meetings of the Health Board Policy and Planning Committee, a move which is being resisted by the Health Boards.[37]

The Local Health Councils can do little to persuade authorities to be more co-operative other than courting administrative officials personally./...

personally. Local Health Councils find it hard to get Health Boards to take them seriously. As Perth and Kinross Local Health Council said in its evidence to the Royal Commission on the National Health Service, as long as Local Health Councils have no fiscal or executive authority their influence can only be marginal.[38]

Consequently, there has been little left for Local Health Councils to do. The impression gained from Local Health Council members is that they are trying to manufacture a role. The Scottish Office had already advised Local Health Councils that they should be able to give advice to individuals on the appropriate complaints machinery without pre-judging the merits of the case themselves or entering into its resolution. In view of the large numbers of complainants who turned to Local Health Councils it seemed only natural that they should concentrate their efforts there.

Health Boards have responded equivocally to this development. While their tendency to work in private has deprived the Local Health Councils of one useful function they deplore the Local Health Councils activities in relation to complaints.

The CAMO for Lanarkshire Health Board expressed the views of many Health Board members when he wrote that: "The main danger, and one which is fully recognised by most Health Councils, is that they turn into a patients' complaint/...

complaint bureau. This is a minimisation and, in some ways, a degradation of their function."[39] While there may be some truth in this statement, it is clear the solution lies in the hands of the Health Boards themselves and it is revealing that the same author also states:"... the allocation of resources in priority is, in the last analysis, a function of management - a function which is best effected free from pressure group influence."

Leaving aside the lack of commitment on the part of health authorities to consumer participation, it is clear that there has always been pressure on Local Health Councils from the community to take up complaints. As early as 1973, National Health Service observers saw the Local Health Council scheme as a natural link-up to the HSC.[40] It was suggested that Local Health Councils ought to do much of the sifting of complaints for the HSC. This has in fact happened, where the Local Health Council merely acts as a referral centre. But again, much depends on the attitude of the Health Boards involved. Lothian Health Board refuses to take cognisance of complaints coming from Local Health Councils whereas Greater Glasgow Health Board will liaise with Local Health Councils by means of letter and phone. The Secretary of State seems unwilling to intervene in the interests of obtaining uniformity.

Of course, Local Health Councils can do nothing/...

nothing to determine facts or allocate blame but they are rightly included in this section because for some of them it is their role in handling complaints which justifies their existence. because they work closely with other complaints systems it is interesting but not unexpected to find that they are not impressed by them.

At first, the Local Health Councils turned to the service committee procedure but were soon disappointed by the outcome. The service committees rarely concluded that there was any breach of the terms of service. The Local Health Councils are suspicious of the composition of the service committees and fear that they overawe complainants. It is not uncommon for complainants to fail to appear at a hearing. Furthermore, Local Health Council members have not been able to obtain any real experience because procedural rules prevent them from appearing as "patients' friends".[41] At least one Local Health Council has taken a policy decision not to involve clients in the service hearing procedure.[42]

Similarly, Local Health Councils have been disappointed by the HSC. In their experiences with him they have found him sympathetic and frank but they share his frustration at the limited remit of his office.[43]

It is evident that although Local Health Councils/...

Councils are seen as patients' complaints bureaux, and they actively promote this image themselves, there is in fact little practical help they can offer complainants once they have advised where and how to lodge a complaint. Their main contribution seems to be to provide moral support and to stiffen the resolve of a would-be complainant.

(d) Resolution of Grievances by the Courts

Since the introduction of the National Health Service in 1948 and more recently the Legal Aid and Advice scheme there has been a considerable increase in the number of actions for negligence brought against doctors and hospitals. The number of actions is stimulated by the publicity given to large personal injury awards and the impersonality of modern medical practice.[44] Patients eventually turn to the courts because they remain the only forum whereby financial compensation might be obtained. The law itself is outwith the limits of this discussion but suffice it to say that it is hedged about by uncertainties and patients assume an enormous financial risk in embarking on litigation. In particular, the law has yet to develop fully standards of care which meet the advances of medicine, e.g. the reconciliation of the concept of informed consent with participation in clinical trials or prescription of experimental drugs. However, it is worth noting that courts are influenced by general considerations when deciding individual cases. Judges shrink from being responsible for bringing/...

bringing about defensive medicine, i.e. deterrence of innovation and advance in clinical treatment.

As Lord Denning said in Woolley & Roe v. Ministry of Health & Others (1954) 1 WLR 65: "We should be doing a disservice to the community if we imposed liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be shifted and confidence shaken."

The judiciary believe that by imposing too strict a standard of care on doctors, with a resulting increase in awards made against them, the result would be catastrophic for the community as doctors sought refuge in "defensive" medicine to protect themselves against future litigation. Each patient would be seen as a potential claimant resulting in poor practices[45] e.g. performing unnecessary diagnostic tasks to take account of every remote possibility in case an expert witness alleges it should have been done; refusing to carry out tests in case they have side-effects; refusing to prescribe new drugs or unconventional therapies.

The resulting course of treatment usually takes longer, costs more and may have an adverse effect on the doctor-patient relationship.

Not/...

Not only is there little evidence that British conditions are ripe for a boom in malpractice litigation, a view expressed as recently as Whitehouse v. Jordan (1980) 1 All E.R. 650, but there is now evidence emerging from USA that defensive medicine can be a good thing. In a British Medical Association Conference session in the United States of America, an American consultant presented data which suggested that medical standards may have been raised by the epidemic of litigation.[46] One indication was the reduction in fashionable but unnecessary operations e.g. to remove tonsils, adenoids, heart by-passes. Another was the reduction in deaths occuring on the operating table because of faulty monitoring by anaesthetists.

Interestingly, a similar process took place in Britain when a number of patients were left in a state of coma following an operation under general anaesthetic. Eminent consultants campaigned in the correspondence columns of newspapers to raise standards and staffing. Obviously there comes a point when, however health services are financed, good medical practice becomes so expensive as to be unobtainable.[47] On the other hand judges may be moved to award expenses against a doctor because they are unduly influenced by the tragic circumstances of the case.[48] Doctors allege that awards appear to be made on the basis of who can best bear the loss.[49] In the case of Whitehouse v. Jordan the parents of a severely brain-damaged/...

brain-damaged child were awarded compensation of £100,000 after ten years of fighting, in the court of first instance, only to lose it all when the Court of Appeal reversed the judgement.[50] The courts themselves are keenly aware of the iniquity of making large awards to medical victims on the basis of negligence when all injuries and disabilities are equally real to the victim regardless of how incurred. The courts have publicly called for reform in this area. As a result, the Pearson Commission on Personal Injuries re-examined the workings of the present system and ventilated some of the arguments for a no-fault system of compensation. But its recommendations have not been fully implemented.

Courts remain the preferred solution of the medical profession. Although it is a drastic remedy it is hedged about by safeguards for their career and reputation. Doctors feel threatened by the informal methods of other complaints-handling agencies which cut right across the concept that truth is revealed by cross-examination.[51] Unfortunately for the public the medical profession appears to insist that this adversarial method of complaints resolution be pursued at every level of the health service, almost regardless of the seriousness of the complaint.

CHAPTER 7 FOOTNOTES

1. Institute for Health Studies, University of Hull. A senior officer's reflections on the National Health Service (anonymous) "The Curate's Egg... Good in Parts" June 1979 p.38
2. Dr. Pyke, quoted R. Klein "New Horizons in Medical Ethics" BMJ 2.6.73 p.529
3. SHHD NHS Circular SHAS 1975 (Gen) 97
4. D. Appleton "Mental Welfare Group Criticised" The Scotsman 18.4.83 p.5
5. HC Debates Vol. 797 cols. 321-322 Mr. W. Ross (Secretary of State for Scotland)
6. SHHD Report on Enquiry into Maternal Deaths in Scotland, HMSO, Edinburgh, 1978
7. J. Leahy-Taylor "The Doctor and the Law" London, 1982 p.182
8. DHSS Report of the Committee of Inquiry into the Regulation of the Medical Profession. CMND 6018, 1975
9. GMC Annual Report, 1980
10. ibid over 100 per year
11. see Footnote 8, p.233
12. Sir Denis Hill "News and Notes" BMJ Vol. 284 22.5.82 p.1564
13. GMC, BMJ Vol.283 14.11.81 p.1343
14. see BMJ Vol.285 24.8.-4.9.72 for an example of the guarantees of anonymity for referee, and confidentiality for sick doctor that these schemes offer. See also J. Lyall "Detection and treatment of alcoholic doctors 'inadequate'" The Times 15.8.83 p.4
15. BBC 1 3.8.82 (repeated transmission)
16. AVMA Press Release 28.7.82
17. AVMA Newsletter October, 1982 p.2
18. Up to March, 1983 AVMA Newsletter of same date
19. Correspondence with Mr. A. Simanowitz (Director AVMA) 13.10.82
20. A. Savage "Correspondence" BMJ Vol.285 11.9.82 p.737
21. see footnote 18
22. BMJ Vol.285 7.8.82 p.445
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24. NHS (Sc) Act, 1972 s.14
25. SHHD Memorandum on Local Health Councils, 1972 SHHD/...

SHHD "Reorganisation of the Scottish Health Services" CMND 4734, 1971
26. D. Phillips "The Creation of Consultative Councils in the NHS" Public Administration (58) Spring, 1980
27. SHHD "Functions of Local Health Councils" NHS Circular 1974 (Gen) 90
28. Correspondence with Mrs. L. Headland, Secretary/Treasurer, Association of Scottish Local Health Councils, 20.10.81
29. Information received from Secretaries of LHCs in GGHB area on various dates
30. Central Government had adopted this policy in an attempt to broaden the composition of its list of "the good and the great"
31. see Footnote 27 p.6
32. South West District LHC at Nitshill (Darnley Hospital)
33. cf. Experiences of Eastern and Western District LHCs in GGHB area. Other LHCs in GGHB area have not been so ambitious as these two to influence HB policy
34. Western District LHC, Information received from Mr. D. Crawford, Secretary, 16.3.81
35. Dr. Griffiths, Chairman, Association of Scottish Local Health Councils, Annual Conference, 1981
36. DHSS Royal Commission on NHS: Report CMND 7615, 1979, Chapter 11
37. Information received from Mr. J. Brunton, Secretary, Eastern District LHC 2.11.81
38. see Footnote 36 19.11.76 (Minutes of Evidence, Scottish Office Record Library)
39. W. Thomson "Local Health Councils - a Personal Point of View" Health Bulletin 36(4) 1978 pp.183-186
40. R. Klein, "Who is the Patient's Friend" BMJ 2.6.73 pp.528-532
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42. Information received from Mr. G. Gillespie, Secretary, S.W. District LHC 12.11.81
43. see Insert photocopy Ch.
44. Medical Defence Union Annual Report, 1982 passim
45. N. Hershey "The Defensive Practice of Medicine" Milbank Memorial Fund Quarterly 1 (1) 1972 pp.69-97

46./...

46. BMA Conference (1981) Report "Transatlantic Contracts: the BMA at San Diego" BMJ Vol.283 7.11.82 p.1234
47. Dr. D. Bolt, Chairman, Central Committee for Hospital Medical Services, BMA Speaking on BBC Radio 4 "Analysis - in the Public Interest" chaired by Mr. I. Kennedy 10.6.81
48. Dr. M. Lees, Law Society of Scotland Seminar "Medical Malpractice litigation" 25.1.82
49. C. Wood (ed) "The Influence of Litigation on Medical Practice", London, 1977
50. Whitehouse v. Jordan HL 1981 (IALL E.R.) 267
51. see Footnote 49, J. Leahy-Taylor at p.77

CHAPTER 8

ISSUES AND THEMES

PART I

A number of themes have recurred throughout this work. A review of them gives rise to some observations which are classified as follows:-

1. Attitudes to Patients' Rights
2. The Nature of the HSC
3. Some Consequences from the Nature of the Office
4. The Value of the SC on PCA
5. Performance Criteria
6. Case for Reform
7. The Will to Reform

1. Attitudes to Patients' Rights

Attitudes to the evolution of patients' rights vary according to the role of the individual in the medical process. However, doctors and patients share a suspicion of the legal system.

When Dr. John Harvard, Secretary of the British Medical Association, was asked, "Is the law capable of dealing with medical negligence cases?" his reply echoed the views of other doctors. He said that Anglo-Saxon law was inherently incapable of dealing with medical and scientific issues because of its unscientific basis and its inability to keep up with technological changes.[1] While this raises a fundamental query it overlooks the many routine aspects of medical treatment.

However/...

However, if Dr. Harvard is implying, however obliquely, that courts are not the appropriate forum to settle cases of medical negligence because they are manned by laymen, then he chooses to ignore the many other highly specialised fields in which judges function effectively and also overlooks the more fundamental objection that judges are deciding ultimately on matters of law, not medicine. But he is correct in asserting that because judges proceed by precedent they have difficulty in handling new issues thrown up by medical advances.[2] The result can be apprehension as to the consistency and predictability of outcome from the medical profession who are convinced that medicine is not yet sufficiently ascertainable to be amenable to the legal process.

Doctors believe that when judges find for patients, public sympathy and heightened economic expectations boost the quantum of damages awarded, setting up a vicious circle which has resulted in a steep rise in the insurance premiums payable by doctors.

The longer experience of doctors in the USA of a high litigation rate suggests that their fear of becoming the subject of a law suit has an inhibiting effect on their medical practices to the detriment of the patients. Regardless of the outcome of court cases, doctors feel stigmatised if only because publicity of this nature is adverse both personally to their reputation and economically to the size of their patient lists.

2. The Nature/...

2. The Nature of the HSC Office

For the patient's part, the fear is that patients' rights are insufficiently defined and developed. A practical illustration of this was the apprehension felt by the Scottish Consumer Council on the publication of its self-help guide to resolving health service complaints entitled, "Patients' Rights".[3] The booklet referred to legal redress as only one of a range of alternative systems available. Nevertheless, as the Council's legal advisers pointed out, this title is a misnomer because the law of delict only provides that a patient has a right of action where a doctor fails to exercise a duty of care owing to him, resulting in damage. Thus a patient has no legally enforceable right to obtain say, the disclosure of the consequences of a proposed course of treatment unless he can show that there was a breach of duty which resulted in harm. However, although patients do not enjoy absolute legal rights they do benefit indirectly from the ethical and legal duties imposed on doctors, and the Health Service Commissioner takes cognisance of these.

The Commissioner is also receptive to the changing attitudes of the public to perceived patients' rights. Sustained compaigning and lobbying by charitable welfare organisations have focused media attention on the principles underlying these and highlighted some of their weaknesses. For example, anti-abortion groups have shown a readiness to avail themselves of the courts of law, however inappropriate the legislative provisions may be, in order to seek the abolition of medical practices of which they disapprove.[4]

Cases/...

Cases are taken to court or referred to the Ombudsman with the intention of uncovering unsavoury, suspect or arbitrary practices and thereby stimulating public concern as much as with any hope of succeeding. The strategy however has succeeded. Publicity has pressurised the British Medical Association into re-formulating its codes of conduct. And, as a result of the publicity generated by the unsuccessful prosecution of Dr. Arthur Leonard, at the instigation of LIFE organisation,[5] the BMA has re-written and extended its guidelines on the treatment of severely mal-formed babies. Because of the pressure from AVMA and television documentaries on the subject, the BMA set up a Working Party in May 1983 to report on no fault compensation for medical injuries.[6] Press coverage on the DHSS proposal to conduct experiments into the incidence of mental handicap by depriving some expectant mothers of vitamins means that doctors are now debating in the correspondence columns of their journals how informed consent can be reconciled with such clinical trials, i.e. the medical profession - at every level - is becoming more receptive to the sensitivities of the public.

The term "patients' rights" is slowly but surely being abstracted from its purely legal connotation, and the HSC has a part to play in this process. It is surely significant that the majority of SC members were impressed by the philosophy exemplified by the World Health Organisation in its codes and charters, that patients' rights derive from the basic human right of self-determination and should prevail over the domestic laws of a country. The HSC is well aware, as/...

as a barrister, that the term has no legal significance but it has a moral dimension which is both persuasive and easily understood.

Patients, doctors, as well as observers are confused as to the role of the HSC and continue to assess his performance by inappropriate criteria. It is impossible to judge the success or failure of the HSC until such appropriate performance criteria have been evolved. These in turn are determined by the agreed function of the HSC. (A further question might be, who should legitimately participate in the process of "agreeing"?)

Obviously, the role of the HSC will be partly influenced by the individual office-holder. However he is only free to influence events within his remit. A major factor therefore is the nature of the legislative provisions regulating the exercise of the HSC's powers. Later in this Chapter, the provisions of the Act will be reviewed critically to assess whether or not they are conducive to promoting the public interest.

One body of opinion holds that the HSC is a kind of adjudicator with all of the judicial characteristics which this entails. This view is superficially attractive bearing as it does an air of compromise. However, the image of HSC as adjudicator is an essential pre-condition for those who would like to make the HSC a stronger figure with mandatory powers. They take their example from the Northern Ireland Commissioner for Complaints whose recommendations are enforceable by leave of court, but this is such an automatic procedure that most parties implement the recommendations without waiting for an application.

The/...

The HSC has found that while adopting a quasi-judicial style of procedure protects him from criticism, it inhibits staff from speaking freely or at all. Adopting a more relaxed attitude can also have its dangers. A recent investigation drew criticism when the HSC investigated and reported on unsupported allegations made by staff against a patient about matters which the patient had not raised in her complaint nor was given a chance to answer.[7] But it would be fair to say that while the HSC generally abides by the principles of natural justice he tries not be hidebound by technical procedural rules.

The Chapter on the case-law supports the view that the HSC has rejected the role of adjudicator. The nature of the complaints received by the HSC show that they are not amenable to being broken down into clear issues. The HSC has had the greatest difficulty in devising coherent categories for the subjects of complaints which appear in his reports. When complaints are broken down in this way the subject headings can appear very numerous and trivial. Some complaints, while amenable to analysis, are not easily remedied. The bringing of the complaint may be in consequence of the lack of communication between patients and staff which can be remedied ultimately only by changes in medical education.[8] Alleged failures in service may be attributable to financial shortages; a deficiency which can only be met by recourse to Parliament. In this respect, heightening the judicial characteristics of the HSC office will not make it more effective.

The empirical findings of the HSC coincide with the views of Professor K. Bell in her study of tribunals/...

tribunals in the social services. She concluded that increasing the legal input to tribunal proceedings did not significantly advance the complainant's cause. The presence of lawyers or the availability of legal aid resulted in cases taking much longer therefore costing more, and the arguments became more technical.[9]

Consumer groups are unhappy that the HSC appears to favour the legal process as his model. The HSC's analysis of complaints in terms of rights and duties implies that someone is right, someone is wrong, and that his function is to determine whom. Consumer groups believe that this confrontation model is detrimental to doctor-patient relationships and, furthermore, irrelevant. The complainant has nothing to gain but an explanation, the subject of the complaint should have nothing to lose by providing one. Since this is the case, patient groups would prefer the possibilities offered by a conciliation-type process. Consumer groups want to enable patients to have a dialogue with their doctors, preferably directly. On the contrary, the HSC actually keeps the parties apart and by invoking legal techniques and procedural safeguards actually makes staff feel more threatened than they need be. The HSC heightens tension between the parties, rather than relieves it, and irrevocably harms doctor-patient relationships.

Chapter 5 on the case-law of the HSC illustrates some of the allegations made against the HSC by consumer groups. There is an under-current of truth in them, but the alternatives offered by voluntary organisations are unrealistic. They assume that the parties have trust/...

trust and confidence in each other and are willing to communicate. They ignore the fact that when the patients complain it is because they have lost their trust and confidence in their doctor and because one or both of the parties are no longer willing to talk to each other.

Professor D.C. Rowatt in his review of Ombudsmen around the world makes it clear that the most successful Ombudsmen are those who adopt an informal investigatory procedure.[10] Capp's thesis on the assimilation of the Ombudsman idea in the UK demonstrates how the British political establishment took and modified the Ombudsman plan to fit into the existing British political and legal climate.[11] He is not a consumer champion but a quasi-judicial officer having many of the characteristics attributed to legal agencies. This transformation makes the Ombudsman politically acceptable and might well have been predicted but also accounts for the initial disappointment of observers who hoped for someone in the Scandinavian tradition. The judicial model has many drawbacks which it was hoped the creation of an Ombudsman-like figure would obviate.

In Britain, and to a lesser extent elsewhere, the Ombudsman is associated with the legislature yet enjoys de facto independence.

Ombudsmen, including our own, at a Conference of Australasian and Pacific Ombudsmen, agreed that: "The Ombudsman is not an extension of the judicial process, he is an extension of the legislative process."[12] As Sir Cecil has said elsewhere, it would not make constitutional sense or be democratically acceptable for the HSC to set himself/...

himself up as adjudicator or one-man court without rights of appeal for the parties or pre-determined rules of procedure or evidence.[13]

A former chairman of the SC on the PCA described the Ombudsman in this way: "The Ombudsman can be regarded, in a case where he has found maladministration, as a kind of prosecutor ..... but he is not the judge. The final judge ..... must be this House."[14] MPs who are conscious of the dignity of the House tend to over-emphasise the significance of Parliamentary links. The Ombudsman is not a servant of the House, but a servant of the Crown and it is this which guarantees his independence.[15]

This mixed conception of the HSC might suggest that he lies somewhere between the administrative and judicial ends of the spectrum of investigatory bodies. While this is certainly true as a functional analysis it is misguided as an indicator of role The model for the HSC remains the CAG and the person who holds the office of HSC is also the Parliamentary Commissioner for Administration. While this title - "Parliamentary" - is slightly misleading in its emphasis it is an essential institutional link which determines how the HSC can carry out his work.[16]

It is tempting to describe the HSC as a mediator especially since the French created their "mediateur" but there are few points of comparison - not even physical features such as the compensation fund from which the "mediateur" can make discretionery awards. The term "mediateur" has/...

has a pacifying image which the HSC feels uneasy about. He resents the suggestion that in any way his office has "no teeth".[17]

It is some measure of his office that he has never failed to initiate and complete an investigation into any competent case. In reserve he has the powers of a court to facilitate his investigations and the support of the SC on the PCA and ultimately, Parliament, to ensure his recommendations are implemented.

Sir Idwal Pugh, Ombudsman between 1976 and 1979, takes as his starting point the view that the Ombudsman is an investigator albeit with a much narrower jurisdiction than other Ombudsmen around the world. He emphatically rejects the notion of Ombudsman as mediator.

"To act on any scale as a mediator would in my mind totally alter the nature of the Ombudsman and certainly call for different skills and larger resources. I believe the Justice All Souls Committee has got the perspective right in considering Ombudsmen in this country as part of the institutional requirements in the area of administrative law".[18]

He adds the proviso that their approach must be flexible. Sir Idwal is drawn, not to the adjudicator role, but to the office of Controller and Auditor-General. In particular he covets the power to initiate actions on one's own volition. And he concludes that this is the role favoured by Justice and the SC on the PCA. Slowly, the Ombudsman is being moved along this road.

Despite/...

Despite many of the criticisms expressed above, it would not be true to say that the HSC has become a mere mediator who has been taken into the bosom of the establishment as claimed by the magazine "New Society".[19] As Hill explains elsewhere, although it is true that Ombudsmen everywhere have become institutionalised this does not necessarily detract from their capabilities:

"Instititionalism is the process by which organisations acquire value and stability ..... (but) ..... not only must an organisation defend itself against its environment, but also it must have an offensive capability. It must carry out its mission, a programatic goal more demanding than mere survival, as well as having an impact upon that environment."[20]

Undoubtedly, the HSC has made an impact. He could not have done so without "teeth".

3. Some Consequences from the Nature of the Office

Parliament has placed the HSC towards the judicial rather than administrative end of the investigatory spectrum, with all the safeguards that this offers. In the context of complaints in medicine, however, these same characteristics can become drawbacks. Because of the scrupulous fairness shown in obtaining evidence from every party associated with a complaint, investigations do take a long time.[21] Investigations are also, relatively speaking, expensive, especially if costs are/...

are linked to the number of completed investigations rather than complaints received.

The public find the HSC inaccessible like the courts and frequently require some advisory source to guide them towards the HSC. The process by which the HSC conducts his investigations is often baffling to complainants and shares the same sense of mystique which surrounds courts and overawes those who are unfamiliar with it. Again, like courts, HSC investigations contain a coercive element which might be suspected of further alienating doctor from patient.

The most frustrating aspect of the HSC office for complainants is his limited jurisdiction. The public find it difficult to determine or understand the rationale which dictates that the HSC may only investigate certain aspects of their complaint. Consequently, many complainants are dissatisfied because the subject of the HSC investigation is frequently not consonant with the issues which they have raised in their complaint.

These drawbacks are not wholly attributable to the legal characteristics attaching to the HSC. It cannot be sufficiently stressed that the HSC methods of operation constitute the only modus vivendi which is acceptable to the Department of Health and Social Security and National Health Service Staff. Furthermore, the characteristics of the HSC office-holders since 1973 also suggest that this is the only method of operating which is acceptable to them.[22]

And/...

And yet, the HSC has been at pains to distance himself from the courts and contrast their proceedings with his own. He described his own investigations as "cheap, quick and private."[23] Such a judgement is only valid in comparison with court cases and these are widely criticised for the delays involved. The PCA and HSC agreed at a meeting of UK Ombudsmen that they did not want the same powers of enforcement as the Northern Ireland Commissioner for Complaints because they did not want to become involved with the courts. The Ombudsmen thought that there would be a great temptation for the courts to look at the facts even if there were statutory exclusion clauses.[24]

It is possible that critics have been misled by the procedure adopted by the HSC. The HSC has chosen to use many of the trappings of the courts but he employs these to his own advantage. His legal powers enhance his authority and sanction his exercise of power in the eyes of the National Health Service staff. However he rarely invokes them formally in practice. The HSC uses his discretion to obviate the need for procedural reforms but is possibly less successful in meeting the need for substantive changes.

4. The Value of the SC on PCA

Chapter 6 explained the historical reasons which brought the SC on the PCA into being and the nature of the brief allocated to it. We must now ask whether those reasons remain sufficient to justify the continued existence of the SC in its present form.

Although/...

Although it is not appropriate to discuss here the wider question of the success or otherwise of the select committee system in the House of Commons, it is worth noting that the experience of the SC on the PCA is not atypical of the problems which arise, i.e. the difficulties in obtaining members of sufficient calibre, with the time and interest to attend meetings and with the degree of knowledge and commitment which membership of a particular SC would imply.

It is difficult to evaluate the contribution of the SC to the work of the HSC since it is largely one of deterrence. The success of the HSC can be counted in the number of cases which have never arisen because of his work rather than the number he investigates. The HSC is accountable to Parliament and the SC is the concrete means of making this possible, but, as Chapter (6) reveals the SC on the PCA has not been very active in the kind of routine work expected from SCs. The publicity value of the SC is not sufficient to justify its existence.

5. Performance Criteria

The confusion resulting from the doubts concerning the true character of the HSC's office is largely responsible for another problem, namely the lack of agreed criteria by which to assess the commissioner's performance.

The SC has failed to formulate performance criteria for the HSC which could serve as a cornerstone for public discussion of the office. It has failed to make it clear whether the interests/...

interests of consumers or producers should predominate, or, if neither, how a consensus of opinion is to be reached. Much of the criticism of the HSC is confused because the parties adopt different standards. Some observers judge the HSC by the level of public consciousness, others by the level of public confidence in the office or its alleged inefficiencies.[25] Those who adopt a less stringent view believe the HSC is efficient but not effective. There is little the HSC can do, for example, to remedy failures in the National Health Service created by a lack of resources. More fundamentally, it appears that insufficient criteria were developed initially to enable the HSC to identify the specific needs to which he should be addressing himself. Thus, he receives a very wide spectrum of complaints, some of which seem wholly unsuitable.

6. Case for Reform

The issues already raised suggest that some reforms, however limited, must be made to the HSC scheme if it is to become more effective. The General trend of these reforms should be to make the HSC more active and to give him more power and authority.

A reformed HSC might be capable of forging new relationships, formal or informal, with outside bodies. At the moment, the HSC holds himself aloof from other organisations because he believes it would compromise his impartiality. A reformed HSC might have to reconsider this decision although obviously a great deal would depend on the nature and/...

and existence of future LHCs and service committees.

7. The Will to Reform

Only Parliament can sanction amendments to the Act but it lacks the political will to do so. The government seems unconvinced of the merits of the case and unprepared to confront established interests. The SC has already made recommendations for reform and been ignored by successive governments; perhaps it could press harder. The HSC has endorsed these recommendations in private but has not used the influence of his opinion because he believes the question must be resolved in the political arena. Instead, the HSC uses the discretion afforded him by the Act to make such changes in style, presentation and interpretation as he thinks necessary. By their nature, these must be minimal.

It also seems unlikely that any group will emerge outside Parliament which is sufficiently influential to secure reform. Although the group "Justice" was influential in securing the adoption of the Ombudsman plan in Great Britain it has not been successful since in bringing about changes to it.

The medical profession is also a very proficient lobbyer but is certainly not interested in promoting an item which it considers runs contrary to its interest.

Likewise, the public is uninterested in the issue of reforms to the Ombudsman, and while this remains/...

remains the case, the prospect of government action remains remote.

Part II

The body of this work contains many detailed criticisms of the institution of the HSC. In the broader context Professor Gwyn has pronounced the Ombudsmen in Britain only a qualified success in comparison with other Ombudsmen around the world.[26] In saying this he is reinforcing a long and respectable line of academic criticism since the inception of the HSC. But as Burbridge, Hill and others have pointed out, each country which adopts the Ombudsman plan modifies it to meet its own needs and make it consonant with its own political culture. Within this narrower context, the appropriate criterion for success must therefore be to ask: how successful has the Ombudsman been relative to institutions with similar purposes?[27] As Chapter 7 indicated, in the field of health services the Ombudsman is one of the most competent complaints-handling agencies, and this is despite all the flaws to which reference has been made.

The following proposals for reform, therefore, are made with these points in mind. Added to this is the requirement that they be practicable, i.e. within the existing powers of the HSC or could command sufficient support from Parliament to be passed as amending legislation if the government were prepared to introduce such a Bill. Proposals 1-5 are aimed at increasing the effectiveness of the/...

the HSC office while proposals 6-8 are intended to strengthen the link between Parliament and the Ombudsman.

1. The need to publicise the HSC Office.
2. Possible improvements in the content and style of reports.
3. The significance of the provisions concealing the indentity of the parties to the complaint.
4. Fragmented structure of the Ombudsman system.
5. The case for extending the jurisdiction of the HSC.
6. Method of appointment to position of HSC.
7. The role of the SC and PCA.
8. Transformation of HSC from reactive to active.

1. Publicity: No matter how effective or efficient the HSC becomes, it is to no avail if the public remain unaware of his existence. Therefore, the basic barometer of his success is public consciousness. The combined HSC and PCA office currently employs an information officer who, as the name implies, is essentially a passive figure to whom one has recourse. He does not actively campaign on the Ombudsmen's behalf. The Ombudsmen should employ a professional public relations officer who would manage their publicity campaign and inject some professionalism into their promotional literature.

2. Published Reports: The need for publicity and the ability to generate it is one of the Ombudsman's real weapons. He somewhat diminished this deterrent by deciding in 1980 that he would no longer publish full reports of his investigations. He took this decision on the grounds of cost and lack/...

lack of public interest. It must be accepted as an irrevocable decision in the light of the current economic recession but was nonetheless a retrograde step. As Mr. Drewry protested in the correspondance columns of "The Guardian", the published reports amounted to "a public code of administrative conduct."[28] The fact that they were not read by many (and this includes some members of the SC of the PCA) ignores the real point; that they should at least be available to be read.

Current volumes of reported investigations and annual reports make fairly unpalatable reading mainly because they are almost entirely factual rather than discursive. If the Ombudsman feels that these publications are not the appropriate forum for comment then he should be urged to make more use of his power to publish occasional reports to the Secretary of State for Scotland on such topics as he thinks fit.

3. Anonymity of Reports: The current form of reports makes them unattractive to the media, in particular the fact that they are anonymous. Ostensibly this provision is to protect the parties to the complaint from media harassment, public embarrassment or loss of reputation. These are all good reasons but the main beneficiaries are the hospitals and their staff. By publishing the names of the parties as well as those of the hospital and health authority the HSC reports would become better known and more influential. It is thought that the complainants are unlikely to feel embarrassed because before reaching the HSC they will have recounted their story to strangers so many times that it has become impersonal. The refusal/...

refusal by the SC to reconsider the issue of publishing names might be interpreted as meaning that it is not confident that the Ombudsman's decisions could stand up to public challenge and debate.

Professor Gregory, in his memorandum to the SC on the PCA recommends that it should be open to the complainants to request that their names be published. Justice goes further in proposing that the onus should rest on the complainants to object if they do not want their names to be published.[30] This seems sensible in the light of human apathy yet retains the essential condition that the complainants have a right to veto. Unfortunately, neither proposal takes account of doctors and other members of National Health Service staff who must surely be accorded the same rights. This would not be likely to render the scheme unworkable. The Ombudsman's statistics on the number of justified complaints show that this provision would be equally agreeable to the medical profession since they are more likely to be praised or cleared by the Ombudsman than criticised.

4. Unification of the Ombudsman system: The critical issue here is the extent to which unification is politically practical. The UK certainly has something of a proliferation of Ombudsmen. We have the PCA, the HSC for England, Wales and Scotland, a series of Commissioners for local administration in England, Wales and Scotland as well as the Commissioner for Complaints for Northern Ireland. Sweden, Israel and New Zealand all have unified and centralised Ombudsmen systems. This/...

This is not the case in the UK where an aggrieved citizen with a composite complaint may have the greatest difficulty in deciding where to go with his complaint. It poses complicated procedural problems for the Ombudsmen involved in deciding on a form of investigation. The increasing complexity of the welfare state makes the likelihood of these complaints more, not less, likely to recur.

Sir Alan Marre, reviewing his five year tenure of office in 1975, noted the spread of the Ombudsman concept and wondered whether sufficient regard was being paid to the convenience of members of the public.[31]

The suggestion that there should be a single "post office" for the Ombudsmen is not really a satisfactory solution since it is not simply a matter of redirection - access to each Ombudsman also differs. This obstacle could be overcome by introducing a method of access common to all Ombudsmen but this is politically unacceptable. MPs would not wish to allow direct access to the PCA.[32] Referral via MP is unacceptable to the local commissioners for administration who see the natural route as being via local councillors. Furthermore, the SC would be a constitutional anomaly in relation to the Local Government Commissioners.

Clearly, formal unification is not a viable proposition and is contrary to the wishes of the Ombudsman himself who believes it would make the office too impersonal.[33] Equally clearly, on the grounds of efficiency, maximum co-operation between the various offices is essential.[34] This is facilitated/...

facilitated by the fact that the PCA is also the HSC and occupies one office, and is an ex officio member of the Commissioners for Local Administration for England, Scotland and Wales. The PCA, HSC and local Ombudsmen issue joint literature but in this matter they could do a great deal more to present a coherent image to the public.[35] The Ombudsmen already have informal contact with one another and these should be reinforced. Immediate steps should be taken to clarify the confusion about nomenclature. The term "Ombudsman" has been accepted and should now be used extensively instead of the statutory titles in promotional literature.

5. Jurisdiction: The Ombudsman's remit is to investigate cases where there is alleged maladministration (as well as failures in the service). This concept of maladministration is relevant to jurisdiction since it relates to the form complaints must take if they are to qualify for investigation. It has been alleged that although this is a vague concept it is a severely limiting one. In fact, the SC believe it is no impediment at all.[36] The Ombudsman appears to interpret it loosely and frames the maladministration provisions around the complaints he receives.

However, the concept has confined the Ombudsman to procedural irregularities and these can appear trivial. The SC urged the Ombudsman to adopt the doctrine of "constructive maladministration", i.e. where a decision is plainly bad, maladministration is inferred. Mr. Fletcher-Cooke, a former chairman of the SC said/...

said that the doctrine was developed to make it possible to deal with those cases where the Ombudsman, like the complainant, thought the decision was wrong but could do nothing about it because it had been reached correctly.[37] The Ombudsman has refrained from applying this doctrine because he appreciates that this would amount to questioning the merits of a decision, an activity forbidden by the Act.[38] Furthermore, as he has no means of enforcing it, it might well result in loss of prestige and co-operation.[39]

This discussion is crucial to the question of clinical judgement. The exclusion of clinical judgement from the jurisdiction of the HSC has been controversial. The HSC himself has repeatedly identified this area as a weakness in his own powers and a gap in the entire complaints system. The available statistics on the operation of the new clinical complaints procedure indicate that it does not answer the Ombudsman's criticisms. The HSC has not experienced any decline in the numbers of cases which he receives relating to clinical judgement. In England, 16,274 written complaints were received by health authorities in 1981 about hospitals and community services. 40.6% of these related to clinical judgement yet only 13 were referred to the new procedure.[40] In Wales, a special regional office was set up to implement the second hearing system because it does not have a regional tier of health administration. The regional office handled 95 cases. In Scotland, the Chief Administrative Medical Officers of the combined Scottish Health Boards handled only three cases.

Sir/...

Sir Cecil put it to the Department of Health and Social Security at a meeting of the SC that the new procedure was under-utilised and not supported by the health authorities.[41] He cited two of the four cases in which he had recommended that the complainants use the new procedure. In one case the AHA said it had not yet implemented the scheme and in another the RHA refused to commence the new procedure because it considered it a waste of time.

The Department of Health and Social Security was unable to defend itself against these allegations other than to counsel patience. It pointed out that the figures were low because, in Scotland, at least, the health boards were still relying on the old procedure and were satisfied with it. In England and Wales, many cases were rejected as unsuitable for the second hearing system because the complainants appeared to contemplate legal action.

Sir Cecil and the SC were unhappy with the Department of Health and Social Security monitoring, although it acknowledged that the Department of Health and Social Security had acted quickly to prepare a report for the SC. For example, there were no figures on how many cases referred to the new procedure related to clinical judgement. Sir Cecil, in particular, felt this was an unfortunate omission but the chairman of the SC concluded by hazarding that whatever the relevant statistic might be the new procedure seemed to have made no impact on the work of the HSC and that this left his dilemma unresolved.

The/...

The medical profession is understandably defensive, and it believes that the HSC is not competent to assess expert decisions even with the benefit of hindsight especially in an area of scientific uncertainty. The HSC has responded by saying that he would work with a panel of medical assessors and would judge cases by the standard of what was reasonable at the time. While it is the conventional wisdom that clinical judgements are essentially subjective, studies have shown that, in fact, ultimately the objectivity of clinical judgements is extremely high.[42]

The Select Committee said that the health services complaints system would be more coherent if all complaints were dealt with by individual hospital authorities and, if still unresolved, were then referred to the HSC.[43] The attraction of this apparently simple proposal is marred because HSC cannot deal with a large segment of those complaints, viz. those on clinical judgement. Thus the problem of fragmentation is perpetuated.

The HSC must enlist the co-operation of the medical profession if he is ever to tackle the area of clinical judgements successfully. He must convey to doctors that the purpose of his intervention is educational and preventative, not punitive.[44]

It is submitted that, if the HSC were allowed to investigate cases involving clinical judgement, the consequences would not be as fearful as the medical profession anticipates. The HSC has divided the complaints which he receives concerning actions arising solely from the exercise of clinical judgement into four groups:-

(i)/...

(i) death or injury through alleged negligence;
(ii) alleged medical incompetence which has no permanent effect;
(iii) death or injury through mischance;
(iv) disagreement with or disappointment in a treatment.

Although it may be difficult at times to separate these categories the HSC is confident that he could handle those cases falling into the last three categories; he would continue to advise complainants in category (i) to seek a judicial remedy.

It is thought that the effects of these investigations would not be as drastic as the medical profession fears yet still advance the public interest. The HSC would still insist on evidence of some maladministration. It seems that this burden is easily discharged; where there is injustice or hardship the HSC tends to attribute this to maladministration. Does this mean that the maladministration requirement would emasculate the exclusion of clinical judgement? The HSC does not think so:

> "Certainly some complainants want a clinical judgement <u>per se</u> reviewed and would not be content with an investigation that merely sought to establish whether there had been maladministration in arriving at the clinical judgement. But I think many complainants would be satisfied if it were possible to give them an assurance from an independent/...

> independent source that the doctor took the steps that, bearing his experience in mind, he should have taken to enable him to reach an informed conclusion."[46]

The HSC is not saying that an adequate explanation will necessarily preclude a finding of maladministration but that the absence of an explanation is likely to result in such a finding.

The HSC already asks himself whether the staff who are the subject of a complaint used all the information available to them to reach a reasonable decision. In the future he will go further and determine what the exact nature of this information should be. He cannot look at the merits of the decision. Clinical judgements are not to be equated solely with the merits of decisions. There is a distinction between the way a doctor reaches a decision and the decision reached. The HSC should be able to look at every aspect of the former but not the latter. Therefore, although the HSC is thus enabled to criticise unreasonable decisions the British Medical Association need have no fear that he will be moving towards a system of absolute liability.[47]

Amending legislation should be passed to allow the HSC to investigate complaints about the services provided by general practitioners and other independent contractors such as dentists and opticians. The service committee procedure has been discredited, and no longer commands the support of the public.[48] Insofar as the HSC has dealt with complaints which have been the subject of/...

of the informal procedure he has already proved his ability.[49]

6. Method of Appointment: The method of appointing the Ombudsman is significant because it depends on a small cadre of suitable candidates already in public service coming to the attention of the government. It is essentially a self-limiting system. Until recently, the government appointed the Ombudsman without consultation. As a result of the controversy created in 1975 by the appointment of Sir Idwal Pugh, the government conceded that in future it would consult the Chairman of the SC on the PCA on possible candidates. In the opinion of many critics this proposal does not go far enough to meet the criticisms of the SC. The candidate should be subject to the annulment procedure. This would have the effect of involving Parliament, however nominally, in the selection procedure.[50]

7. Role of the SC on PCA: HSC investigations bring the HSC into close contact with health authorities and the Department of Health and Social Security but not individual MPs. The relationship of the HSC via the SC to Parliament is a very tenuous one. The house journal of the House of Commons describes the function of the SC in this way: "Its function evolved into providing the presence of Parliament around the Commissioner and pursuing the cases were he has passed an opinion."[51] This is a much more accurate summary of the SC work than a reading of its brief would imply.[52] As any observer of SC meetings can confirm, the SC exercises very little supervision over the HSC. It receives the reports on a pro-forma/...

pro-forma basis and appears to do little more than rubber-stamp the HSC conclusions. Although the SC has issued some policy guidelines in the past these appear to have originated from the Ombudsman.

Chapter 6 is intended to show that the Ombudsman, in fact, utilises the SC system to his own advantage as a public forum for cases and issues which concern him. Sir Idwal Pugh drew a useful analogy in this context by comparing the relationship of HSC and SC on PCA to the PAC and the Comptroller and Auditor General. The HSC is not in any way an expert adviser to the SC and he does not act as an investigatory agency on the Committee's behalf. However, although it is not the raison d'etre of the HSC to create the conditions under which the SC can operate effectively, the fact remains that the HSC provides the SC with all the information it needs upon which to act, and the advice as to how to make the best use of it.[53]

It would not be fair to infer from this evidence that the SC is ineffective. It suffers from all the usual handicaps imposed on the SC system in the House, as well as deficiencies of its own. Neverthless its intangible institutional authority makes it an essential ingredient in the success of the HSC and more than justifies its retention. However, it could be improved in a number of ways:

(i) The current calibre and commitment of members of the SC calls for a change of personnel. This is acknowledged in private by sources close to the HSC[54] but it can only be brought about by pressure on/...

on the party whips who are responsible for controlling the nominations to select committees. The whips will have to be persuaded that the prestige and influence of the SC on the PCA warrants such a change. Proposal (iii) may be instrumental in this.

(ii) The SC has been successful in pursuing remedies but less successful and less active in pursuing reforms to the office of HSC. A re-constituted SC should take the opportunity presented in the House via Parliamentary Question Time, Early Day Motions, Private Members' ballot to press for a government response to SC recommendations for reform.

(iii) The reports of the HSC and SC should be debated in the House of Commons at least once annually. The purpose of this regular set-piece debate would be to strengthen the ties between Parliament and the Ombudsman and stimulate debate in the House, and interest from the media. It must be conceded that the last debate (1978) was not well attended - there were only 12 MPs present.[55] But that debate was held on a Friday morning when many MPs traditionally travel home to their constituencies. It is evident that much of the power of the SC derives from its ability to take matters to the House, and although this has on occasion been ignored by the protagonists there is no doubt that providing for a regular opportunity to ventilate the issues would enhance the authority of the SC still further.[56]

8. Reactive to Active: The HSC should have the power to initiate investigations. At the moment the/...

the HSC is always seen to be acting at too late a stage and after the harm has become irreversible. If the HSC were allowed to initiate actions he would be able to underline his preventative role and, moreover, reach those cases where there is discernible suffering or hardship resulting from maladministration or failures but no individually named complainants.[57] His present inability to do so is not conducive to promoting the public interest.

The SC has given his suggestion its qualified approval; the SC proposed that the HSC should only be able to act with the approval of the Chairman.[58] This is probably a sensible provision since it promotes the analogy between the HSC and Comptroller and Auditor-general rather than turning the HSC into a kind of troubleshooter. However, the SC has taken an over-narrow view of the situation in which the HSC might act. The SC thinks that if the HSC is investigating an individual's case and finds it reveals a "hornet's nest" then he might consider conducting a full investigation.[59] The SC is overlooking the fact that the press is the most likely source of cases warranting consideration. Perhaps the SC believes that this would open the door to a flood of cases which would overstrain the resources of man-power available and alter the nature of the office but this is thought to be unlikely. The experience of Ombudsmen elsewhere in the world who enjoy this power suggest that it is one used with extreme caution, and there is no reason to believe that the UK Ombudsmen would act differently.[60] But there is every indication that the minority of cases/...

cases in which it arose would be amongst the most significant dealt with by the Ombudsman.

Conclusion:

The tenor of this work has been critical but one also hopes it has been constructive because the office of HSC is worth preserving. Some of the shortcomings encountered have undermined the raison d'etre of the office but never completely. The arguments set forth by Justice in their Whyatt Report for the creation of a Commissioner are more persuasive than ever.

The HSC represents at its core, a simple and appealing ideal of justice for the individual under the heavy hand of government. No government, of whatever persuasion, is likely to reverse substantially the volume of government activities which necessitate the existence of such an officer. Indeed, as the public sector expands, so must the remit and powers of the HSC.

The HSC's powers and jurisdiction were inadequate in the first place. There is now no counteracting argument which is sufficiently compelling to warrant further delay in the introduction of reforms on the lines detailed in Part II of this Chapter.

CHAPTER 8 FOOTNOTES

1. Dr. J. Harvard, BMJ Vol.283 7.11.81 p.1234
2. Vide difficulties formerly surrounding legal status of children born as a result of AID, and now attaching to children born as a result of in vitro fertilisation
3. Scottish Consumer Council "Patients' Rights" Glasgow, July, 1982
4. A. Veitch "Life Carries on and Vows to take up more Cases" The Guardian 6.11.81
5. ibid
6. BMJ Vol.286 14.5.82 p.1592
7. L. Saunders op cit
8. Dr. P. Peitroni quoted The Times 8.8.83 p.6
9. K. Bell "Tribunals in the Social Services" London 1969
10. D.C. Rowatt "Ombudsman - the Worldwide Spread of an Idea" Toronto, 1973
11. D.L. Capps, "Britain's Ombudsman: The Politics of Adoption" (unpublished thesis) Glasgow University Library, 1970
12. Clothier, Laking, Davidson et al "Conference of Australasia and Pacific Ombudsmen" New Zealand Law Journal October pp.431-6 p.431
13. See Footnote 22
14. Mr. M. Stewart HC Debates Col.959 Vol.924 1.12.78
15. Mr. J. Cope HC Debates Vol.959 Col.954 1.12.78
16. For a further discussion of the tenuous nature of the relationship between Parliament and the Ombudsman both here and in New Zealand see L.B. Hill "Parliament and the Ombudsman in New Zealand" Legislative Research Series (Monograph No.8) 1974
17. "The Parliamentary Commissioner" The House Magazine 19.11.79 p.5
18. Sir I. Pugh, op cit The reference to the Justice-All Souls Committee relates to a Joint discussion paper published by them in July 1981. Sir Idwal is a member of the Advisory Panel
19. P. Burgess "Whose side is the Ombudsman really on?" New Society 13.1.83 pp.55-56. An article which Sir Cecil asserts was motivated by personal considerations. Mr. Burgess, a Manchester social worker, took up a case on behalf of a client and vigorously pursued it; he was extremely disappointed with the outcome (In conversation with Sir Cecil 6.7.83)

20./...

20. See Footnote 16 and also L. B. Hill "Institutionalisation, the Ombudsman and Bureaucracy" The American Political Science Review Vol.18 p.1075-80, 1974
21. Sir Cecil Clothier has concentrated on reducing the time taken for investigations. They now take 11 months, on average. Information received from Sir Cecil 6.7.83
22. Vide Sir Cecil's remarks at Seminar convened by Glasgow College of Technology, Department of Public Administration 28.1.83
23. ibid
24. ibid
25. Combined PCA and HSC staff, each member handles only 6 cases per annum. Cited "Election Call", Chairman Sir Robin Day BBC1 30.5.83
26. W.B. Gwyn op cit
27. HC SC on PCA "Review of Access and Jurisdiction" 4th Report HC 444(i) (Session 1977-78)
28. 26.1.80
29. NHS (Sc) Act, 1972 S.48 (4)
30. See Footnote 27
31. HC PCA Annual Report, 1975 HC 141 (Session 1975-76) para. 55
32. HC SC on PCA 4th Report HC 615 (Session 1977-78) paras. 6-10
33. See Footnote 22
34. HC SC on PCA "The System of Ombudsman" in the UK HC 254 (Session 1979-80)
35. See enclosures
36. HC Debates Vol. 959 Col. 905 Sir Antony Buck, Chairman of SC on PCA 1.12.78
37. HC Debates Vol. 959 Col. 929 1.12.78
38. NHS (Sc) Act, 1978 S.97(2)
39. See Footnote 27
40. BMJ "Parliament" Vol.286 p986 19.3.83
41. HC SC on PCA Meeting at which representatives of DHSS, Scottish and Welsh Offices were present 22.3.83
42. M. Scriven "Clinical Judgement" in H. Engelhardt, S. Spicker, B. Towers (eds) "Clinical Judgements: a Critical Appraisal" Holland, 1979
43. HC SC on PCA 1st Report HC 45 (Session 1977-78)
44. A. Donabedian "Promoting Quality through evaluating the Process of Patient Care" Medical Care Vol. VI(3) May/June, 1968

45./...

45. See Footnote 43 memorandum by HSC to SC, Minutes of Evidence, p.34
46. ibid p.37
47. See Footnote 43 BMA Memorandum to SC on PCA, Minutes of Evidence p.59 para. 19
48. R. Klein op cit
49. HC SC on PCA 2nd Report HC311 (Session 1978-79)
50. Mr. I. Gow, MP, proposed a PCA (Amendment) Bill 29.4.76 to require that the Ombudsman's appointment be subject to confirmation by both Houses of Parliament. (Sunday Times 25.4.76). This might have resulted in the successful nominee being exposed to political pressures.
51. 19.11.79 p.4
52. See Chapter 4
53. R. Gregory op cit
54. Information received from Mr M Hanson P.S. to Sir Cecil 22.3.82
55. 1.12.78 Sir Antony Buck drew a place in the ballot for Private Members' Bills
56. See the Court Line Affair, HC Debates Vol. 896, 28-31, July 1975 and Vol. 897 1-7 August, 1975
57. HC HSC 5th Report and Annual Report, 1979-80 HC 650 (Session 1979-80)
58. See Footnote 43
59. See Footnote 36
60. K. Bratton "The Office of the Provedor de Justicia in Portugal from the Point of View of the Commission for Local Administration in Scotland". International Ombudsman Institute Occasional Paper No.16, April 1982. The statistics of the Portugese Ombudsman show that between 1976-79 only 1% of total complaints arose from initiated investigations.

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HC SC on PCA 4th Report HC 593 (Session 1979-80)

HC/...

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Report/...

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AR	407	1974-75
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1R	21	1976-77
2R	160	1976-77
3R	321	1976-77
1R	130	1977-78
2R	343	1977-78
4R	589	1977-78
1R	98	1978-79
1R	1	1979-80
3R	187	1979-80
4R	550	1979-80
1R	1	1980-81
2R	306	1980-81
2R	372	1981-82
1R	9	1981-82
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Expenses

If the Ombudsman requires someone concerned in an investigation to incur expenses (for example, by attending an interview), then expenses and compensation for loss of time may be paid.

Legal Costs

The investigation procedure is usually informal and legal representation is not normally necessary. However, the Health Service Ombudsman has the power to assist with the costs if it is decided that a person involved in an investigation should be represented by counsel or a solicitor.

Enquiries

The Health Service Ombudsman's Office cannot answer questions about specific cases because of the need to maintain the confidentiality of investigations. But general enquiries about whether a particular action by a National Health Service body is within the Health Service Ombudsman's jurisdiction are welcomed.

Health Service Ombudsmen for England and Wales

Posts of Health Service Ombudsman for England and also for Wales have been established (at present these two posts and that for Scotland are held by the same Commissioner) and complaints concerning health authorities in these areas should be referred to:

The Health Service Commissioner for England
Church House
Great Smith Street
London SW1P 3BW
Tel: 01-212 6271

The Health Service Commissioner for Wales
4th Floor
Pearl Assurance House
Greyfriars Road
Cardiff CF1 3AG
Tel. Cardiff (0222) 394621
or to the London Office

Other Ombudsmen

Complaints concerning central government departments must be made through a Member of Parliament, but general advice is available from:

The Parliamentary Commissioner for Administration
Church House
Great Smith Street
London SW1P 3BW
Tel: 01-212 6271

Complaints concerning local authorities should be sent to:

The Commissioners for Local Administration –

Scotland
5 Shandwick Place
Edinburgh EH2 4RG
Tel. 031-229 4472

England
21 Queen Anne's Gate
London SW1H 9BU
or
29 Castlegate
York YO1 1RN
Tel. York (0904) 30151/2/3

Wales
Derwen House
Court Road
Bridgend
Mid Glamorgan
CF31 1BN
Tel. Bridgend (0656) 61325/6

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The Health Service Ombudsman for Scotland

Can the Health Service Ombudsman help you?

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ce of Health Service sman (or Health Service ssioner as it is officially was established by Act of ent in 1973 to investigate nts about actions of health ies within the National Service. The Ombudsman's are free and completely dent of government and uthorities.

leaflet is a brief guide to s in which the Health Ombudsman can help further advice and tion, contact the address ack page.

v the Health vice budsman help you

lth Service Ombudsman's consider and investigate nplaint if you feel that you ffered injustice or as a result of:

ure in a service provided the health authorities low;

ure by one of those ies to provide a service has a duty to provide:

dministration which has any other action taken by alf of one of these ies.

Who can the Health Service Ombudsman investigate?

The Ombudsman has power to investigate the actions of:

- health boards;
- the Common Services Agency for the Scottish Health Service. This agency's functions include the Ambulance Service and the Blood Transfusion Service.

What the Health Service Ombudsman cannot investigate

Matters which the Health Service Ombudsman cannot investigate:

- grievances for which there is or has been a remedy in the courts or some other legal tribunal (although they can be investigated if the Ombudsman thinks it unreasonable for you to go to court);
- actions taken in connection with the diagnosis of illness or the care or treatment of a patient, if, in the Ombudsman's opinion, it was taken solely in consequence of the exercise of clinical judgment. But see also the 'second opinion' procedure under **Clinical Judgment**.
- actions of family practitioners, dentists, opticians and pharmacists in connection with the services they provide under contract with health boards;
- actions taken by a health board in investigating under the formal procedure, complaints against doctors, dentists, pharmacists; or opticians;
- personnel matters like staff appointments or removals, pay, discipline and superannuation;
- contractual or other commercial transactions;
- properly taken discretionary decisions which an authority has a right to take (but the Ombudsman can look at whether the authority has followed proper procedures and considered all relevant aspects in reaching its decision);
- complaints made more than a year after the events complained of (but if the Ombudsman considers it reasonable, an investigation may be made);
- action which has been or is the subject of an inquiry set up by the Secretary of State in any circumstances where he thinks it advisable to do so, such as a serious incident or major breakdown in service;
- action in relation to which the protective functions of the Mental Welfare Commission have been, are being or may be exercised under the Mental Health (Scotland) Act 1960.

Clinical judgment

Although the Health Service Ombudsman cannot investigate complaints relating to the exercise of clinical judgment by hospital medical and dental staff, there is a special procedure within the National Health Service for dealing with complaints of this kind – particularly those of a substantial nature which do not seem likely to involve court action.

With such a complaint, there may be a review of the case by two independent consultants in active practice in the appropriate specialty or specialties. In suitable cases complainants have the opportunity of discussing their complaint with these consultants. If you would like to know more about this procedure, the secretary of the health board responsible for the hospital involved will be able to provide full details. Remember that such complaints remain outside the responsibility of the Health Service Ombudsman.

Who can complain to the Health Service Ombudsman?

Complaints may be made by any individuals or organisations (except those listed below) who feel that they have suffered injustice or hardship of the kind described on the previous page.

Individuals who feel that they have a complaint should approach the Ombudsman themselves. However, if the people directly concerned have died or are unable to act for themselves, the complaint may of course be made on their behalf by a person (such as a close relative) or organisation suitably qualified to represent them.

The Health Service Ombudsman is **not** able to investigate complaints made by:

- a local authority or any other public service or local government body, although in some circumstances, a health authority may take the initiative in referring a complaint against itself to the Health Service Ombudsman for investigation;
- a national industry;
- an authority whose members are appointed by Her Majesty, any Minister of the Crown or government department, or whose revenues consist wholly or mainly of money provided by Parliament. (This includes a local health council.)

How to complain to the Health Service Ombudsman

Before asking the Health Service Ombudsman to consider your complaint, you must first give the health authority an adequate opportunity to investigate it and reply. So write to the secretary of the health board responsible for the service. The local health council can give you the address and help with your complaint, as can the local Citizens Advice Bureau. If, however, you are not satisfied with the reply from the health board, the Health Service Ombudsman may be able to help you.

Your complaint should be made in writing to:

The Health Service Commissioner for Scotland
Second Floor
11 Melville Crescent
Edinburgh EH3 7LU
Telephone: 031-225 7465

Your letter should include the following information:

- the name and full address of the person making the complaint;
- the name of the health board concerned and the full name and address of the place (eg the hospital) where the problems occurred;
- the best account you can manage of the circumstances and copies of any relevant documents you may have, especially letters to and from the health board. These will be returned to you later.

Is there any time limit?

Your complaint should normally reach the Health Service Ombudsman within one year of the date on which the matter first came to your notice. However, the Health Service Ombudsman has power to waive this limit depending on the circumstances involved. If you are complaining late, you should explain why.

The investigation and afterwards

First of all the Health Service Ombudsman decides whether a complaint can be accepted for investigation and explains the reasons if it is not possible.

During an investigation you will normally be able to discuss your complaint with one of the Health Service Ombudsman's staff and it is important to remember that the investigations themselves are conducted in private. At the end of the investigation you will be sent a written report giving the Health Service Ombudsman's findings. The report is also sent to the health board complained against. If the Ombudsman has upheld all or part of the complaint the report will describe what remedy the board has agreed to provide for any injustice or hardship suffered.

The Health Service Ombudsman's work is described in annual and other reports made to Parliament – copies of these can be obtained from HMSO bookshops.

ANNEX A

Departments and Authorities whose actions are subject to investigation

Advisory, Conciliation and Arbitration Service
Ministry of Agriculture, Fisheries and Food
Certification Officer
Charity Commission
Civil Service Commission
Crown Estate Office
Customs and Excise
Ministry of Defence
Department of Education and Science
Department of Employment
Department of Energy
Department of the Environment
Export Credits Guarantee Department
Office of the Director General of Fair Trading
Foreign and Commonwealth Office
Forestry Commission
Health and Safety Commission
Health and Safety Executive
Department of Health and Social Security
Home Office
Department of Industry
Central Office of Information
Inland Revenue
Intervention Board for Agricultural Produce
Land Registry
Lord Chancellor's Department
Lord President of the Council's Office
Management and Personnel Office
Manpower Services Commission
National Debt Office
Department for National Savings
Northern Ireland Office
Northern Ireland Court Service
Office of Population Censuses and Surveys
Public Record Office
Public Trustee
Department of the Registers of Scotland
General Register Office, Scotland
Registry of Friendly Societies
Royal Mint
Scottish Courts Administration
Scottish Office
Scottish Record Office
Stationery Office
Board of Trade
Department of Trade
Department of Transport
Treasury
Treasury Solicitor
Welsh Office

Notes

1 The reference to the Ministry of Defence includes the Defence Council, the Admiralty Board, the Army Board and the Air Force Board.

2 The reference to the Lord President of the Council's Office does not include the Privy Council Office.

3 The reference to the Registry of Friendly Societies includes the Central Office, the Office of the Assistant Registrar of Friendly Societies for Scotland and the Office of the Chief Registrar and the Industrial Assurance Commissioner.

4 The references to the Management and Personnel Office and the Treasury do not include the Cabinet Office, but subject to that include the subordinate departments of the Management and Personnel Office and of the Treasury and the office of any Minister whose expenses are defrayed out of moneys provided by Parliament for the service of the Management and Personnel Office or the Treasury.

5 The reference to the Treasury Solicitor does not include a reference to Her Majesty's Procurator General.

6 In relation to any function exercisable by a department or authority for the time being listed in this Schedule which was previously exercisable on behalf of the Crown by a department or authority not so listed, the reference to the department or authority so listed includes a reference to the other department or authority.

ANNEX B

Matters (relating to the Departments and Authorities listed in Annex A) not subject to investigation

1 Action taken in matters certified by a Secretary of State or other Minister of the Crown to affect relations or dealings between the Government of the United Kingdom and any other Government or any international organisation of States or Governments.

2 Action taken, in any country or territory outside the United Kingdom, by or on behalf of any officer representing or acting under the authority of Her Majesty in respect of the United Kingdom, or any other officer of the Government of the United Kingdom, other than action which is taken by an officer (not being an honorary consular officer) in the exercise of a consular function on behalf of the Government of the United Kingdom and which is so taken in relation to a citizen of the United Kingdom and Colonies who has the right of abode in the United Kingdom.

3 Action taken in connection with the administration of the government of any country or territory outside the United Kingdom which forms part of Her Majesty's dominions or in which her Majesty has jurisdiction.

4 Action taken by the Secretary of State under the Extradition Act 1870 or the Fugitive Offenders Act 1881.

5 Action taken by or with the authority of the Secretary of State for the purposes of investigating crime or of protecting the security of the State, including action so taken with respect to passports.

6 The commencement or conduct of civil or criminal proceedings before any court of law in the United Kingdom, of proceedings at any place under the Naval Discipline Act 1957, the Army Act 1955, or the Air Force Act 1955, or of proceedings before any international court or tribunal.

7 Any exercise of the prerogative of mercy or of the power of a Secretary of State to make a reference in respect of any person to the Court of Appeal, the High Court of Justiciary or the Courts-Martial Appeal Court.

8 Action taken on behalf of the Minister of Health or the Secretary of State by a Regional Health Authority, an Area Health Authority, a District Health Authority, a special health authority except the Rampton Hospital Review Board, a Family Practitioner Committee, a Health Board or the Common Services Agency for the Scottish Health Service or by the Public Health Laboratory Service Board.

9 Action taken in matters relating to contractual or other commercial transactions, whether within the United Kingdom or elsewhere, being transactions of a government department or authority to which this Act applies or of any such authority or body as is mentioned in paragraph (*a*) or (*b*) or subsection (1) of section 6 of this Act and not being transactions for or relating to—

(a) the acquisition of land compulsorily or in circumstances in which it could be acquired compulsorily;

(b) the disposal as surplus of land acquired compulsorily or in such circumstances as aforesaid.

10 Action taken in respect of appointments or removals, pay, discipline, superannuation or other personnel matters, in relation to—

(a) service in any of the armed forces of the Crown, including reserve and auxiliary and cadet forces;

(b) service in any office or employment under the Crown or under any authority listed in Schedule 2 to this Act; or

(c) service in any office or employment, or under any contract for services, in respect of which power to take action, or to determine or approve the action to be taken, in such matters is vested in Her Majesty, any Minister of the Crown or any such authority as aforesaid.

11 The grant of honours, awards or privileges within the gift of the Crown, including the grant of Royal Charters.

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Parliamentary Commissioner for Administration

PARLIAMENTARY COMMISSIONER FOR ADMINISTRATION (PCA)

This leaflet has been prepared to give general guidance about the functions and scope of the PCA and the way in which his office operates. It is not intended to be exhaustive but it explains the main provisions of the Parliamentary Commissioner Act 1967.

Functions and Scope

1 Government Departments only. The function of the PCA is to investigate complaints referred to him by Members of the House of Commons from members of the public who claim to have sustained injustice in consequence of maladministration in connection with administrative action taken by or on behalf of Government Departments. Nearly all Government Departments are subject to investigation under Schedule 2 to the Act; the full list is contained in Annex A of this leaflet.

2 Actions taken by other public bodies (such as local authorities, the police, the courts, the Post Office, nationalised industries and tribunals) are outside the PCA's scope.

3 Government Department actions excluded. Certain types of action by Departments are excluded from investigation by Schedule 3 to the Act; these are shown in Annex B. Examples of important exclusions are: Government contracts; personnel questions of members of the armed forces and other public servants.

4 Recourse to tribunals and courts. The PCA cannot investigate any matter in respect of which the person aggrieved has exercised a right of appeal to a tribunal or has taken proceedings in a court of law. Normally, he will not investigate if the person aggrieved has or had a remedy by way of appeal to a tribunal or proceedings in a court of law, but he has discretion to act, exceptionally, where he is satisfied that there are special circumstances which have prevented the use of such a remedy.

5 Time limit. Unless the PCA decides that there are special circumstances which make it proper for him to make an exception, he may not investigate any complaint about matters of which the person aggrieved allowed more than twelve months to elapse before making the complaint to a MP.

6 Access to Information. Parliament has given the PCA full powers of investigation into matters that are within his scope. He may obtain information from such persons and make such enquiries as he thinks fit. He has full access to Government Departments. Section 8(1) of the Act gives him power to 'require any Minister, officer or member of a Department or any other person who in his opinion can furnish relevant information or documents to furnish any such information or produce any such document'.

7 Reports. If the PCA completes an investigation he reports the results to the Member who referred the complaint. The PCA will also make an annual report, and if he thinks fit interim reports, to Parliament on the performance of his functions, and he may make special reports to Parliament upon cases of maladministration where it appears to him that the injustice has not been or will not be remedied.

8 Privilege. For purposes of the law of defamation, anything the PCA says in his reports to Parliament or to individual Members is absolutely privileged.

Source and Form of Complaints

9 A complaint to a MP intended for the PCA may be made by either an individual or any body of persons, but not a local authority, nationalised industry or other public body.

10 Normally complaints must be made by the person who claims to have personally suffered injustice, though exceptions may be allowed if that person has died or is for any reason unable to act for himself.

11 The person aggrieved must be a person who is resident, or was at the time of his death resident, in the United Kingdom, or was present in the United Kingdom when the action complained of took place, or whose complaint relates to rights or obligations which accrued in the United Kingdom (but see Annex B, paragraph 2).

12 A complaint should be made in writing to a Member of the House of Commons, and include:

(a) a statement that the person making the complaint gives his consent for the Member to refer it to the PCA;
(b) the name and full address of the complainant;
(c) the identity of the Department against whose action the complaint is made; and
(d) a statement of the circumstances in which the complainant claims to have sustained injustice.

Investigation Procedure

13 Stages of investigation. A case received by the PCA from a Member may be expected to pass through the following stages:

(a) examination to decide whether the case is within the PCA's jurisdiction;
(b) investigation;
(c) report on the case by the PCA to the Member from whom it was received.

14 Privacy. When the PCA investigates, the Act requires the proceedings to be held in private. For the purpose of his investigations he has powers to examine Departments' internal papers and records and to take written and oral evidence from anyone whom he considers can provide relevant information. The extent to which these powers are used in practice depends on the circumstances of each complaint.

15 In the course of his investigations the PCA may need to seek further information from the complainant or other persons concerned. Such information may be obtained by correspondence or the PCA's officers may visit the person concerned or ask the person concerned to attend for interview.

16 Expenses. If the PCA requires a person concerned in an investigation to incur expenses (for example, by asking him to attend for an interview), the PCA may reimburse expenses properly incurred and pay compensation for loss of time.

17 Legal costs. As regards legal costs, the Act lays it upon the PCA to determine whether any persons may be represented by Counsel, Solicitor, or otherwise. If the PCA does so determine, he may consider a payment towards the legal costs in that case. It is expected, however, that such cases will be very exceptional, and that the informal nature of a normal investigation need not involve the persons concerned in legal or other representation.

The Commissioner's Relations with the Public

18 Enquiries about cases. The PCA will not accept enquiries from the Press or public about particular cases. There are provisions in the Act prohibiting him from divulging information obtained in the course of his investigations, except for the purpose of his reports to MPs and to Parliament.

19 Enquiries about PCA's jurisdiction. The PCA will answer general enquiries from the public about his jurisdiction, e.g. whether a particular Government Department or a particular type of action by a Government Department is within his scope. But other enquiries about jurisdiction, especially on matters where the exercise of the Commissioner's discretion is involved, cannot be answered without some measure of investigation into the circumstances of particular cases. Members of the public must therefore expect to be told by the Commissioner's Office, in reply to such enquiries, that the point can only be dealt with on the basis of a specific complaint referred to the Commissioner by a Member of Parliament.

Office of the Parliamentary Commissioner for Administration
Church House
Great Smith Street, London SW1P 3BW
01-212 6271

(Revised January 1982)

by any part of the National Health Service or that
you have been treated unjustly through bad administration,
the Health Service Ombudsman may be able to help you.

Can the

The Health Service Ombudsman is
completely independent of government
and of health authorities.
His services are free.

Health Service

Your complaint should be made first to the health authority.
If their reply is not satisfactory,
you can approach the Ombudsman.

Ombudsman

For further information, write to:
The Health Service Ombudsman,
Second Floor, 11 Melville Crescent, Edinburgh EH3 7LU.
Telephone 031-225 7465

help you?

Prepared by the Office of the Health Service Ombudsman and the Central Office of Information 1984

by a central government department
and you have not had a satisfactory reply to your complaints,
the Parliamentary Ombudsman may be able to help you.

Can the

The Parliamentary Ombudsman is
independent of government departments.
He investigates cases of maladministration.
His services are free.

Parliamentary

If you have a complaint against
any central government department, you can ask
a Member of Parliament to send it to the Ombudsman.

Ombudsman

For further information, write to:
The Parliamentary Ombudsman,
Church House, Great Smith Street, London SW1P 3BW.
Telephone 01-212 7676

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