Resolving complaints and promoting openness:
Can the Ombudsman Help?

SEVENTH

H.M. QUEEN ELIZABETH

THE QUEEN MOTHER FELLOWSHIP

Resolving Complaints and Promoting Openness:

Can the Ombudsman Help?

Sir William Reid
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HER MAJESTY QUEEN ELIZABETH
THE QUEEN MOTHER FELLOWSHIP

Her Majesty Queen Elizabeth the Queen Mother, who is the Patron of the Trust and has always shown a keen interest in its work, approved the founding of the Fellowship by the Trust to commemorate her 80th birthday.

The Trustees of The Nuffield Trust will select a Fellow who will be invited to undertake a review in a monograph of a subject within the sphere of the Trust which is believed to be of particular interest to Her Majesty. The monograph will be launched by a lecture.

THE AUTHOR

Sir William Reid was a civil servant from 1956 to 1989, serving in the Ministry of Education, the Cabinet Office, the Department of Education and Science and the Scottish Office. He resigned on being appointed Parliamentary Commissioner for Administration and Health Service Commissioner for England, Scotland and Wales. He retired from those Ombudsman posts after seven years in office in January 1997. For four years from 1992 to 1996 he was one of the European directors of the International Ombudsman Institute. He was appointed Chairman of the Mental Welfare Commission for Scotland in February 1997. Later in the same year he was appointed Chairman of the Advisory Committee on Distinction Awards for doctors and dentists.

He was Sydenham Lecturer in 1994 of the Society of Apothecaries of London, Crookshank Lecturer of the Royal College of Radiologists in 1994 and John Hunt Lecturer of the Royal College of General Practitioners in 1996.

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In preparing this monograph I have been particularly grateful to all my former collaborators in the office of the Parliamentary Commissioner for Administration and the Health Service Commissioners for England, Scotland and Wales (the Ombudsman). They will understand why I cannot name them all but I single out my predecessors and my successor, Mr Michael Buckley; my successive deputies Mr Don Allen, Mr John Avery, Miss Pat Edwards and Mr John Tait on the Parliamentary side; and Mr Richard Oswald, Miss Isabel Nisbet and Mr Clive Wilson on the Health side together with Mrs Olive Braman, our Information Officer. In the British and Irish Ombudsman Association Mr Gordon Adams, the Secretary, has been of great help. Other national or regional Ombudsmen or chairmen of human rights commissions belonging to the International Ombudsman Institute gave me, through their reports, friendship and discussion of common problems, an insight into the issues which Ombudsmen have to tackle and which are of relevance to good governance in whatever part of the world or under whatever political regime they operate. To my former colleagues, more especially those in Europe with whom contacts were most frequent, my warm thanks are due.

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Those who made justifiable complaints to the Ombudsman, those who were subject to investigation, those who provided redress, if possible, those who learned lessons from complaints and those who provided a better service of health care as a result are the ones who truly deserve to be acknowledged.

WILLIAM REID

July 1998

INTRODUCTION

"The pension appointed to be paid me at Michaelmas I have not received, and know not where or from whom I am to ask it .... To interrupt your Lordship ... with such petty difficulties is improper and unseasonable, but your knowledge of the world has long since taught you that every man's affairs, however little, are important to himself. Every man hopes that he shall escape neglect."

Samuel Johnson to the Earl of Bute, 3 November 1762.

'The way in which an authority handles a complaint is of vital importance. Poor handling is at the very least irritating. At worst it can destroy the credibility of a reply with the result that the complainant is not prepared to accept anything that is said." Those words from the Annual Report for 1991-92 of the Health Service Ombudsman are as apt as any with which to introduce the topic. Complaints, how they arise, their effect on audit and on the efficiency of large organisations, what redress is sought and how it can benefit users of services well beyond the original complainant, the implications for those who are the subject of complaints (whether justified or spiteful), the hierarchy of adjudication, the possibilities of mediation, the sanctions which may exist to make remedies effective, the implications for equity and for human rights, the fraught question of whistleblowing, the fear that complaining will bring retribution, the growth of Charters explaining what are citizen's entitlements - and how and when to complain should those promises not be fulfilled, the proliferation of customer services managers in the public and private sectors

of the economy, the steady expansion of Ombudsman schemes around the world, the widening and narrowing of the jurisdiction of Ombudsmen and of Human Rights Commissions in many countries - all these are matters which are relevant at the end of the twentieth century. They attract the attention of regulatory bodies like the General Medical Council, of the Audit Commission and of the National Audit Office; of consumers, aided by Community Health Councils and Local Health Councils and at national level by the National Consumer Councils; they provide work for tribunals on a wide front; they are the source of work for those who handle complaints locally or nationally as adjudicators or Ombudsmen or judges; they offer pabulum and research opportunities for academics; they provide copy for the newspapers, radio and television.

From this wealth of material it is necessary to select the more significant aspects which are familiar to one who performed the duties of Parliamentary Commissioner for Administration and Health Service Commissioner - commonly known as the Ombudsman - for seven years. If it can be said that the United Kingdom came in the second rather than the first wave of establishing a national Ombudsman in 1967 and excluded health complaints from his jurisdiction, it can equally well be maintained that, by creating a Health Service Ombudsman six years later, this country gave a special focus to the performance of its National Health Service. At first the Ombudsman was excluded, because of opposition from the medical establishment, from looking into certain complaints. It was my lot to be in office when the exclusions of clinical judgement and of actions by general practitioners offering primary care were ended. Those two large areas of care were then added to the Ombudsman's jurisdiction. More than that, the caring professions - and I do not use that term sarcastically - did not oppose that extension. Having some knowledge of the work of Ombudsmen throughout the world, I consider that the United Kingdom is well in the forefront of countries granting to a specialist Ombudsman powers of investigation into health matters which have given rise to complaint.

Later on it will be my intention to refer to a report 'The Powers, Work and Jurisdiction of the Ombudsman" made at the end of 1993 by the Select Committee on the Parliamentary Commissioner for Administration (PGA). The work done by the Parliamentary and Health Service Ombudsmen would be less effective, were it not reinforced by the legislature in dealing with the executive. The Select Committee's report, taken in conjunction with the Wilson report, had a seminal effect on handling complaints in the Health Service.

Chapter 1

INVOLVING THE OMBUDSMAN TO ENHANCE STANDARDS

"He that goeth about to persuade a multitude that they are not so well governed as they ought to be shall never want attentive and favourable hearers."
Richard Hooker, The Laws of Ecclesiastical Polity.

IT IS NOT MY INTENTION TO REPLICATE THE VERY USEFUL analysis of general principles, objectives, international comparisons, effective procedures and helpful simplifications in the handling of complaints which can be found in the report produced by Professor Alan Wilson and his colleagues in May 1994. That report was aptly entitled "Being Heard". To be heard and, more importandy, to be listened to is the desire of those with a genuine grievance. To improve performance through effective complaint-handling should be the aim of any public service.

"We do not live in a perfect world. There are doctors who are rude, inconsiderate, unsympathetic, even negligent or venal. Our complaints procedures should be strengthened to identify and suitably chastise them. There are also doctors who are ill-informed or ignorant of modern medicine, whose judgement is inadequate, whose use of costly medical techniques in the management of patients is too extravagant or too parsimonious, who make too many errors that lead to suffering, or even death - who are, simply, incompetent. Experience suggests that not many are seriously incompetent, but how do we know how many there are or who they are if we do not look?" So wrote Sir Raymond Hoffenberg in the 1986 Rock Carling lecture "Clinical Freedom" (p. 89)'. He also observed that choices and limitations were inevitable since "no system can offer the

best possible medical services to all of its people at all times"[2].

Twelve years on from Hoffenberg's percipient evaluation of his fellow-professionals we have a transformed General Medical Council, with a substantially greater number of lay members than when he wrote. We have an increased emphasis on clinical audit. We have the press clamant for more detailed audit of individual doctors' performance. There is statutory provision for "second opinion doctors" in relation to psychiatric patients. We now have a role for the Ombudsman in relation to clinical judgement and to general practitioners, which at least one journalist applauds. In an article in June 1998 a woman journalist wrote[3] "It used to catalogue tales of little old ladies kept on casualty trolleys and doctors treating patients callously. Now the Health Service Ombudsman's reports are far more interesting. This year for the first time he looks at clinical issues (such as why did my grandmother die of a heart attack when the casualty doctor sent her home with some indigestion tablets?) and also complaints against GPs." But it has taken effort and time to reach this stage of development. It has required a public change of stance by the medical profession or at least by those who represent it publicly. That is made clear by an article written two years after Hoffenberg's Rock Carling publication. It was by Professor Chris Ham. In relation to the professional accountability of medical staff Ham and his colleagues wrote[4] in 1988:

'The procedures for handling complaints concerning clinical judgement are particularly relevant to our interests. This is because a major concern of the committees and organisations that have analysed these procedures in recent years has been to create a system which satisfies complainants who have the option of taking a case to court but who chose not to do so. It can be argued that if an adequate system can be devised for handling complaints concerning clinical judgements then patients and their relatives will be less likely to pursue a legal remedy. Against this, organisations representing the medical profession have argued that the option of taking a case to court should preclude other methods of independent review.

"In addressing this question, the Davies Committee (1973) proposed the establishment of investigating panels of professional and lay members to conduct investigations into hospital complaints concerning clinical judgement. This proposal was not acceptable to the profession and was not implemented [...] the Select Committee on the PCA (1977) argued that the Health Service Commissioner or Ombudsman should be empowered to look into clinical complaints as well as other complaints incapable of being resolved by a health authority. This too was unacceptable to the profession. Following lengthy negotiations, the government secured the agreement of doctors to introduce in 1981 the procedures described above [HC(88)37]. These procedures place responsibility for investigating complaints about clinical judgement firmly in the hands of the profession and do not provide for the sort of lay and independent involvement envisaged by the Davies Committee and the Select Committee. The reason for this is the reluctance of the profession to relinquish control over the handling of complaints. This reluctance stems from the perceived threat to clinical freedom and the risk of double jeopardy if patients decide to go to court after using the independent review process.

The defects in the complaints procedure have been acknowledged by Hoffenberg who has argued for strengthened and improved arrangements to be introduced[5]. Hoffenberg has argued that the medical profession has shown considerable resistance to the concept of audit. Hoffenberg contends that the profession should welcome greater scrutiny of clinical competence, for only in this way will public confidence be maintained and the threat of external regulation avoided.

The work of an Ombudsman can cover matters of apparently slight significance to the service but of substantial importance to the individual patient or relative. When reviewing the activities of the Australian Commonwealth and Armed Forces Ombudsman, the Australian Senate Standing Committee on Finance and Public Administration considered his activities as fly-swatting and only rarely lion-hunting[6]. The same could be said of almost any

Ombudsman. As I observed in 1993 in my capacity as Parliamentary Ombudsman, it is surely salutary for an Ombudsman to look at individual complainants' grievances which matter a great deal in their eyes. Here it is worth noting what is said of the Swedish system[7]. 'The Ombudsmen do not devote their time to mere trifles. If a complaint refers to an issue of minor importance, the Ombudsman can either dismiss the complaint, or conclude it without further inquiry, even if it is not evident that the complaint lacks basis. The reason for this routine, which has been endorsed by the Riksdag, is of course that it is important that the relatively modest resources of the Parliamentary Ombudsmen should be used as effectively as possible."

However, occasionally there will be lions to hunt as well. I noted in 1993[8] that there will be what might otherwise be termed a "class action" where the number of individual complaints is so great that the Ombudsman will rightly examine performance to see if there are systemic faults that underlie or cause those complaints. That method of operation met with the approval of at least one independent commentator. Professor Alan Page commented in 1997 in a seminar at the Institute of Advanced Legal Studies, University of London[9] that commitments to quick and accurate decision making, to openness and to speedy and effective mechanisms of redress were to be welcomed as being at the heart of any system of administrative law. Commenting on the definition of his jurisdiction and "the key position he occupies in relation to the new administrative law", it is with the work of the Parliamentary Ombudsman over the period covered by the developments [since 1990] that a constructive comparison could be made. Professor Page detected a distinct shift in the underlying conception of the role of Parliamentary Ombudsman by quoting from my annual reports. In the report for 1990 I had defined my ultimate aims as being "to sift every complaint in order to determine whether it merits investigation, to investigate *prima facie* instances of maladministration and to achieve redress for persons with justified complaints." To these aims my report for 1994 had added: "to identify any measures needed to improve

systems, practices and procedures which the investigations of complaints have shown to be deficient, with a view to avoiding or reducing the repetition of maladministration"; and "to promote higher standards of administration by publishing evidence of bad practice to enable Government departments and other bodies within jurisdiction to assess what steps they can take to improve the standards of service they offer." Those aims are identical to those in the Health Service Ombudsman's mind.

It was with the benefit of my experience as Parliamentary Ombudsman that I judged it appropriate to use a statutory power which had always been available to the Health Service Ombudsman but had remained hitherto unused. That power, under Section 119 (4) (b) of the National Health Service Act 1977, was to present a special report to Parliament on one topic; in other words a lion-hunt rather than a fly-swat. What appeared was "Failure to provide long term NHS care for a brain-damaged patient".[10]

Previously I had published reports of investigations into similar complaints in the volumes of Selected Investigations; but on this occasion the benefit of setting out the whole of my investigation, findings and remedy in one free-standing report was considerable. In brief the investigation found that Leeds Health Authority had failed by discharging a man in his fifties from a hospital which had provided him with acute care and had not provided the nursing care he required thereafter. Instead the man's wife had been expected to pay for his nursing care in a private establishment because the Health Authority neither ran an appropriate nursing home itself nor was willing to pay for a bed in a private nursing home. The individual redress which the Ombudsman achieved from the Authority was to repay the money which the wife had been obliged to disburse; to undertake to pay for the man's future nursing care; and to make provision under the NHS for similar patients in future.

It was a report which led to a reformulation of the Department of Health policy in relation to long term care. In February 1995 the Department issued new guidance (HSG (95) 8) on NHS responsibilities for meeting continuing health care needs. The guidance specifically said

that it addressed a number of concerns "raised in the report made last year by the Health Service Commissioner". I issued another report in June 1996" because after my first special report similar complaints had been put to me about failure of the NHS to provide continuing inpatient care in nursing homes or hospitals. My investigations showed that some health authorities were making some provision for certain severely disabled patients but not for others; and they did not have clear written eligibility criteria for funding such care from NHS resources. My staff discovered problems caused by poor arrangements for planning discharge from hospital. While it was true that implementation of parts of the NHS and Community Care Act 1990 had enhanced and clarified the role of social services departments, some hospitals failed to refer to social workers, patients who still needed long-term care. Patients therefore did not receive a comprehensive assessment and advice before being discharged from hospital; and the Health Department guidance (HC (89) 5) that patients should be told in writing before being discharged to a private nursing home was too often ignored. It is a gratifying, if also depressing, thought that, as the proportion of elderly increases, patients and their long term care are now the subject matter of a Royal Commission. Previously they had been inquired into by the Health Select Committee of the House of Commons, reporting in November 1995. In passing I should observe, from my present scrutiny of mentally ill patients from the Chair of the Mental Welfare Commission for Scotland, that discharge arrangements still provide cause for concern. As I have observed on a number of occasions, it is not for the Ombudsman (in the United Kingdom scheme of things) to intervene in policy; but he is certainly entitled to be concerned at how policy is implemented to see whether its outcome is effective or not.

This is the place to note that Parliament conferred wider statutory powers on the Health Service Ombudsman than it had conferred on the Parliamentary Commissioner for Administration. It did not in terms empower the Parliamentary Commissioner to look into a failure in

providing a service, nor yet into a failure to provide a service which it was the duty of the relevant authority to provide. Those powers are enjoyed by the Health Service Commissioner and the last mentioned was the nub of the Special Report on failure to provide care of February 1994.

I shall return with a later example to the effect on policy which a report made by the Ombudsman can produce, especially when there is a subsequent hearing before a Parliamentary Select Committee and when the outcome is that the Committee endorse his conclusions and pass a request to Government that his recommendations be fully implemented.

In order to conclude the consideration of special reports - and I should make it clear that their judicious use is a facility strongly to be recommended at intervals - let me mention two other examples. The first arose from a higher than average number of complaints being submitted with the assistance of the local Community Health Council about the local handling or mishandling of complaints in a particular NHS trust. That occurred at about the time new procedures were being introduced from 1 April 1996 in order to implement proposals announced in "Acting on Complaints" (Department of Health 1995). The report was entitled "Investigation of complaint-handling by Salford Royal Hospitals NHS Trust"[12]. My staff's investigations showed that incoming and outgoing letters at the Trust went astray. Doctors did not always respond to requests for information as quickly as they should have done. It took too long to reply to complainants. In some cases the replies reflected superficial investigations. The monitoring of complaint-handling by senior management was inadequate. No real thought appeared to have been given to measures which might improve the service to the public and reduce the pressure on staff. The staff handling complaints must be adequate in number, properly trained, good at communicating and not afraid of reminding seniors that they have still to answer some questions. It was a report directed not so much at the Trust, which by then had taken much-needed steps to improve its performance, as at the NHS as a whole. The objective was, by pointing to failures, to

show which weaknesses needed to be cut out of practice and how procedures could be improved - indeed how procedures could be put in place if none existed. However good procedures may be in theory, they will be useless if they are ignored or left without audit. My report was intended (a) to promote better standards locally, (b) to provide lessons to be learned widely and (c) to make best and economical use of the resources of the Ombudsman. As in other reports I was not anxious to criticise front-line staff but instead wanted to encourage the top of the organisation to support, train, supervise and monitor relevant staff and also to provide more staff to handle complaints if the promises about complaint-handling made in national or local Charters were being ignored. The Ombudsman can help as an external monitor of quality. He can also see from his national vantage point where particular areas are given a poor service. His comments may help in providing a more equitable service - it is still a national service - to all its users, wherever they live. Uneven provision of health care in these islands is a problem which has been evident for very many years. The readjustments of resources which were promoted by means of the work of the Resource Allocation Working Party (RAWP) and its Scottish equivalent SHARE at die beginning of the last quarter of the twentieth century have still some way to go to attain what Walter Holland[13] termed their underlying objective, namely "to secure, through resource allocation, that there would eventually be equal opportunity of access to health care for people at equal risk".

The final special report of my period in office related to another Government initiative to extend my jurisdiction. It too was aimed at improving standards of implementing policy, although it also had the incidental purpose of reminding the public that there was now a new policy of openness. It is dealt with in the chapter on Openness.

Chapter 2

OPENNESS, GOOD PRACTICE AND AUDIT

"To reprehend princes is dangerous; and to over-commend some of them is palpable lying. "

Webster, The White Devil, Act V, Scene iii.

MY LAST SPECIAL REPORT DEALT WITH ACCESS TO Official Information in the National Health Service[14]. In introducing it to Parliament and to the Press I suggested that openness in the NHS was a well-kept secret. The Codes of Practice on Openness in the NHS had come into effect in June 1995. My impression was that knowledge of the Codes and how complaints about non-disclosure of information should be handled was not sufficiendy widespread among NHS staff. NHS bodies needed to give more attention to ensuring that staff were aware of the changes in attitude and in practice required by the Codes. It was not as if little had been done: Ministers had published a leaflet "Openness in the NHS" for the general public and had issued guidance to the NHS expecting every NHS organisation to ensure that the Codes had wide publicity, with specific references to the local person to whom requests for information should be put and how to complain if such requests were not met. The Ombudsman's own leaflet "How the Health Service Ombudsman can help you" had been revised, expanded and reissued in July 1995 and again in April 1996 in order to make as widely known as possible that the Ombudsman could take complaints that information had not been provided under the terms of the Codes.

It is a matter to note with regret in passing that my successor, Mr Michael Buckley, is still finding ignorance of

or disregard for the Code in his investigations. In his report[15] as Parliamentary Ombudsman on access to official information he criticised a government department for its failure, more than two years after the Code had come into force, to acknowledge its relevance or observe its provisions. The relevant Permanent Secretary apologised for the performance of those concerned and took action to remind all staff of the requirements of the Code and of the rules governing its application. The Ombudsman stressed the need to observe the terms of the Code itself rather than the Guidance issued in connection with it.

The underlying principle of the Codes, whether on Government or on NHS information, has been that information (not necessarily the documents in which the information is found) will be made available, unless it can be shown to fall within one or more of the exemptions specified in the Codes. I had detected under the NHS Code an apparently slightly less favourable intention to the seeker of information than under the Government Code and it seemed apt to ask the Health Departments to bring the Code more into line with the Government Code. (The Chief Executive of the NHS in England told Parliament in December 1996 that the matter would be reviewed and that it was not the intention to have a code different in its scope from the Government Code.) The preamble of the Government Code had postulated that, if non-disclosure under any of the exemptions was being considered in relation to any public interest that might be served by disclosure, both sides of the argument should be weighed up before a decision was reached. The Codes seem likely to be eventually superseded by the Blair Administration's proposals for Freedom of Information legislation.

Why do I stress this issue? I do so because of the long experience of any Ombudsman's office that failures in communication are at the root of many complaints. Complaints about the withholding or denial of information are no exception. They can arise from undemocratic procedures, as witness the meeting of Winchester Health Authority in February 1994 from which the public were excluded, while the Authority decided to close a ward for

elderly patients 21 months sooner than had been planned. Of that episode I shall say more later. If it is in order to refer briefly to my recent experience as Chairman of the Advisory Committee on Distinction Awards for Doctors and Dentists, my considered view is that far greater openness and much greater transparency of the process whereby names of consultants are put forward for consideration and are appraised is essential. To keep confidential the actual discussion about individual candidates is very important; but bringing more into the public domain by publishing the names of those who have received awards was an achievement of my predecessor Sir William Doughty and of the Advisory Committee's Medical Director, Sir Christopher Paine. Greater awareness among members of the profession of how the system operates is necessary. Even more necessary is public awareness and understanding of what happens. If the public perception of how the process works is that it is a mystery wrapped in an enigma, that it favours certain specialties to the disadvantage of others, that it gives inadequate credit to those who work in district general hospitals or to women or to those from racial minorities, then public perception needs to be changed, starting with the process. And in doing so uncertain assertions should be trounced by real facts and transparent actions. Public perception is a powerful instrument for encouraging best practice.

GOOD PRACTICE

Best practice was a concept to which the Select Committee on the PGA devoted a session on 4 December 1996[16]. The Chairman of the Joint Consultants' Committee (JCC) and the President and the Registrar of the General Medical Council (GMC) gave evidence. They responded to remarks made by the Ombudsman about failures in communication and, more seriously, about failures to cooperate with the investigation of complaints about individual doctors' behaviour. Sir Norman Browse for the JCC accepted that a few poor performers were intransigent but said that there had been no mechanism for drawing the attention of the

JCC or the Royal Colleges to those people, although some NHS Trust managers had contacted Colleges and the JCC for help in dealing with them. Sir Donald Irvine referred to the booklet "Good Medical Practice" first issued in October 1995 (and revised and reissued in 1998). In it the GMC set out for the first time to inform doctors and the public what good medical practice was in the eyes of the regulatory body. As he said 'This is guidance which is there partly to inform the public but essentially to ensure that doctors know what is expected of them". Sir Donald was reported[17] to have said on the occasion of the publication of the revised edition: "Our new guidance recognises that doctors have wider professional and ethical responsibilities than the law requires them to have. Patients have a right to expect that doctors will explain things to them fully and honestly, especially in the unlikely event that something goes wrong with their treatment." That sentiment was entirely in accordance with the observations made by successive Ombudsmen. It was also encouraging to learn of commitments to question doctors' attitudes and how they are formed, of attempts to ensure that the professionals' attitudes were in tune with what patients want and expect, and of the encouragement of local self-regulation and arrangements for doctors and nurses to monitor their own performance and, where possible, make the results known. If there have been tragic examples in recent years of the need for guidance on good medical practice and its implementation, the fault does not lie with the GMC but with individuals.

By issuing guidance the regulatory body no doubt had the aim also of preventing situations where a complaint could arise because of a failure in service or a mistake in attitude towards a patient or a patient's family or another professional.

Sometimes breaking confidentiality is a virtue, sometimes it is reprehensible. I forbear to comment on anything recent but I quote an example from a nineteenth century murder in Glasgow about which the Lord Justice Clerk, Lord Cullen, lectured so engagingly in December 1997[18]. Lord Cullen reported that a Dr Paterson had not taken any direct action

although he suspected that his medical colleague Dr Pritchard was a wife-poisoner. Dr Pritchard was found guilty and hanged. Dr Paterson, though suspecting that Dr Pritchard was poisoning his wife with antimony, wine, chlorodyne and cinnamon water, did not take action against his colleague. Lord Cullen tells us that the trial judge, Lord Inglis, observed "I care not for professional etiquette or professional rule. There is a rule of life and a consideration that is far higher than these - and that is, the duty that every right-minded man owes his neighbour to prevent the destruction of human life in this world, and in that duty I cannot but say that Dr Paterson failed."

At the end of my period in office the NHS Chief Executive gave a positive response to my suggestion that the Health Service itself should issue guidance aimed at avoiding circumstances which might call for intervention by the Ombudsman. Already I have mentioned one advantage the Health Service Ombudsman has over the PCA in respect of failures of service being within jurisdiction. Another advantage *was* in having his reports and the lessons to be learned from them circulated to the whole Service. That advantage I contrived to have removed by extending the benefits to those within the PCA's remit. The Health Departments earned my office's gratitude for the pioneering way in which they circulated to those in the Health Service and those with the task of training professional staff the epitomes of selected cases investigated by the Ombudsman. They followed that up by taking similar action when the Ombudsman's jurisdiction was widened to cover the Code on openness. It has always been my view that guidance is more likely to be effective and to be followed if it comes from within an organisation. It is more likely to be resented if it comes from outside. Therefore I invited the NHS to devise and issue a publication analogous to "The Ombudsman in your Files". That was produced by the Cabinet Office as a parallel piece of admonition to "The Judge over your Shoulder" which gives advice on how to behave so as to reduce the likelihood of having your actions judicially reviewed. The advice was aimed chiefly at officials but it is no less relevant to Ministers or to Chairmen and

members of health bodies. Having had the Cabinet Office's guidance issued to improve performance in the bodies subject to the Parliamentary Ombudsman's jurisdiction, I considered it opportune to do the same on the Health Service Ombudsman's front so that failures identified in his reports should not be repeated. Mr (now Sir) Alan Langlands told the Select Committee that the suggestion had been agreed in principle [11 December 1996]. However it is likely that with the best possible guidance there will still be local ignorance of it or departures from it. The Local Government Ombudsmen in England and Wales are statutorily charged with issuing "best practice" guidance and have done so with good effect. Even so, my preference is to avoid putting the Ombudsman in the position of nanny. Of course the top of an organisation can learn from the outside auditor's findings, but it is then the top of the organisation which should take on the responsibility of issuing guidance about improving performance and about avoiding past mistakes.

If professionals are to be judged on their performance, it is right that they should know what is expected of them. Regulatory bodies such as the GMC and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting have published clear guidance on that. If an Ombudsman is to pass judgement on performance, it should help those who are within jurisdiction to know what the charge-sheet might look like. For that reason the catalogue of what might constitute maladministration was given by Mr Crossman to Parliament in 1966 when the legislation was being enacted to set up the Parliamentary Ombudsman. In due course an up to date catalogue was included in the Ombudsman's Annual Report for 1993. Later that updated list of examples was endorsed by Treasury Ministers in November 1994, when giving evidence to the Select Committee on the PCA; and it was incorporated in 'The Ombudsman in Your Files" published in December 1995. In order to assist those within my jurisdiction as Health Service Ombudsman I published in the Annual Report for 1993-94 the catalogue of examples. For the sake of completeness it is repeated now, and

something like it could go into any general guidance from the NHS Executive:

- rudeness (though that is a matter of degree);
- unwillingness to treat the complainant as a person with rights;
- refusal to answer reasonable questions;
- neglecting to inform a complainant on request of his or her rights or entitlements;
- knowingly giving advice which is misleading or inadequate;
- ignoring valid advice or overruling considerations which would produce an uncomfortable result for the overruler;
- offering no redress or manifestly disproportionate redress;
- showing bias, whether because of colour, sex, or any other grounds;
- omission to notify those who thereby lose a right of appeal;
- refusal to inform adequately of the right to appeal;
- faulty procedures;
- failure by management to monitor compliance with adequate procedures;
- cavalier disregard of guidance which is intended to be followed in the interest of equitable treatment of those who use a service;
- partiality; and
- failure to mitigate the effects of rigid adherence to the letter of the law where that produces manifestly inequitable treatment.

It may be apt in connection with the second and third items to repeat the remark of Professor William Cullen, the eighteenth century Scottish physician, whom Dr John Brown reported as observing "I have been obliged to please my patients sometimes with reasons; and I have found that any will pass, even with able divines and acute lawyers". It is possibly more dangerous to try subterfuge than to be open. A woman complained to me that she had seen her own medical records in which a consultant had described her as

a difficult patient. On being challenged he had offered the explanation that the disease she was encumbered with was difficult to manage. That did no good at all. My investigation established beyond doubt that she was indeed a difficult patient. However the regulatory bodies are not in themselves enough for guaranteeing standards of performance. To the regulatory bodies and to the Ombudsman or the courts must be added the public and its perceptions.

We now live in a consumer society. Governments and political parties of different complexions have expressed desire to give power to the citizen. I have quoted in the past from a work published in 1976 entitled "Doctors talking to patients" the following comment "I see no reason at all to explain a patient's condition to him. If he asks an intelligent question I might offer some simple explanation, but on the whole I prefer not to". That was over 20 years ago and Professor William Cullen was speaking 200 years ago. It is likely that such an attitude, maintained as a matter of principle, would be very rarely held nowadays; but in an investigation I completed in 1994 I criticised a consultant who had not told a patient or his family that he suspected cancer, had not briefed the nurses about it but said that the nurses could have deduced it from the clinical records and could have passed on the diagnosis to the patient. The public, in this case represented by the House of Commons Select Committee, did not stand for that.

Great areas of the public sector are audited. The National Audit Office, the Accounts Commission for Scotland and the Audit Commission in their various ways cover broad issues of audit and particular issues of financial audit. They have published value for money studies. They have commented on the effective use of resources. The NHS Executive in England published a work "Promoting Clinical Effectiveness" in January 1996. Those audits are broader in scope than the clinical audit of a particular surgeon but on what grounds could one legitimately exclude that surgeon from making available the results of clinical audit? In an extreme case clinical audit - let us say of keyhole surgery - can lead to someone being deprived of professional status. Matters should not however be left to the ultimate sanction

of a GMC disciplinary decision. Clinical audit and judgement by one's peers ought to be a means of guaranteeing that the standard of service offered through one's practice is, if not impeccable, at least sustainable and defensible. The activity of the Health Service Ombudsman also provides an external quality audit. His reports provide a wealth of examples where standards have been investigated and shown to be deficient in some way or other. The reports also include instances of unjustified complaints where he has upheld the professional who has been maligned.

In March 1996 the NHS Chief Executive told a Select Committee of Parliament that research commissioned by the Department of Health had not tackled the primary goal of clinical audit - improvements in patient care. He promised that a new centre to disseminate good practice, to collate audit results and to feed information into management networks in the health service would put that right. He accepted that regional management of audits had not been handled in a consistent enough way to be truly valuable. The Chief Executive's forecast came to pass in July 1998 when the present Government published its consultation paper "A First Class Service" to coincide with the fiftieth anniversary of the NHS. As the weekly Hospital Doctor[19] reported the event 'The foundation stone of the proposals is the creation of two regulatory bodies - the National Institute for Clinical Excellence and the Commission for Health Improvement. The Institute will research and disseminate best-practice guidelines on clinical and cost-effectiveness of new and established treatments, while the Commission will ensure the guidelines are implemented nationwide." It remains to be seen to what extent the impact of these two new bodies will reduce the number of complaints made to the Health Service Ombudsman. It is also relevant to inquire whether the actions of these two regulatory bodies will fall within the Ombudsman's jurisdiction. As the Select Committee on the PCA[20] put it: "all decisions of civil servants and others within appropriate departments and public bodies involving maladministration should be subject to investigation by the

Parliamentary Commissioner, unless any constitutional principle dictates otherwise". In a memorandum which I prepared for the Select Committee when it was considering the powers, work and jurisdiction of the Ombudsman, I observed that much time and effort needs to be spent establishing whether new public sector bodies are (or are to be) brought within the Commissioner's jurisdiction. Both Members of Parliament and members of the public can be left uncertain whether new bodies are included or not. Despite the difficulties which the Cabinet Office maintained would arise in listing bodies *excluded* from jurisdiction instead of listing those to be *included* within jurisdiction, the Select Committee recommended[21] that legislation be amended so as specify exclusions rather than inclusions to the Ombudsman's jurisdiction. While these new entities, including the Director of Health Improvement who is intended to head the Commission for Health Improvement, are not likely to generate many complaints about their activities, the principle should be observed of making them subject to an Ombudsman's jurisdiction. The Socratic principle remains valid that "the unexamined life is not for man to live", particularly for regulatory bodies which should themselves be susceptible to scrutiny.

At a seminar on surgical audit in spring 1996 at the Royal College of Surgeons of Edinburgh the Ombudsman spoke the following words: "When I drive along a road, I do so with some, if decreasing, confidence that all the other drivers on the road have been required to pass a test of aptitude, health and ability plus knowledge of the rules of the road. If I am admitted to hospital to have an operation, despite the stories which appear it seems to me with increasing regularity that charlatans with bogus qualifications are admitted to carve me up, I nevertheless have very good expectation that the surgical staff will have passed examinations and kept their knowledge up to date before exercising their benevolent care upon me. Competence has been assessed by the driving test: but it is performance that matters as well. So with doctors and surgeons. If however I am told that the clinical audit data for the surgeons practising in a particular hospital are known to them but to

nobody else, what confidence can I have that they are more rather than less likely to share knowledge with the laity? That is one of the concepts built into the new NHS complaints system. It is a concept already established and being further developed by the methods of professional regulation with a greater lay involvement in the work of the regulatory bodies like GMC and GDC."

It should not have to come to a matter of litigation or of disciplinary striking off before a patient or a patient's family should be aware that the standards of service provided by a surgeon - or any other professional member of the NHS - are at least adequate or at the most very good indeed.

Chapter 3

WIDENING JURISDICTION AND INFLUENCING PEOPLE

"It is therefore as well to go back to that first principle which alone affords a solid base for civil and penal justice alike, namely, the requirement that wrong, of whatever kind, should be repaired."
G. del Vecchio, La Giustizia (Ed. AH Campbell).

THE COMPLEXITY OF THE SYSTEM FOR LODGING AND processing complaints in the NHS was the subject of widespread criticism in the first part of this decade. It led to the establishment of the Wilson Committee. It also impelled the Select Committee on the PCA to include in its report the acerbic words "The current complaints system in the National Health Service seems designed for the convenience of providers of the service rather than of complainants".[22] The Select Committee assessed the evidence it obtained on the clinical complaints procedure and found that the system did not do enough to manifest impartiality in its procedures. The Committee recommended that the clinical complaints procedure should introduce a lay element into its procedures. After rehearsing the views of certain organisations which favoured the Ombudsman having jurisdiction over clinical complaints and noting that in 1992-93 he had rejected a quarter of complaints put to him for investigation on the grounds that they concerned clinical judgement, the Select Committee recommended that clinical judgement should remain outside jurisdiction mainly for reasons of workload. However they believed that the Ombudsman should be seen as the apex of any new unified complaints system.

The Select Committee went on to observe the strength of

support - including support from the British Medical Association - for extending his jurisdiction to the formal complaints procedures of Family Health Service Authorities and Health Boards and recommended such an extension. I had advocated it by recognising that the Ombudsman would not question the conclusions of a service committee any more than he would comment on the decisions of any other tribunal; but the power to investigate the administrative aspects would help to restore a sense of fairness and bring about improvements in procedure. (In passing I observe that the present Ombudsman, Mr Michael Buckley, devoted the whole of Chapter 5 of his first annual report[23] to the working of the new complaints system and to failures in procedures in implementing it.)

Next the Select Committee rejected my reluctance to see complaints against general practitioners coming within the Ombudsman's jurisdiction. They agreed that local resolution of complaints should be attempted but "the Ombudsman is there because of the sad fact that such resolution is not always possible". They asked the Wilson Committee and the Government to consider enlarging the Ombudsman's jurisdiction on the basis that the exclusion deprived the public of a right considered necessary in all other sectors of the NHS. In turn the Wilson Committee supported the Select Committee's recommendations to extend the Ombudsman's jurisdiction both to GPs and to the operation of the service committee procedure. In their deliberations they had had Mr Richard Oswald, then Deputy Health Service Commissioner, present as an observer, representing the experience and procedures of the Ombudsman's office. After due consideration the government of the day published in 1995 "Acting on Complaints" outlining new unified arrangements in the NHS for responding to complaints. On St Andrew's Day in the same year they published draft legislation as the Health Service Commissioners (Amendment) Bill.

Given the prospect of taking on complaints about clinical judgement and about GPs, what steps was it necessary for the Ombudsman to take? Strictly speaking none. He could have lain back and thought of England, of Scotland and of

Wales. But if there was to be change, it seemed sensible to take two steps of importance. The *first* was to make sure that those who were to enter the jurisdiction understood what would be involved, to evaluate their reaction and to lay at rest any fears or misapprehensions. It is prudent for an Ombudsman, while maintaining independence, to meet, understand and become known to those who may be the subject of his investigations. The *second* was no less important but more delicate. It was to build on the existing relationships with members of the House of Commons and in particular the Select Committee and to inform that House and also the House of Lords of the considerations underlying the proposed legislation and its implications for the work and staff of the Ombudsman's office as well as for those who use and those who deliver health care through the NHS. It is a strange feeling to observe from the gallery members of the lower and upper Chambers of the legislature commenting sometimes with imperfect knowledge on your work and how you should discharge your new responsibilities without being able to intervene personally. In the general absence of pre-legislative scrutiny in the United Kingdom by Parliament (and yet in other countries the Ombudsman can be given the task of commenting on proposed legislation) it is pragmatic and sensible to try to have members of each House as well informed as they can be about the proposals laid before them. Such proposals are a result of Parliamentary draftsmen interpreting the instructions of civil servants responding to the desires and intentions of Her Majesty's ministers. So just in case the instructions had become distorted in transmission, it seemed sensible to produce a document in the Ombudsman's office, as is described below.

For the *first* of those steps I undertook a series of consultations, beginning on 9 June 1995 at the Medical and Dental Defence Union of Scotland, with relevant professional organisations about how to handle such complaints and how to obtain advice involving clinical matters. It proved useful to join in consultative meetings organised by the Department of Health without compromising the independence of the Ombudsman's

office; but in addition meetings took place with the Joint Consultants' Committee, the General Medical Services Committee, the nursing and other unions and professional bodies, the groups representing consumers and Health Service users, and the regulatory bodies. Within the office the lead was taken by one of my deputies, Mr Clive Wilson, whose background in the Department of Health and talents made him invaluable in driving forward the necessary preparations which were coordinated by an implementation group.

There was an interesting and unexpected link between the consultative process just described and the report made in Session 1977-78 by the Select Committee on the PCA. In their report entitled "Independent Review of Hospital Complaints in the National Health Service"[24] they observed that, in the light of the report of the Merrison Committee on the Regulation of the Medical Profession (Cmnd. 6018), the Government accepted that the GMC should be given power to control the registration of doctors "whose mental and physical health is such as to endanger their patients". At the Ombudsman's meeting held on 24 July 1995 with the regulatory bodies, the GMC representative proposed including a provision in the forthcoming legislation which related to that. It also had the effect of breaching the normal confidentiality which attaches to an Ombudsman's investigation but only in the interests of patients who might otherwise be treated by a doctor whose actions could seriously damage their health. Refer back, if you will, to my earlier quotation from the Scottish judge, Lord Inglis, about "the duty that every right-minded man owes to his neighbour to prevent the destruction of human life". To summarise, the GMC proposal was then put to the Department of Health and is now enshrined in Section 11(3) of the Health Service Commissioners (Amendment) Act 1996 which amended Section 15 of the 1993 Act. It provides that, if in the course of an investigation, a Commissioner or any of his officers obtains information which does not fall to be disclosed and is to the effect that a person is likely to constitute a threat to the health or safety of patients, the Commissioner may disclose the information

to any persons to whom he thinks it should be disclosed in the interests of the health and safety of patients. That disclosure could be to a body which regulates the profession to which the person belongs or his employer or any person with whom he has made arrangements to provide services. The obvious example is of a doctor or dentist practising invasive procedures on patients without disclosing that the practitioner is HIV positive.

Now let us turn to the *second* important step. In the light of the consultations just described the Office of the Health Service Commissioner issued in December 1995 a document entitled "Responsibilities of the Health Service Commissioner". This provided an explanation of how the Ombudsman exercised his existing powers, and what they were. It described the new proposals to extend his jurisdiction and how the revised system would operate. In particular it drew attention to the innovation introduced in 1993 of the Ombudsman naming the Health Authority, Trust or hospital involved in complaints which he had investigated and included in his publications. That innovation, derived from the Parliamentary Ombudsman's practice, had been a useful step forward in promoting local accountability and openness. During the consultations of 1995 arguments had been deployed both for and against extending that practice to cases involving Family Health Service practitioners. The Ombudsman indicated his preference for consistency but said that early cases would be looked at on their merits before a decision was taken to apply that element of open accountability to published reports. The publicity which would attend the publication of the name of a GP practice (or individual member of staff in such a practice) would be likely to have a much more direct effect on the work and viability of a practice than would publicity about a Trust or a hospital. For that reason consistency in making the name of the body about which a complaint had been lodged publicly known could be damaging. Mr Michael Buckley has not yet judged it necessary to have the Ombudsman's report name such a practitioner. The document was circulated very widely to the professional regulatory bodies, to other relevant

Ombudsmen, Select Committees and Health Departments, to professional bodies, staff associations and trade unions, to bodies representing consumers, patients and advocacy organisations, to Lord Woolf s inquiry into access to justice and to independent providers of health care. Both Opposition and Government spokesmen in each House of Parliament referred, during the passage of the Bill into law, in positive terms to the document. My belief is that it was a sensible step to set out the Ombudsman's stall in such a way that many of the doubts which might have arisen and taken time in Parliament were resolved by reference to that exposition. It was not possible for the Ombudsman to be questioned in person in either House, but his views were there on the record. It was reassuring for my staff and me to hear the Opposition spokesman (Mr Galbraith) say "I have absolute confidence in the Ombudsman and believe that he will get it right" and the Government spokesman (Mr Horam) to observe "The hon. Gentleman has spoken of his confidence in the Ombudsman and we believe that the Ombudsman should have the final say in such matters. As we know, the Ombudsman has set out clearly in his report how he will consider these matters"[25].

The two additional powers which the Ombudsman has been empowered to exercise from April 1996 are to investigate complaints about the exercise of clinical judgement by doctors, dentists, optometrists and pharmacists and other health professionals; and to investigate complaints about the actions of those professionals providing family health services - in other words local practitioners - and the exercise of clinical judgement by them. Interestingly enough the term "clinical judgement" had not been defined in the Act to extend the Ombudsman's jurisdiction. Attempts were made in the House of Commons and then in the House of Lords to insert some definition but after discussion the proposed amendments were withdrawn. It was left that the Ombudsman would use his noted discretion on how to apply it to cases under his investigation, bearing in mind the views of patients and professions.

FROM LOCAL TO NATIONAL CONCERN

Let us now return to the example, forecast above, of the effect on policy which a report by the Ombudsman can produce when at a subsequent hearing a Parliamentary Select Committee endorses his conclusions. In this instance the outcome eventually came after a change in Government, though no party political considerations can be discerned in what took place. As was explained in the Ombudsman's Annual Report for 1995-96[26], a man complained that his elderly father-in-law who suffered from dementia had been discharged in March 1994 with several other elderly patients from a hospital to a private nursing home. The complainant had not received a satisfactory explanation for the circumstances surrounding the discharge. My investigation[27] which followed a local independent inquiry established that the patient's discharge and the closure of the ward in which he had been a patient were part of a phased run down of the hospital's services. A plan for closing the ward was changed by the Health Authority and the patient's discharge was brought forward by 21 months, the decision being taken at a meeting of the authority described as 'informal'. That meant that it was not open to the public, a practice I considered totally undemocratic and contrary to guidance issued by the Department of Health.

The man died some two weeks after discharge from hospital and only on the day before he died was he registered with a general practitioner. Three patients died within 22 days of being discharged. The man's consultant had opposed his discharge from hospital but, while she was on leave, another consultant acquiesced to the move, believing that there was no alternative. When the case was the subject of evidence before the Select Committee on the PCA, in November 1996, the MPs were deeply concerned - so much so that in their own report[28] of March 1997 they described the case as an example of how harmful unwarranted secrecy can be in the management of the Health Service. The Select Committee criticised very strongly the attempt to ignore the expert advice of the responsible clinician who had known the patient for six

years, observing that her advice was inconvenient to the relevant managers. They referred the matter with their criticisms to the Secretary of State for Health. Because of the General Election and its outcome, the Government's response on this aspect was made to the successor body, the Select Committee on Public Administration, in December 1997[29]. In that response it became known that the Secretary of State had personally undertaken a further review, interviewing many of those involved. He had accepted the resignation of the person who had been in the chair of the Health Authority. In his investigation of the circumstances of the meeting from which the public had been excluded the Secretary of State, according to the Government's response, "has found no evidence of ... an attempt to rush through a decision without proper scrutiny". The Ombudsman had. The Select Committee had[30].

The Secretary of State went further. He told the Chairman of the Select Committee on Public Administration that he believed that other individuals and organisations were at fault in this case and that some form of action against *the other individuals involved* (my italics) was appropriate. Recognising that the law constrained the action he could take in relation to anybody employed by a Health authority or NHS Trust (as distinct from non-executive board members and chairmen) he asked the chairmen of the NHS bodies involved to look again at whether any further action was necessary. At this point two comments are appropriate. The first is that the Ombudsman's jurisdiction does not extend to personnel matters. Those are for the employers and other regulatory bodies. Where an investigation by the Ombudsman discloses matters of concern, his report (which goes to the complainant and also to the body complained against) may indicate that the employing body may wish to pay particular heed to what the investigation has disclosed but it can go no further: that denotes a proper division of responsibility. The second comment is that the words put into italics by me appear to go wider than was judicious by referring to "the other" (which is a comprehensive term) instead of to "other" (which does not enfold all the individuals involved).

What happened then? The Parliamentary correspondent of the British Medical Journal reported evidence given by the Secretary of State, Mr Frank Dobson, to the Select Committee on Public Administration in connection with the case[31]. According to the reporter, Mr John Warden, Mr Dobson said that he had asked for evidence that frail elderly people die after they are moved. The impression he got was that moving them was dangerous, no matter how well it was done. The number of deaths in these circumstances seemed to be very high. He agreed with the Committee chairman that 10 per cent of elderly patients may die after transfer. However, he could not currently back that up with evidence and wanted to be very careful before he marched in and asked the NHS Executive to issue a circular based on his impression before he had the information.

Whether or not that information was produced, or whether, if it was produced, the powers that be judged it unsuitable to make widely known for fear of creating undue worries is not clear. What is clear and to be welcomed is the guidance issued on 2 April 1998 as HSC 1998/048 by the NHS Executive in England. It is entitled 'The transfer of frail older NHS patients to other long stay settings". Not only does it cover consultation, a project plan (flexible enough to adapt to changing circumstances), the needs of individuals and their relatives or carers, the process of transfer and the role of what is termed the receiving setting, and arrangements for follow-up and monitoring; but it includes checklists of actions to be taken under each of those five headings. Admirable, one may agree, provided that such guidance is not ignored, as was the Department's earlier guidance on openness. Perhaps the words of Dame Julian of Norwich apply in the end to this sad story: "Sin is behovely but all shall be well and all shall be well and all manner of thing shall be well".

Are there lessons to be drawn from this episode? Six can be drawn. The *first* is that a local investigation by itself may not achieve change, or may achieve it only locally. The local investigation in this case could not be faulted but it did not impact on the Health Service nationally. The *second* is that it takes moral courage, as well as a thorough knowledge of

patients, for a consultant to maintain the validity of his or her clinical judgement in the face of administrative or financial determination to act in a way which imperils patient care. The *third* is that it is unwise to ignore the measured central guidance issued by Health Departments, especially if to do so leads to inequities in the standard of patient care which cannot be readily justified. The *fourth* is that an investigation by a national Ombudsman leading to a dispassionate and independent report which draws conclusions endorsed by a Parliamentary Select Committee is capable of identifying systemic faults which can then be put right by the authorities. The *fifth* is that it is better to be open with the public about decisions which will affect them vitally and to explain what is proposed rather to have to apologise for the results of such decisions. The *sixth* is that a Minister will do well to base his utterances on fact rather than supposition. The legal tag "audi alteram partem" - hear the other side - is still a valid guide to sound action.

A FURTHER DEVICE FOR USE?

When discussing earlier the special report on the Leeds case,[32] I remarked that I had adopted a device used hitherto by the Parliamentary Ombudsman but not until 1994 by the Health Service Ombudsman, except by making reports of selected investigations separate from the statutory annual report. Such reports are made under Section 14 (4) (b) of the consolidated Health Service Commissioners Act 1993 as amended by the Health Service Commissioners (Amendment) Act 1996, Section 10 (5). There is, however, a more spectacular instrument available in Section 14 (3) of the 1993 Act as amended. That provides that, if the Health Service Ombudsman finds after conducting an investigation that the aggrieved person who raised a complaint has sustained injustice or hardship through maladministration or a failure in a service provided by a health service body or a failure to provide a service which it was the function of the body to provide *and* the injustice or hardship has not been and will not be remedied, the Ombudsman may lay before each House of Parliament a special report on the case. In

other words the Ombudsman can make a big fuss if redress is merited and is not readily forthcoming. There was almost a need to use the heavier device in another case but eventually redress was given. The case [E615/94-95] was one of those included in another special report "Investigations of Complaints about Long Term NHS Care" published in June 1996. Avon Health Authority and United Bristol Healthcare NHS Trust were involved in a complaint by a man that his widowed mother with multiple sclerosis had been discharged from Bristol General Hospital and admitted to a nursing home. He complained that the Trust had failed to follow the correct hospital discharge procedure and the Authority had failed in their duty to provide for his mother's care. When the Ombudsman recommended an *ex gratia* payment by the Authority in recognition that they had not acted well, the Authority declined to make such a payment. When questioned by the Select Committee, they still declined and were the recipients of the following observation from Mr Bill Etherington MP, a member of the Select Committee: "The point is that because of your policies or lack of policies you have caused someone distress. The fact is that you are failing to acknowledge that and you are failing to give these people some redress. I have to say that the vast majority of other authorities ... who have been involved where there has been a recommendation of this nature have shown a lot more generosity and a lot more compassion than you are showing here." As the Select Committee later noted in their report "We were pleased to learn that after their appearance before the Committee Avon Health Authority had agreed to make an *ex gratia* payment of £1000."[33]

For the sake of completeness it should be noted that on two occasions when the Parliamentary Ombudsman used this device of a special report under the provision in the Parliamentary Commissioner Act 1967 from which section 14 (3) of the Health Service Commissioners Act 1993 was derived, the outcome was redress - eventually. But not at once did the relevant Minister grant redress. In each case the Select Committee backed the findings of the Ombudsman. In each case it took time for the Department

of Transport to come round to the desired conclusion[34]. The two cases were in 1977-78 (Rochester Way, Bexley for householders affected by upgrading the A2 trunk road) and 1995 (The Channel Tunnel Rail Link and Blight). The track-record therefore shows that this unusual statutory device of laying a special report before Parliament can be effective. It is not one to be used lightly nor is it guaranteed immediate success; but it is salutary to know that in extreme circumstances it lies available for use, rather like Milton's two-handed engine at the door.

Chapter 4

INTERNATIONAL ASPECTS

"I have never thought it easy to be just, and find it daily even harder than I thought."
Robert Louis Stevenson, Travels with a Donkey.

THE STUDY OF OMBUDSMEN IN OTHER COUNTRIES CAN help us to appreciate the way in which our own institutions operate and how they might adapt to changing needs and circumstances. In their titles they show the different emphases placed on their actions: the Mediator, the Commission on Human Rights, the Defender of the People, the Civic Defender, the Ministry of Correction, the Justiciar. Within the United Kingdom and Europe we have witnessed in the last decade of the twentieth century a rapid growth of Ombudsmen. We have regulators of industries or of enterprises like OFWAT, OFTEL, the Office of Fair Trading, OFLOT, the Rail Regulator. These regulatory bodies, headed by a Director General in most cases, are not independent of Government and their actions are within the jurisdiction of the Parliamentary Ombudsman. Then there are Complaints Adjudicators for different Departments or Agencies such as the Inland Revenue, Customs and Excise, the Child Support Agency, the Prison Service in England and Wales, the Prison Service in Scotland, and OFSTED. With a fair measure of independence they handle a wide range of complaints. A complainant who is dissatisfied with their disposal of an issue can take the matter to the Parliamentary Ombudsman. The complaints about health service matters are handled initially by the complaints officer in the body which is the

subject of complaint; and thereafter a dissatisfied complainant can go to either of the Mental Health/Welfare Commissions, if appropriate, or to the Health Service Ombudsman for investigation, should the complaint fall to be looked into further. Within the United Kingdom there is a wider sharing of the responsibilities of national ombudsmen than is usually the case in other countries. The following entities' functions are in several other countries the responsibility of the National Ombudsman: the separate Commission for Racial Equality and the Equal Opportunities Commission, both within the Ombudsman's jurisdiction; the distinct inspectorates of constabulary and of prisons; and the separate Commissions charged with the visiting and protection of psychiatric patients whether in hospital or in the community, namely the Mental Health Act Commission in England and Wales and the Mental Welfare Commission for Scodand. Both are in certain respects within the jurisdiction of the Health Service Ombudsman.

These two Commissions are empowered to look into complaints raised by mentally ill patients about their care. As a result of one complaint to the Ombudsman about their handling of a complaint which the Ombudsman took up for investigation, the Mental Health Act Commission revised their complaint-handling procedures and placed them on a more effective footing. The Mental Welfare Commission in addition has the statutory power to inquire into deficiency in the care of a patient. To stimulate the exercise of that power the Commission may have received a complaint which it resolves to investigate; but it may autonomously initiate an inquiry into deficiency in care if it finds in the course of its visits or in some other way that there are *prima facie* grounds for doing so. In other words it has a power (similar to that of an Ombudsman) to look into a failure in providing a service; unlike the Ombudsman, it has the self-starting power to initiate an investigation without having received a prior complaint. These two Commissions in their different ways are charged with the task of protecting directly the human rights of those who are mentally ill. The Ombudsman has a broader remit for the human rights of all who are the clients of the NHS. In some foreign jurisdictions

the national Ombudsman may be uniquely charged with safeguarding the rights of psychiatric patients. Indeed it was very significant to find that task featuring prominently in the varying drafts of legislation prepared in 1997 for the purpose of setting up in the Ukraine a High Commissioner for Human Rights, whose role would be essentially that of an Ombudsman. In countries moving from a totalitarian to a democratic regime it is particularly necessary to have special regard to those whose presence in a psychiatric hospital may not have been justified by a sufficiently rigorous medical assessment. Later on in this chapter is a relevant quotation from the Polish Ombudsman on that very theme. Even in a fully democratic country there must be vigilance, preferably reinforced by an independent body with protective powers or by an independent Ombudsman or by both, to ensure the well-being of those who are mentally ill. They may need to be kept in hospital for their own and others' safety or they may be returned to the community after clinical treatment for further medication and care. I have in mind not just the United Kingdom when mentioning fully democratic countries but also Mauritius. There in the circumstances of that multicultural society I recommended in 1997 the establishment of a body composed of three persons equivalent to the Health Service Ombudsman. Such a body would be able to extend the limited functions which are discharged by the Parliamentary Ombudsman, to reduce the need for resorting to litigation to solve problems and complaints about health care, and to provide an independent assessment of the standards of care.

In the United Kingdom we have separate national Ombudsmen to deal with local authority matters. Abroad the pattern is variable. In some countries what is done by local authorities may be within the national Ombudsman's remit or may be outside it. In the latter case there exist in several countries in Europe, Latin America and North America either regional Ombudsmen or Ombudsmen for cities. It is a commonplace to note that, where there are boundaries, problems will arise. We must therefore admire the way in which the United Kingdom's legislators have provided a most useful means of diminishing or removing

any boundary problem between the Parliamentary Ombudsman, the Local Government Ombudsmen and the Health Service Ombudsmen. The solution to the potential problem was to allow them to consult on matters relating to a complaint; and to extend such consultation to the conduct of any investigation into the complaint and the report of the results[35]. With the greatly increased use of care in the community and the interplay between the Health Service and the social services provided by local authorities, there is much in favour of the statutory provision for collaboration between the Ombudsmen responsible for those services. The United Kingdom is unusual in having had separate Ombudsmen for health matters, namely the Commissioner for Complaints in Northern Ireland and the Health Service Commissioners in Great Britain. Up to now the health posts have been held by the Parliamentary Ombudsman in each of the constituent countries of the United Kingdom. The new pattern of handling health complaints below the level of the Ombudsman has been set up by the response to the Wilson report "Being Heard". A further boundary problem was solved by enacting in the Health Service Commissioners (Amendment) Act 1996, Section 1 that independent providers of services under arrangements with health service bodies or family health service providers are subject to investigation by the Ombudsman. In that way the patient is catered for instead of losing the chance of having his complaint independently examined.

Abroad there are marked differences to observe. In the Republic of Ireland the Ombudsman Act of 1980 was extended to bring health board activities into jurisdiction from 1985. Mr Kevin Murphy, the Ombudsman, has no jurisdiction at present over any hospitals other than health board ones, though that could change to include public voluntary hospitals. The awareness of standards of care and expectations, which were made prominent in this decade by the various Patients' Charters in the UK, are shared in the Republic as a result of the 1992 Charter of Rights for Hospital Patients. From this year also in the Republic the Freedom of Information Act will give more rights, which are expected to focus on access to medical records. Complaints about Health

Boards formed 8.4% of all the complaints within the Ombudsman's jurisdiction in 1997. Just as in Great Britain the problem of finding patients' records is a familiar one. The Ombudsman has been appointed the Information Commissioner. Under the Freedom of Information Act he is explicitly authorised to seek to effect a setdement between the parties as an alternative to a formal decision being made by him. This aspect of mediation is one which is becoming more prominent in the work of Ombudsmen and I would expect it to be a more frequent disposal of complaints than in the past. It was encouraged by Mrs Jill Mclvor when she was the Northern Ireland Ombudsman. Her example was followed cautiously at first and now to good effect by the Health Service Ombudsmen in England, Scodand and Wales. Mediation featured in the list of principles, to which a specialist ombudsman should conform in the address given by Sir Brian Elwood, Chief Ombudsman of New Zealand, to the Sixth International Conference of the International Ombudsman Institute held in Buenos Aires in October 1996.[36]

- Adoption of the basic Ombudsman characteristics of independence in appointment, funding, operation and accountability.
- Use of the Office as one of last resort.
- Access to the Ombudsman by those affected personally by the matter complained of, direcdy and without cost.
- Observance by the Ombudsman of non-adversarial complaint investigation techniques designed to emphasise an informal and speedy resolution of grievances.
- Willingness by the Ombudsman to recommend a form of resolution, where justified, that will resolve the grievance.
- Preparedness by the Ombudsman to recommend changes to practices to avoid repetition of actions giving rise to grievances.
- Public reporting by the Ombudsman on a regular basis of his/her work.

While observing that the complainant should not expect miracles or the last drop of blood, Elwood maintained that

nothing would push the Ombudsman concept towards demise faster than if the Ombudsman did not conduct himself with the independence and impartiality for which the office is renowned or if the organisation complained about got a reputation for ignoring his recommendations.

Elwood rightly emphasised the need for the complainant to be able to go for free help as distinct from the costs of litigation[37]. The Slovenian Human Rights Ombudsman, whose office is a recent creation, offered a disturbing comment in his criticism of the Slovene Medical Chamber which is charged with monitoring the professionalism of doctors and medical staff and with undertaking an inquiry at the request of an insured person. A complainant claimed that a professional mistake had been made in the production of a dental prosthesis. Disagreeing with the findings of an internal inquiry carried out by the hospital in question, he requested a professional inquiry from the Medical Chamber. The Chamber told him that a professional inquiry would cost DM 4000, payable in advance but refundable if his complaint were found justified. The Chamber did not explain the legal basis for the charge. The Ombudsman maintained that redress that is preconditioned by such an advance payment can be available only to a select few who can afford it; that such inequality ran counter to Article 22 of the Constitution; that the view of the chairman of the Chamber was that its legal services were there primarily to protect the rights and interests of the medical profession and to provide consultation on contentious matters; and that the provision of such inquiries, which call for an objective approach, should be withdrawn from the Medical Chamber or a different approach by the Chamber should be secured. In short the Ombudsman stood up for the individual patient against the vested interests of the profession.

The Wilson report contains a useful description of the complaints procedures in other countries, where they exist. It is not for me to emulate that but rather to offer lessons to be learned from other Ombudsmen. Some of them deal chiefly with personnel or financial matters. The Maltese Ombudsman (Parliamentary Commissioner for

Administrative Investigations) in his 1995-96 report has a story without an ending: "A punctuality check at the hospital established that some medical doctors had arrived late for work and were charged accordingly. The disciplinary action taken against them after a long lapse of time was not properly carried out and reconsideration of the case was recommended."

Further to Elwood's observation that a complainant must not expect miracles or the last drop of blood, I reflect gloomily on the propensity of relatives to demand a public inquiry when something has gone badly wrong. It is some comfort to read the Danish Ombudsman's words "To inspire confidence it is not enough for the Ombudsman merely to bring to light any errors or omissions that may occur .... He has almost as important a task to perform in the many cases in which he concludes that no maladministration has occurred. ... Sad to say, a number of complainants end up by including the Ombudsman in the ranks of the authorities, departments and bodies who are unable or unwilling to understand the complainant's case and to set it right in accordance with the complainant's own notions."[38] For that reason it was my practice to include in published volumes of selected investigations examples of investigations where the complaint had not been found to be justified. The names of some of the Ombudsman's dissatisfied customers appeared in the annexe to the Wilson Report which listed those who had submitted evidence to that inquiry. But it is essential that those who work in the NHS and those who use it should understand that the Ombudsman is dispassionate and fair. For that reason it was encouraging to read in the Health Service Ombudsman's annual report for 1997-98[39] about a GP who had complained to Mr Buckley. "A GP complained to me, that is, the Ombudsman, that he had been unfairly treated by an independent review panel which had considered a complaint about his clinical management of a patient. ... I concluded that the panel's findings in respect of the GP's actions were reached by a flawed process and could not be regarded as reliable."

The Ombudsman of the Netherlands is not in broad terms a Health Ombudsman but he has the Health

Inspectorate of the Ministry of Health Welfare and Sport in his purview. Dr Oosting observed in his Annual Report for 1997 the radical changes in complaints procedures whereby the Client's Right of Complaint (Care Sector) Act came into force in 1995, obliging every health care provider to establish a complaints committee with an independent chairman. In 1996 the existing complaints guidelines for the Public Health Supervisory Service were replaced by new guidelines on investigations by the Health Care Inspectorate. Under the new guidelines complaints are no longer to be handled by the Inspectorate unless they are of general significance to the entire health care system. The National Ombudsman has argued that the Inspectorate should retain a role in relation to the investigation of complaints so that it can continue to receive warnings about possible problem areas in health care. I agree with that argument on the basis of my experience as Parliamentary Ombudsman. Several Permanent Secretaries told me that, although they disliked having to handle the complaints I raised with them, my interventions helpfully shed light on problem areas of their administration not all of which would otherwise have come to attention. The Ombudsman's external audit role in respect of the performance of an organisation is of great importance.

He cannot perform that role without adequate funds or staff. The Nigerian Ombudsman has reported considerable backlog in processing complaints for lack of resources. In some Canadian provinces economies applied to government offices have applied just as much to Ombudsman offices. Not every Government is prepared to have itself criticised. As Justice Florence Mumba of Zambia has said "The old political institutions of government in many countries still look at the Ombudsman institution with suspicion. They are not sure of its authority to question their use of power vis a vis the individual's right to good governance. The political practice which is prevalent in those countries generally is that of rulers placing obligations and duties on those whom they rule without clearly spelling out the duties and obligations of the rulers. Hence many political systems do not welcome easily any institution with

powers to police their authority to rule in any manner they see fit."[40] It is not easy to guarantee that an Ombudsman office will continue, once established. Some have been associated with an instrument which might not be regarded as wholly independent in every part of the world - the Attorney-General's or State Procurator's office. South Africa (in its former state), Venezuela and some former Communist bloc East European countries come to mind. Even in a stable Western democracy like Norway, the Ombudsman has prudently sought to have his office entrenched into the Constitution, like that of the Auditor-General. The Argentinian Constitution was revised to take account of the appointment of Dr Jorge Luis Maiorano as the first national Defensor del Pueblo. It is open to the Westminster Parliament to repeal the legislation under which the Parliamentary and Health Service Ombudsmen are appointed and do their work. Perhaps it is not entirely fanciful to imagine a Government spokesman moving the repeal on the grounds that the subordinate complaints handlers have become so wide spread that there is no longer a need for a national one. I say this in all seriousness because it is not so long since a retired Permanent Secretary mooted the demise of a local government ombudsman's office.

The standing of the Ombudsman nationally is not just a matter of protocol but of reality. The sombre words of Justice Mrs Mumba indicate the possible disfavour or animosity with which an Ombudsman can be regarded by a state. The Latin American Ombudsmen had to make diplomatic and public representations in order to defend one of their colleagues whose own life was at risk and whose family were under threat of violence. Sergey Kovalyov, appointed as Russia's High Commissioner for Human Rights by President Yeltsin, was dismissed from his post because he took a firm line in remonstrating about the infraction of human rights in Chechnya. At the other end of the spectrum, the French Mediateur de la Republique had personal audience with the Head of State on 9 March, with the President of the Senate on 14 March and on 21 March with the Prime Minister to present his annual report in 1995. Here the Ombudsman lays his reports without

ceremony before each House of Parliament and then the Select Committee takes evidence on them. It was, however, useful also to meet successive Secretaries of State for Health after the Health Service Ombudsman's annual report was published. It was after one such meeting that Mrs Virginia Bottomley set up the Wilson Committee to survey complaints. The Parliamentary Ombudsman's meetings were less regular and were at the level of Chancellor of the Duchy of Lancaster who was responsible for machinery of government. One slight but not insignificant procedural change made was to align the practice in presenting the Ombudsman's reports to Parliament. Originally the Parliamentary Ombudsman's reports went direct to Parliament while the Health Service Ombudsman's reports were sent to the Health Ministers for them to lay before Parliament. In order to remove any scintilla of suspicion that the Health Ministers might intervene or even interfere in the process, it was proposed, endorsed by the Select Committee on the PCA and accepted by the Government that the reports, like the reports of the Parliamentary Ombudsman, should be laid direct by the Ombudsman: and that is now the law.

To return to France and the international scene. Both the French and British Ombudsmen had taken part in a meeting, within the framework of the Conference for Security and Cooperation in Europe, convened by Senor Alvaro Gil-Robles, their Spanish colleague, in Madrid in May 1992 on the defence of human rights and the part to be played by Ombudsmen. The conclusions of that conference are at Annexe A. One of the ten conclusions reached read: "(9) An Ombudsman has a lonely task. It is important that Ombudsmen should meet, exchange views, and learn from one another. We applaud the initiatives that have been taken to develop international links in Europe, and recently in Latin America, with the creation of new national Ombudsmen." Stimulated by that and by his experience as a former French Minister for Overseas Development, Mr Jacques Pelletier invited his European colleagues to meet in Paris in 1994. More than that, he asked if the United Kingdom would join France in inviting the attendance for

part of the occasion of both the Francophone and Anglophone Ombudsmen from Africa. Those African Ombudsmen had never met jointly before then. The opportunity for Britain of playing a significant part in promoting good governance (particularly as there was considerable international interest in the progress of empowering the citizen through Citizen's Charters of various kinds) was there. It was not taken. Her Britannic Majesty's Government declined to make any contribution to assist Anglophones from Africa to attend. The first Europe-Africa meeting of national Ombudsmen took place on 17 March 1995 at the UNESCO building in Paris but all the credit went to where the funding had come from - France.

The United Kingdom, unlike other countries which have more recently appointed Ombudsmen such as Cyprus and Malta, has never hosted any international meeting of Ombudsmen. The nearest to such hospitality came when the UK held the European presidency. Mr John Major and Mr William Waldegrave invited the French Mediateur to take part in a conference "Service for the Citizen" in London on 4 December 1992. On that occasion M. Pelletier played a significant part, just as he had done at a similar French forum in November 1992 on modernising the public service in which his Spanish and UK counterparts took part. For a government and an Ombudsman to maintain their distance from each other is salutary; but other countries seem able - indeed eager - to host meetings of Ombudsmen without compromising the independence of the post-holder.

Where a country has decided, despite Justice Mumba's critique, to establish an Ombudsman, it then has to choose one. We need only look across the Channel to France for the example of a former Prime Minister, M. Antoine Pinay, being appointed Mediateur de la Republique. In Portugal it is not uncommon for a former Minister of Justice to become the Provedor de Justica. In Argentina it was the Minister of Justice, a distinguished former Professor of Law, who became the first Defensor del Pueblo. The Republic of Ireland appointed a well-known journalist as its first Ombudsman and a distinguished civil servant as its second. In most European countries a jurist is chosen. In Britain the

first Parliamentary Ombudsman had been Comptroller and Auditor General but he was not also Health Service Ombudsman, since the post had not been created in 1967. Of the Health Service Ombudsmen, two have been judges and four have been former civil servants, of whom two had held posts in Health Departments and one had been chairman of a NHS Trust. But I remember being asked by the Cabinet Secretary of a nation in Asia what sort of person should be considered for appointment to the new position of Ombudsman. When I suggested that in some countries it was the justiciary from whom a candidate emerged, his response was "We couldn't do with a judge - they're all corrupt".

One danger which any Ombudsman can run is being regarded as partisan, whether he has held political office or not. A former Danish Ombudsman, Professor Lars Nordskov Nielsen put this well when he wrote[41]: "It is absolutely vital that the Ombudsman is perceived to be neutral party-politically .... There must never be a scintilla of doubt that his handling of cases and his statements of opinion are free of any party-political sympathies or antipathies. But this does not mean that the Ombudsman can avoid getting involved in politics. Every time the Ombudsman delivers a statement which contains a criticism of a ministry in a case of some importance, he is thereby supplying ammunition which the Opposition can use for a political assault on the minister in question. And conversely, if his opinion states that there are no grounds for criticism of a ministry, he runs the risk that the Opposition will criticise the Ombudsman for being subservient to the Government." I recall an occasion when an evening newspaper received the Health Service Ombudsman's report but did not bother to send a correspondent to the press conferences held about the report. The newspaper's early afternoon edition carried a headline which owed more to febrile sensationalism than to the report's contents. That headline provided ammunition which naturally provoked Opposition questions to the Prime Minister at Question time in the House of Commons. The newspaper was prevailed on to publish a correction which made it clear that

I had reported facts in the dispassionate way which becomes an apolitical Ombudsman.

Here may I pay tribute to the politicians who formed the Select Committee on the PCA while I was the Ombudsman. Under the chairmanship first of Sir Antony Buck and then of Mr James Pawsey the Committee members acted cohesively in the pursuit of improved performance by the bodies within jurisdiction and of redress, where that was appropriate, for the complainant with a justified grievance. Some of the questions they put to witnesses occasionally showed their own political colour, but their reports were unanimous. That cannot be said of all such Committees. It certainly strengthened the effectiveness of the reports and recommendations delivered by the Ombudsman to have such support.

At this stage it may be relevant to draw to notice other aspects of the work of an Ombudsman or similar body in a country which has not hitherto had such a bulwark of democracy. First, in the context of human rights, it was complaints about deficiency of health care, not imprisonment or maladministration, that bulked largest in early complaints to the Mexican National Commission of Human Rights. However, in a wide-ranging report published in 1995[42] the then Chairman of the Human Rights Commission, Dr Jorge Madrazo, commented on other topics which had engaged that Ombudsman institution. He mentioned the problems of AIDS, discrimination and public health but he also covered the fight against torture and against corruption, the battle for achieving equality of opportunity in education and higher education, and the struggle for combating poverty and achieving economic development. He recognised that the Ombudsman cannot alleviate all the grievances and cure all the ills of the State but can make a serious contribution towards solving some of its problems. He observed, rather as Justice Florence Mumba did, that totalitarianism and the Ombudsman are irreconcilable extremes. (In another country the problems of AIDS and discrimination also engaged the Ombudsman's attention, namely in Israel. It is remarkable that in the State of Israel there exists probably the most formidable

combination in one office of State Comptroller, equivalent to our Comptroller and Auditor General, and Ombudsman. The huge respect owed to the holder of those two offices, Justice Miriam Ben-Porat, is a token of her fair and fearless monitoring of state bureaucracy and service in the discharge of her dual role.) Second, the new Defensor del Pueblo de la Nacion in Argentina has gone for systemic inspections and criticisms of deficient provision in his critique of public hospitals contained in his third Annual Report, for 1996[43]. He records that his recommendations for providing services and medical staff which were lacking in certain parts of the areas investigated had been implemented. That contrasts with my third point. In his fourth report (1995-96) the then Polish Commissioner for Civil Rights Protection, Professor Tadeusz Zielinski, remarked that "the addressees of general motions of the Commissioner agreed with his suggestions but said they were impossible to carry out because of the lack of financial means. This concerned, among other things, ... the inadequate observation of the rights of children in children's homes and the ordinance of the Minister of Health and Social Welfare exempting health care institutions from meeting technical and sanitary conditions". Later on he observed "as in past years, the protections of the social rights of the poorer part of society and the principle of equal chances of some groups of citizens are in a state of crisis. ... a very clear retrogression has taken place in citizens' rights to health protection and assistance in the case of illness or incapacity to work on account of underinvestment in the health service". He then went on to detail infringements such as forcing citizens to pay for health care; regional inequalities in financing health care; unequal access to medicines; and restricting citizens' possibility of availing themselves of sanatoriums. Somewhat ominously he added: "The practice of applying the provisions of the Mental Health Act should remain under the control of the Commissioner's Office, because psychiatrists are of the opinion that these provisions are being wrongly applied."

There is a shrewd commentary made by Poland's first

Ombudsman (1987-1992) Professor Ewa Letowska. It is relevant for the more recent countries who have set up an Ombudsman, for countries contemplating that step, but also for Ombudsmen in the older democracies as well. She wrote "The Ombudsman exists and works in Poland only because the institution was established during the systemic transition period. Earlier the regime was too strong; later the Ombudsman was perceived too clearly as being inconvenient to the authority in general .... The conclusion is that the creation of an efficient, well-functioning Ombudsman's office is facilitated by the weakness of the establishment, characteristic for the moment of systemic transition. On the other hand, in the period that follows, characterised by a low level of awareness of the principles of a state under the rule of law and consequences of separation of power in addition to an insufficient level of political culture, the appointment of an Ombudsman can prove much more difficult. The Polish experience ... could encourage other countries in transition to establish the Ombudsman as an office with considerably limited terms of reference and a lower status. It has become clear that the Ombudsman can prove inconvenient to any authority, even a fully legitimate and democratic one."[44]

Professor Page[45] was perhaps gloomily in tune with this when he wrote "Only in the Open Government White Paper do we find any discussion of the strengths and weaknesses of judicial and ombudsman methods of enforcement and that I suspect is more than a little coloured by the fond hope that ministerial responsibility may yet prove to be trumps in relation to the Ombudsman in a way in which it has ceased or is believed to have ceased to be in relation to the courts." My own view was much less pessimistic at the time because the Government had been persuaded to apply the practice of the Health Departments in circulating the Health Service Ombudsman's "Lessons to be Learned" to all other Departments. Not only in respect of the conventional or orthodox work by the Parliamentary Ombudsman did the Cabinet Office promulgate widely the brief descriptions of his investigations and the lessons to be learned from them; they did so also in relation to his work on openness. Can my

optimism endure? To revert to my native tongue "I hae ma doots". My doubts are due to the way in which the Government's proposals were published for Freedom of Information legislation. It is not at all encouraging to read what Mr Michael Buckley had to put into his Annual Report:[46] "Considerable changes to my jurisdiction will result when the proposed Freedom of Information Bill is enacted .... I am concerned that the creation of yet another public sector complaints authority will make an already complex and fragmented system still harder for complainants to use and understand. ... What is essential, in my view, is that I and other public sector Ombudsmen should continue to be able to investigate complaints of maladministration which have a freedom of information element without putting complainants to additional time and trouble. I was also much concerned by the serious misrepresentations of my status and method of working contained in paragraph 5.7 of the White Paper 'Tour Right to Know" (Cm 3818) about which I protested to the Government." As Mr Buckley's predecessor, I share his disquiet. What he wrote as Parliamentary Ombudsman applies just as much to his role as Health Service Ombudsman.

Chapter 5

OMBUDSMAN PRACTICE

"When complaints are freely heard, deeply consider'd and speedily reform'd, then is the utmost bound of civil liberty attain'd that wise men looke for."
John Milton, Areopagitica.

THE REMARK OF THE DANISH OMBUDSMAN HAS ALREADY been quoted that a number of complainants end up by including the Ombudsman in the ranks of those bodies who are unable or unwilling to understand the complainant's case and to set it right in accordance with the complainant's own notions. Two examples of that phenomenon which form part of my experience of letters sent to the Ombudsman may give the flavour of what is written.

(i) "I now know from many years of litigation that the planning matters I have been involved in are so complex that most authorities simply do not understand what is going on, and I have to include the Courts and in this case the Ombudsman."

(ii) "As anyone familiar with the ways of bureaucracy knows, bureaucrats are reluctant to tell direct and flagrant lies to those who outrank or have authority over them in case they should be found out. The truth of the matter is that if I have made any statements which are unsubstantiated, they are only unsubstantiated because you wanted them to be. If you are ever going to make the grade as an Ombudsman, it's about time you pulled yourself together."

The chief comfort I derived from the second letter was that it included the following, which made me glad that I

was not a lawyer as well as an Ombudsman. "As for lawyers, the present unholy mess in our legal system speaks for itself, and is the logical outcome of an adversarial system operated by ill-educated actors who are steeped in eighteenth century tradition and out of touch with the modern world."

The kind of person appointed as a national Ombudsman has already been mentioned in the international part of this monograph. Now it is appropriate to say something about the post-holder's jurisdiction. Only very few functions are statutorily reserved to the Ombudsman (Commissioner) to perform by the relevant statutes, the chief being the presentation of reports to Parliament. Even though the statutes permit his appointment of staff, little is said about their way of recruitment, service or method of work, except in relation to official secrets and pay. The jurisdiction is a personal one; but it would be unrealistic to expect the one person to discharge all the functions of the office himself or herself. Nevertheless it was clear that the MPs who were members of the Select Committee on the PCA expected the Ombudsman in person to have a fairly close knowledge of all the work in hand. Gradually they accepted that the increase in casework made schemes of delegation to staff an essential part of the processes of the office. They even tolerated the state of affairs on the Parliamentary side where individual new complaints about the Child Support Agency (CSA) would not be taken on for investigation if they exhibited no novel feature but merely replicated matters already under scrutiny, unless the complainant had suffered financial loss which an Ombudsman investigation might remedy. The letters addressed to MPs sending on such complaints had to be couched tactfully, explaining that they were not being ignored and that the senders would stand to benefit from any redress to be gained from the CSA as a result of the Ombudsman's other investigations into similar matters. In effect those investigations led to Special Reports which produced results of wide effect. No Ombudsman relishes having to turn away cases. This particular departure from normal practice lasted from 1994 until October 1997. No such departure from rectitude has affected the health side of the Ombudsman's work. I do not envisage that it ever

should so long as personnel matters fall outside jurisdiction.

On the Parliamentary side a scheme of delegation was feasible whereby run-of-the-mill cases could be designated as 'ruby'; harder but not exceptional cases as 'tawny'; and difficult and exceptional cases as 'vintage'. The last named were reserved for the full treatment, involving the Ombudsman personally, while arrangements were made for the former classifications to be processed at varying levels of delegation. It was also clearly established that a case which had started off at a lower level of classification could, and should, be raised to a higher level if the detailed investigation revealed more serious implications meriting the involvement of senior staff. On the health service side delegation was also used but in a less formally stratified way because of the problem of classifying neatly the human aspects of such cases. I am gratified to observe that delegation has now been taken further by my successor and with good effects on the time taken to investigate complaints or to resolve matters by mediation. There is a price to be paid for this organisational change. It means that, once a complaint has been investigated and a report issued under delegated authority, the outcome is not subject to further appeal to the Ombudsman. When the member of staff issues the report, the Ombudsman's task is done. Nothing can change unless new facts come to light which would justify reopening the case or unless the decision proves susceptible to judicial review.

What consequence does this have for staffing the office of the Ombudsman? Traditionally few members of the staff were on permanent appointment. The post of Ombudsman itself had a new incumbent every five, six or seven years to try to ensure that a fresh look was taken at reasonably regular intervals at the persistent or novel problems to be tackled. Below that, some of the senior staff were on the strength of the office but most members of the complement were seconded for a period usually of three years but sometimes more. The advantages of having seconded staff were that newcomers would learn new skills for their own career, they would understand the circumstances in which those whose acts they had to investigate had to work, they

would (if they chose) question received wisdom, and on completion of their secondment they would return to their parent organisation with a better understanding of what generates a complaint, of how to handle it and how to instruct work colleagues in ways of avoiding the situations which lead to complaints. The disadvantages were that the seconded staff had a learning curve before becoming wholly useful, the changes in the public service now make secondment much more difficult to arrange, especially return from the Ombudsman's office to a different Trust or organisation from the one which had arranged the secondment, and the need to be leaven in the lump on return has decreased now that the doctrines of the Citizen's and other Charters are becoming more widespread. The result is that more staff are now taken on for a substantive posting. That will make them more experienced and better able to assume the responsibilities delegated to them. It will require care and finesse to prevent the separation of an Ombudsman cadre from the rest of the public service; but the benefits in experience and skills are likely to be shown in quicker resolution of complaints. Whether the detailed knowledge of abstruse and complex areas of administration which seconded staff bring with them can be maintained - along with the ability to appreciate when a bureaucrat is "pulling a fast one" - remains to be seen.

Another area of staff change has been the appointment of a small number of in-house professional staff and the ability to call on independent professional assessors to assist the Ombudsman in the investigation of complaints about the exercise of clinical judgement. As the Ombudsman's jurisdiction was extended to that field, it became essential to have access to sound professional guidance, even if the final decisions lie with the Ombudsman or those members of staff to whom such decision-taking is delegated. There can be little doubt that one crucial aspect of using such professional staff will consist in rebutting uninformed criticism that they will tend to see matters as if they were defending the professionals involved in the complaints. One member of the Select Committee in the early 1990s used to ask the Ombudsman if he was taking a risk in having staff

seconded from the Inland Revenue to investigate complaints about the tax-man. The answer was first, that one seconded individual was part of a team, the other members of which would see that fair play ensured no favouritism, and second, that the office was not likely to choose as a member of staff someone with a closed or biased mind. The same arguments should be valid in relation to a doctor or nurse serving in the Ombudsman's office.

So far as the way in which the Ombudsman or a member of staff should go about his work is concerned, the words written in 1836 by Sir Henry Taylor in his brilliant short work, 'The Statesman", have always seemed to me of value. He was writing about the way in which a Minister of the Crown should comport himself but the advice is just as relevant to the functions of an Ombudsman. The standard recital of the matter or matters which form the complaint, the response to it, the findings of fact, the conclusion and the remedy or redress, where the complaint has been found to be justified, conform to the wisdom of Taylor.

"I would in the first place earnestly insist upon this: that in all cases concerning points of conduct and quarrels of subordinate officers, in all cases of individual claims upon the public and public claims upon individuals, in short in all cases ... wherein the minister is called upon to deliver a quasi-judicial decision, he should on no consideration permit himself to pronounce such decision unaccompanied by a detailed statement of all the material facts and reasons upon which his judgement proceeds. I know well the inconvenience of this course; I know that authority is most imposing without reason alleged; I know that the reasons will rarely satisfy, and will sometimes tend to irritate, the losing party, who would be better content to think himself overborne than convicted; I am aware that the minister may be sometimes by this course inevitably drawn into protracted argumentation with parties whose whole time and understanding is devoted to getting advantage over him: and with a full appreciation of these difficulties I am still of opinion that for the sake of justice they ought to be encountered and dealt with. One who delivers awards from which there is no appeal, for which no one can call him to

account ... if he do not subject himself to this discipline, if he do not render himself amenable to confutation, will inevitably contract careless and precipitate habits of judgement; and the case which is not to be openly expounded will seldom be searchingly investigated. In various cases also which concern public measures, as well as those which are questions of justice, ample written and recorded discussion is desirable." In these days of electronic mail that doctrine may be less easy and audit trails may be harder to achieve but the attempt should be made to stick to Taylor's principles.

To return to the present century, mention has been made of the various Charters issued in its final decade. The merit which exists in those documents is that in general they set out what standards of service or of performance are to be expected by those who have to use the facilities of the organisation which issues the Charter. That has the incidental benefit of informing those in the organisation of what is expected of them. Next the Charters explain what the user (parent, taxpayer, traveller, patient or whoever) should do, should the promised level of service not be provided. Finally the Charters set out how to complain, and to whom, if the level of service does not come up to scratch. In some of the early Charter documents the authors failed to give clear details of how to complain to an independent arbiter, such as the Ombudsman, if the internal complaints mechanism failed to produce a satisfactory response. Later versions did better. In doing so they helped to increase the public visibility of the Ombudsman.

In order to inform the bodies issuing Charters what to expect from the Ombudsman when he received complaints connected with Charters and also in an endeavour to promote wide consistency of approach by the bodies which issued Charters, I included the following in one of my annual reports:[47] "If targets are expressed as mandatory, or a promise has been given that the citizen has an expectation to compensation should they not be met or should they be missed by a specified period, the case for compensatory redress is strong. Otherwise targets are to be taken as indicators of a satisfactory or unsatisfactory performance

rather than as a firm commitment that a specific performance will be achieved in every individual case. They will be persuasive indicators, but they are not positive guarantees." Whatever targets are set, whatever standards of care are promised, whatever indicators of better resources are published, it is a fact of human nature and of politics that the citizens of a country will want more. It is a phenomenon which I have named the Erysichthon syndrome. In Greek mythology Erysichthon[48] was punished by the goddess Demeter for his insolence by being given an uncontrollable appetite. The more he ate, the greater his hunger grew. The more he drank, the greater grew his thirst. So it is in our demand for healthcare. Hip replacements were rare in the 1960s. Now they are expected on demand. The sophistication in instruments, in prostheses, in diagnostics adds to the costs and to the expectation generated in patients. It adds also to what they expect of an Ombudsman, particularly in a newly emerging democracy which has a poor economy and a history of inadequate health care. Who else can intervene to provide what is desired? But even in this country it can lead to unreasonable demands, to take examples, for domiciliary physiotherapy services or requests for night calls by GPs on trivial matters which could easily wait until the morning and be resolved by attendance at the local health centre or even by a telephone discussion. If an Ombudsman receives a complaint based on such demands and finds it to be unreasonable, he will not be looked on with favour by the Erysichthonite.

One of the problems every Ombudsman faces is trying to assess situations with hindsight. Hindsight makes it possible to take a cool, calm look at a situation which at the time of the real events was fraught. There are obvious dangers, however, in trying to evaluate matters only with hindsight instead of with an attempt to appreciate the problems of a crisis and the stresses involved in an under-staffed ward or a speeding ambulance. Not all complaints put to an Ombudsman are about such matters, and they can be considered not in relation to stress but by reference to whether existing guidance was adequate, whether it was

ignored or observed, and whether it was relevant or irrelevant to the facts of the case. Many complaints put to the Health Service Ombudsman are in the shape of appeals against the way a complaint has been handled at a level below that of the Ombudsman's office. The Ombudsman has a very long experience of how poorly handled complaints can make matters worse; clumsy and insensitive responses to complaints have aggravated the initial grievance out of all proportion to what caused it or have made the distress of a patient or family much worse. Moliere in "Le Misanthrope" gave a warning about trying to tell people to how to put matters might: "C'est une folie a nulle autre seconde/ De vouloir se meler a corriger le monde." Despite that Ombudsmen and governmental groups associated with the Citizen's Charters have ventured to give advice on how to tackle responses to complaints - and perhaps we are getting better. Perhaps we now respond to all the questions posed in a complaint. Perhaps we ensure that our replies are free of jargon. Perhaps we try to make what we write clear and easy to understand. Perhaps we give enough background information to make our report to the complainant self-contained and adequate. Perhaps the changes to be made in the light of the complaint have been already instituted. Perhaps it is unambiguously stated who is going to take what action and by what future date. Perhaps the report is free of any factual inaccuracy which would otherwise call into question the validity of its conclusions. Perhaps any necessary apology has been given graciously rather than grudgingly or in a way which suggests that the fault originated with the complainant. Perhaps we do not give the impression of passing the buck - but surely that impression would have been conveyed by the correspondence quoted in a letter published by The Financial Times[49] from someone who had written to the Royal Mail: "Perhaps I should explain that Royal Mail wish to ensure that their customers receive the best possible standard of service, which is why we have provided local contact points for all enquiries and complaints. I hope, therefore, that you will understand why I am forwarding your enquiry to your local customer care unit at Nottingham

Customer Care. I can assure you that the staff there will be only too pleased to help and reply to you as quickly as possible." and then a further letter, "I am writing to let you know that this is now being dealt with by Parcelforce. You can contact them at Customer Care, Parcelforce, Glasgow. They will make enquiries and reply to you as soon as possible." Perhaps the good intentions of the writer of those official letters should be sensed by in their recipient rather than irritation over being passed from one part of an organisation to another. Once again the platitude resurfaces that it is poor communications or a failure in them that lies at the bottom of most complaints.

Chapter 6

LAST THINGS

"The weakness of patients and sweetness of life, and nature of hope, maketh man depend upon physicians with all their defects."
Francis Bacon, "Of the Advancement of Learning", book ii, chap. 10, sect. 2.

ANY OMBUDSMAN DEALING WITH HEALTH MATTERS WILL find that the events of birth and death produce more difficult complaints, and less satisfactory accounts of proceedings than do the intervening episodes of health care. In order to be scrupulously fair it is right to point out that the reference to physicians in the quotation above from Bacon should now apply to all those involved in caring for patients and their families. Patients may complain - and in my experience the majority do - for wholly altruistic reasons. They may not be wanting anything but an assurance that what went wrong in their case will not be repeated with other patients. If that is so, they are likely to be comforted and assured if the resultant medical attitudes are positive. The converse will be the case if they feel they have been given the brush off, or ignored, or treated with disdain. The medical fear of litigation unfortunately can produce a defensive, unhelpful response to a perfectly innocuous request for information. Patients may complain for reasons which are not at all altruistic but for self-interest or for catharsis, to cleanse themselves of blame and place it on a scapegoat. Possibly the most difficult to deal with are those complaints which say "If only my Dad/my Mum/my baby/my husband had received treatment when promised - if the biopsy results had not been lost, if the ambulance had

come to the right address, if the recall appointment letter had not been mislaid, if the specialist had not been in America that week, if the nurse had understood what I was saying, if the oxygen cylinder had not been empty, if the surgeon had had the right gadget, if the hospital ward had not been closed at the weekend, if somebody had really been in charge, it wouldn't have been necessary to complain."

I do not intend to discuss complaints arising from the birth of a child except to give instances of what can cause a complaint to be made, whether or not it is justified. Complaints can arise from the absence of, or rationing of, *in vitro* fertilisation; from delays in an ambulance due to take a woman in labour to hospital; from the visiting arrangements of a community midwife; from divergent advice coming from different midwives; from mothers dissatisfied about the method of delivery; from fathers dissatisfied with the progress of labour; from midwives losing patience with a difficult pregnant woman and forgetting professional standards; from staff shortages; from obstetricians treating patients as teaching objects and neglecting professional courtesy and politeness. What is particularly distressing is death and birth combined.

Bereavement can make the bereaved act out of character. I used to think that it would have been better for a bereaved person to wait, say, six months before deciding whether to make a complaint; to complain may be for some persons an element in the grieving process. The Rev. Francis Kilvert recorded in his diary that on Christmas Eve 1878 a parishioner's child, little Davie, had died. 'The father seemed greatly distressed and indignant because he thought the child's life had been thrown away by some mistake of the doctor." The same attribution of blame may come from a family member who has nursed an aged parent for years at home. When the aged parent's health declines to the stage of needing hospital treatment and the patient dies soon after admission, it is not too fanciful for the carer to believe (in the depths of grief) that the hospital staff killed the patient. It would be wrong to assume, however, that every bereaved person acts out of character. Unfortunately, some

complaints are only too well justified. Perhaps the most frequent is that the family were not told in time of a deterioration in health before the death occurred. Another variant is that the wrong member of the family was notified - wrong either because the person notified would be too ill or confused to tell other members of the family or because there was a family feud. In the latter event the doctors or nurses are drawn into a warring faction which is likely to waste time they should be giving to the care of other patients.

Let us consider other examples. The nurse ordering transport will assume that the ambulance taking old Mr Docherty to a hospice will be equipped with a stretcher and take him directly there. Only the ambulance that collects him is for sitting patients; and since it has to deliver other patients on the way, old Mr Docherty has his last living journey in great discomfort for far too long. If only the nurse had found out that she could have ordered a proper ambulance and a direct journey. In yet another case Mrs Callaghan is told to take her husband away to a nursing home to die, because he is blocking an acute bed in hospital, and to pay the fees. If only the managers of the Hospital Trust had bothered to read the clear guidance about how to explain in writing, in good time, what the right way was to discharge such a patient.

What about other problems causing unnecessary and avoidable distress? After a death has occurred, pain can be caused by the place in which the family, hurrying to hospital for a last word, are informed that they have arrived too late. Pain can be avoided if a suitable quiet place can be found in which to break the bad news rather than in a busy hospital corridor. Distress can be caused if the family view the corpse before it has been prepared for viewing, while tubes and instruments are still attached. Equally distress can be created if the family have to wait hours before being allowed to see the body. Religious requirements of different religions are at variance with other religious practices, so it is important for nurses and mortuary attendants to understand and comply with such niceties of behaviour in order not to compound grief with insult. It is just as

important for bereavement officers, if there are such in hospitals, to be trained in sympathy and delicacy. It does not help to present the effects of the deceased in a black plastic rubbish bag to the next of kin. It can help to refer a deeply disturbed relative to bereavement counselling, should that seem appropriate, or to suggest to someone who is in shock that it might help to see a chaplain, to read one of the leaflets that describe what to do in the event of a death, to consult an advice bureau, to contact the GP or social workers, to be in touch with some other caring agency.

It is also vital to abide by promises. At the same time great woe to families can be caused by a hospital sending out a computerised reminder to attend for an appointment months after the patient has died. A distressing complaint I investigated[50] came from a mother who was delivered of a still-born baby. She signed a form consenting to a post mortem examination and was told that she would be told the results at her post-natal check. The post-natal check was made two months after the baby's body - on which no post-mortem had taken place - had been collected for cremation. The mortuary technician had gone on leave and there was no cover for him. A hospital porter misinterpreted a note from the ward and released the body for cremation without checking whether a post-mortem examination had taken place. The result of the Ombudsman's investigation was new procedures for requesting and recording post-mortems. And the mishandling locally of the parents' complaint added to their grief.

What about the events preceding death? They can be as productive of complaints as events after a death. Some patients and families assume that, if a diagnosis is made at one stage of an illness and a different one is made at a later stage in the light of further pathological investigation or other tests, the doctor made a mistake over the first diagnosis (and that the first diagnosis was either too bland and reassuring or too gloomy and depressing). It may not be possible to avoid incurring blame or misunderstanding in such circumstances; but the risks may be reduced if the doctor can bring the patient or family to understand the provisional nature of the diagnosis and can explain that a

more accurate estimation will depend upon the results of further tests. It may help to indicate how long the results of such tests will take to become available and who will communicate them. Such an indication will have to rely on systems which do not allow priority references to be downgraded to standard (if there are such gradations in process-timing); on the availability of the staff to process tests; on a dependable reminder system if the tests will take time to yield results; and on room for debatable results to be evaluated and assessed before being passed on to the anxious patient. One device which can be very helpful, though costly, is to tape-record the interview at which the first diagnosis is made known; then to give the tape recording to the patient to take home, replay it in a calmer atmosphere and let the family (if that is desired) hear the doctor's explanation; and, if need be, return to the doctor who gave the interviews with any questions that occurred, once the original message had had time to sink in. The important point for the professional to remember is that what he or she is saying represents a routine action which occurs very many times in the professional's day or week, whereas it is a unique experience for the patient. So it is something to be said clearly, not too rapidly, and in as simple terms as are necessary for the message to be taken in and digested. To ensure that the education of medical and nursing staff fully involves training in how to break bad news seems an elementary preparation; yet it is clear that not all staff are adequate to the task. It is also the case that ancillary staff play just as significant a role in some aspects of this duty; and they too deserve some relevant training. Others have written with far more experience and involvement than it is possible for me to do, except in the sense of my knowing what has provoked complaints which have not been resolved at a local level. In that connection let me touch briefly on suicides before returning to the questions of resuscitation and of letting nature take its course.

The natural question to ask when an act of suicide takes place is "Why?" In some cases the surviving members of the family may prefer not to know the reason but in others they will. A child in relation to any relative's death, let alone a

suicide, may want to know "Was it my fault?" or may think the same question. If a surviving relative wants to know more, it may be very helpful to provide as many detailed pieces of information as possible about the events preceding the death. To withhold them or to show reluctance in providing them may arouse baseless suspicions that there is a cover-up; and the sense of affront, added to the reality of bereavement, may cause a grievance to fester unnecessarily.

During the time when I was Health Service Ombudsman, two detailed investigations into the events leading to suicide proved to be welcomed by the bereaved relatives. The reports gave them information previously withheld and clearly provided solace, as their letters of thanks to the investigators demonstrated. In other investigations of suicides the outcomes showed that death *might* have been averted had there been correct implementation of procedures at each of the hospitals involved: if correct levels of observation had been followed; had a search of hospital grounds been thorough and speedy; had there been a proper channel of communication between staff dealing with accident and emergency admissions and staff in the psychiatric department of a hospital. Let me emphasise the words *"might* have been averted." The words are not *"could* have been averted" for it is extremely hard to predict whether or when a person will take his or her own life. The detailed scrutiny which is devoted to individual cases of reported suicide by the Mental Welfare Commission for Scotland has made me realise how inexact a science it must be to predict whether suicidal tendencies in patients will be consummated by a successful attempt at self-destruction or not. However, anything which on careful scrutiny suggests that a procedure could be improved in order to inhibit a successful suicide attempt can lead to tightening up such a procedure. The hospital or medical practice responsible for such a patient does need to audit the circumstances; and the Ombudsman or some other external body can help with a dispassionate scrutiny of events and protocols. One small but sensitive area is the correspondence which takes place with the family when a patient has committed suicide. It has always seemed insensitive for the official letter to go on the

kind of NHS paper which boast a slogan such as "Dedicated to Care" or "Working together - for health". Such paper may appear incongruous on a letter inviting a patient to come back for further tests because of faults in earlier screening processes or in radical surgery undertaken in the absence of adequate biopsy? It should be incumbent on anyone signing a letter to convey bad news to study its appearance and its contents and to give some thought to the effect the missive will have on the person to whom it is addressed.

Let us now turn to perhaps the most emotive issue to generate complaints on which an Ombudsman may have to adjudicate: resuscitation. A number of cases occur on this matter. It raises important clinical and ethical issues but also involves systematic record-keeping and good communications among professional staff and between them and the families of patients. An example of clinical records containing an entry that an elderly woman in hospital should *not* be resuscitated, if she was thought to require cardio-pulmonary resuscitation, provoked a complaint from the woman's son who happened to see the records. After investigating it[51] I was concerned that there appeared to be no general or written guidance on such an issue and I invited the Chief Medical Officer at the Department of Health to give it consideration. (Later on when the CMO had gone out to consultation letters from one or two consultants were received in my office written in intemperate terms. Their letters revealed that those consultants had neither read my report nor thought that such decisions were any concern of lay persons: they were reserved for clinical judgement!)

In a more recent case[52] the NHS Trust concerned had a written policy which was made known to Senior House Officers and House Officers when they took part in their induction course. It is of interest to record and publicise what that policy stated, since it is not very likely that a non-resuscitation policy statement will feature in many, if any, of the helpful documents provided by hospitals for new in-patients. The policy was set out by the Eastbourne Hospitals NHS Trust. To that I assign a particular significance, as will appear later. The policy, as summarised in the

Ombudsman's report, read:

> "(a) All patients are for resuscitation unless a clear decision has been made to the contrary.
>
> (b) A decision not to resuscitate should involve the consultant, junior medical staff, and ward nursing staff. Responsibility lies with the consultant to ensure a common policy is followed.
>
> (c) Relatives are not normally involved in the decision making but should, where possible and appropriate, be informed of the decision, why it has been made, and their comments noted.
>
> (d) ... Those involved in the decision making and the views of any relatives informed should be noted.
>
> (e) The nursing staff must be informed of the decision and "not for [resuscitation]" must be clearly written in the nursing process.
>
> (f) Any "not for resuscitation" decision should be reviewed on each consultant ward round. ... Any policy change should be clearly written in the patient's notes and nursing process.
>
> (g) In general, any decision not to resuscitate will involve the consultant caring for the patient. However, there will be occasions when the most senior of the on-call junior staff can make the decision. ... Housemen should not make "do not resuscitate" decisions."

In this instance the Ombudsman recommended that the Trust remind all medical staff of the requirements of the above policy and of the need to follow it. In my opinion the Trust's policy was a distinct advance on the situation investigated in another Trust in 1990. It was written, it was clear, it was methodical. Some families might take issue with note (c) indicating that relatives should where possible and appropriate (what does that mean?) be informed (not consulted) about the decision and their comments noted (not necessarily taken into consideration). The significance of the policy being the Eastbourne version is related to a percipient, short note by the Reverend Ray Morrison, Church of England chaplain to the Eastbourne Hospitals NHS Trust which appeared as Personal View in the British

Medical Journal of 25 June 1994. Under the title of "Patients' sense of completion" he wrote:

"Resuscitation is the prolongation of life at its most dramatic. Hippocrates would have cheered. Or would he? I have observed a more subtle version of the Hippocratic tradition that is far more worrying. This is to be seen in wards where the elderly are being cared for. From antibiotics to tube feeding, the professionals have an armamentarium of treatments to keep the very old and infirm alive a few days longer. Fair enough, if this is what the patient wants. But how often are the doctors right in their judgement of what the patient wants? How often are they swayed by thoughts of dissatisfied relatives or predatory lawyers? Their Hippocratic oath states that a doctor should do no harm to his patient. In 20th century medical practice this is too often mistranslated into "a doctor should always treat his patient". But doctors should not officiously keep alive.

"These stories typify those many patients who have opened up to me in the wards, revealing the common characteristic of what can best be called a sense of completeness about their lives. In their own way each is clear that they have fulfilled whatever it was that their life was about. So now they would welcome death as coming at the appropriate time.

"If I am right, doesn't it follow that we should take account of this sense of completeness when discussing the possibilities of further medical or surgical intervention? Nowadays the accent is on looking at the future physical quality of life for such patients when making assessments. This ignores the equally important - if not more important - fact of the individual's own feelings about the present completeness of their lives.

"Many in the caring professions react quite strongly against the idea that someone may rightly want to die. Patients who express such a desire are made to feel guilty, or may even be treated as if they were depressed. This violates the integrity of such patients just as seriously as the refusal to treat a patient who needs and wants medical help. Doctors and others caring for patients should listen more

attentively to them. These patients are individuals whose feelings about themselves deserve respect. Prolonging their lives could be said to be doing harm to them. They may well know better than their doctors that their natural end has come."

These sensible comments by a hospital chaplain deserve the widest circulation to doctors and they received it through the columns of the British Medical Journal. Since good guidance can, like auld acquaintance, be forgot, it is helpful to give them a fresh airing. They bring to mind the question posed in Petronius[53] to the Sibyl of Cumae and her reply. Question "Sibyl, what do you want?" Answer "I want to die". Some elderly will want to die peacefully without the intervention of what is termed the "crash team". Some relatives would prefer their aged parent to be spared the sedulous efforts to prolong a life which has run its course. It is not for me to comment on the growing tendency for there to be "living wills" setting out the wishes of an individual about the conclusion of life; but I quote from William Cowper's stanzas[54] of 1789:

"O most delightful hour by man
Experienced here below,
The hour that terminates his span
His folly and his wo!
Worlds should not bribe me back to tread
Again life's weary waste,
To see again my day o'erspread
With all the gloomy past."

Cowper's words are at variance with the quotation from Bacon at the beginning of this chapter. They epitomise the dilemma for patients, their families and those who care for them. A complaint about the circumstances of death will never be foreign to an Ombudsman. Different individuals will see such complaints in different lights.

In this monograph are set down one man's perception of how an Ombudsman can help those whose complaints cannot be resolved at a local level; and of how the institution of Ombudsman is expanding throughout the world as an

element of good governance. It is a visible instrument to use in the defence of individual human rights. It can benefit not just those who have the courage to complain because it can procure systemic improvements in the delivery of public services. It is an institution which will not endear itself to every model of government because it reveals what was hidden. It uncovers deficiencies and lays bare failures in communication. It will not lack work. To end with Milton's words in Areopagitica, "that no grievance ever could arise in the Commonwealth, that let no man in this world expect."

ANNEXE A

CONCLUSIONS OF THE OMBUDSMAN AND OTHER ORGANISATIONS IN DEFENCE OF HUMAN RIGHTS CONFERENCE, WITHIN THE FRAMEWORK OF THE C.S.C.E., HELD IN MADRID FROM THE 28TH TO THE 30TH OF MAY 1992, CONCERNING THE FIRST DEBATED PROPOSAL ON THE NON-JUDICIAL PROTECTION MECHANISMS FOR THE FUNDAMENTAL RIGHTS OF PERSONS.

The conference reached the following ten conclusions:

1) The Ombudsman concept is one of the important mechanisms for protecting human rights.

2) The institution of Ombudsman has developed and is developing at different speeds in the countries of Europe since its successful launch in Scandinavia. It has significance both in those countries with a long parliamentary tradition of democracy and in those countries emerging from a history of recent absence of democracy.

3) There are many types of institutions for protecting and enhancing human rights and also for correcting administrative injustices. They may be grouped in a number of ways, but within those groups each mechanism uniquely reflects the traditions and patterns of democracy in the country to which it applies. There are many other bodies which very usefully act, not in competition with the Ombudsman or committee on petitions of a parliament,-but to complement their work.

4) In any country it is important that:

a) the institution of ombudsman should be linked with parliamentary democracy;

b) its services should be free to the citizen wanting to complain about maladministration or violation of human rights;

c) its functions should rest on a firm legal and statutory base;

d) it should be completely independent of the administration;

e) its findings and recommendations must be treated with the greatest of respect and responded to;

f) ideally, no area of public administration should be immune from the jurisdiction of the Ombudsman.

5) While the primary objective should be to investigate and provide redress for the justified complaints of individual citizens, a secondary aim should be to amend or improve systems of administration which have made injustice possible, so that mistakes or injustice will not be repeated. The Ombudsman may suggest changes in the Law, but it is for the Government and Parliament to make such changes through the parliamentary process. Similarly, when the Ombudsman recommends redress, it is for the body which has created injustice to provide the remedy.

6) The Ombudsman should be adequately provided with resources to enable him to fulfil all his duties and deal with every complaint.

7) The Ombudsman's office must be sufficiently well known so that citizens will know to whom they should turn for help. Press and media will help, but so should the Government, and so should Parliament.

8) An Ombudsman should be able in course of time to persuade governments to announce publicly to their citizens what rights they have in general and in particular sectors, what standards of service they should expect to be provided, and how to complain if those standards are not applied and honoured.

9) An Ombudsman has a lonely task. It is important that Ombudsmen should meet, exchange views, and learn from one another. We applaud the initiatives that have been taken to develop international links in Europe, and recently in Latin America, with the creation of new national Ombudsmen.

10) The conference does see a place for a new European Ombudsman, in coordination with and in no way affecting the responsibilities of the National Ombudsmen of the E.E.C. countries, and will look with interest on the development of that concept.

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