NEWS BRIEFING · HEALTH
BRIEFING · HEALTH NEWS
HEALTH NEWS BRIEFING
NEWS BRIEFING · HEALTH
BRIEFING · HEALTH NEWS

Association of Community Health Councils for England and Wales

30 DRAYTON PARK, LONDON N5 1PB. Tel: 01-609 8405

NHS COMPLAINTS PROCEDURES

A REPORT OF A CONFERENCE, HELD 11 OCTOBER 1988

ACHCEW CONFERENCE: NHS COMPLAINTS PROCEDURES

11 OCTOBER 1988: REGENTS COLLEGE, LONDON

C O N T E N T S

ACHCEW CONFERENCE: NHS COMPLAINTS PROCEDURES

11 OCTOBER 1988: REGENTS COLLEGE, LONDON

S U M M A R Y

Introduction

The credibility of the NHS rests largely on patients having confidence that their grievances - both minor and major - will be dealt with in a professional, equitable, just and sympathetic manner. In other consumer sectors the simplest way to express dissatisfaction is by changing to another brand or supplier. The NHS is a near monopoly provider and for the majority of its users there is no alternative. Even where choice does exist, for example the right to change GPs, this is often a lengthy and over complicated procedure. It is therefore imperative that the NHS runs as effectively as possible, that GPs abide by their contracts and that "a simple and well understood mechanism (exists) through which people who use the National Health Service can suggest how it can be improved and complain when things go wrong". (Royal Commission on the NHS, Report, Paragraphs 11.12, 11.13)

On 11 October 1988, the Association of Community Health Councils for England and Wales - the national body representing users of the health service - held a one day conference on NHS complaints procedures.

The aim of the conference was two fold. Firstly, as part of a policy consultation exercise, the current procedures were examined to determine whether a consensus exists regarding defects and possible remedies. Secondly, the conference provided a forum for Community Health Councils to exchange information and learn from others' experiences in an attempt to ensure that current procedures are used as effectively as possible.

Community Health Councils and patients' groups have long argued that within the National Health service there is very little in the way of consumer choice, the balance of power is strongly weighted in favour of the medical profession. With delegates from CHCs, FPCs and HAs present it was anticipated that the conference would provide an opportunity to debate how this imbalance might be redressed.

After a general overview on the role and nature of complaints by Mr. Maurice Healey, Director of the National Consumer Council, participants divided into five workshops to examine specific aspects of the complaints procedures: Professional Accountability: the General Medical Council; Professional Accountability: the Family Practitioner Service Committees; Complaints as Quality Assurance; Hospital Complaints and the Independent Professional Review; and the Role of the Professional Advice Worker. The second session began with an account of how professionals view complaints by Dr. D. Williams, representing the British Medical Association. This was followed by a panel

discussion chaired by Mr. Chris Ham of the Kings Fund Institute, where issues arising from the workshops and the other session were developed.

Edited transcripts of the days proceedings, including reports from each of the workshops and details of the participants follow this summary.

Issues Arising from the Conference

The first subject for discussion was the role and nature of "complaints" as a concept to which all providers of goods and services should address themselves. It is generally accepted that a good consumer service should have an accessible complaints procedure which is seen to be fair by complainants. The National Consumer Council has developed this principle into a set of criteria against which all complaints systems can be measured, including the current NHS procedures. Delegates considered how the following criteria for a successful complaints-handling mechanism reflected their experiences of NHS procedures:

- visibility: potential complainants must know that a system exists.
- accessibility: those with a grievance must be able to lodge it formally with someone in authority with minimum difficulty.
- speed: complaints should be acted upon without delay.
- impartiality & fairness: those responsible for acting on complaints must be seen to be independent.
- effective: complaints should be dealt with by those with the competence to judge and the authority to act to improve services for the future.

The strongest theme which emerged throughout the conference was the multi-faceted nature of complaints and the inability of current procedures to deal with complaints to the satisfaction of all concerned: the patients, the management and the profession. Speakers throughout the conference illustrated how the current procedures fail to meet the general criteria listed above and in particular has procedures appear not to be designed to meet patients' needs. Dr David Williams, representing the BMA, pointed out that the existing Family Practitioner Service Committee Hearing procedure is not a complaints procedure at all - rather it is a management device to investigate alleged breaches of contract. Jean Robinson, lay member on the GMC argued that the General Medical Council is not concerned with patients' grievances unless they constitute a breach of the Council's own definition of "serious professional misconduct".

In relation to hospital complaints it was suggested that the Independent Professional Review, is difficult to get established and is designed to reassure patients' without critically examining faults in the service. It also fails to deal with multidisciplinary complaints.

There was some consensus that these failings arise mainly because the aim of existing complaints procedures is not clear to patients, management or the professional bodies. The need to identify the various facets of any complaints system was highlighted, for example:

- conciliation: many complaints can be resolved with conciliation and a frank discussion amongst all parties, leading to explanations and apologies where appropriate. In cases of major complaint and possible litigation, conciliation is equally important to restore patients and relatives confidence in health care workers.

- investigation: complaints need to be investigated and patients need to have confidence that such investigations will be impartial and fair, this is particularly important where facts are in dispute. The results of any investigations need to be made available to complainants.

- management, disciplinary or other action: where complaints are found to be justified management or the professional organisations need to consider if and what disciplinary or other action should be taken. Again there is a strong case for keeping complainants informed of action taken.

- compensation: finally there are some cases where an explanation and apology are not sufficient and patients should be adequately compensated without having to go through the legal system.

Much of the discussion throughout the conference centered on how to disentangle the various aspects of what a complaints system should do. Whilst many participants agreed that the first and second points above could be pursued in tandem, it was generally agreed that there should be a distinct separation between investigation and explanation of a complaint and any subsequent managerial or disciplinary action. In practice this would mean that all complaints should be investigated on their own terms and not in reference to some pre-determined managerial or professional standards of reasonable behaviour. Only after a full and proper investigation of the background and nature of the complaint, should management or professional bodies be asked to take appropriate disciplinary action.

A USERS' MODEL FOR A COMPLAINTS SYSTEM?.

It is evident from the experience of Community Health Councils that that the existing NHS complaints procedures offer little credibility to users. Set out below, ACHCEW has begun the process of defining a complaints procedure which genuinely puts the needs of users first. At this stage, this model is presented only as an outline, in the anticipation of provoking consideration, discussion and criticism. Considerable work now has to be undertaken to develop this model and ACHCEW invites comments from all interested parties.

1. Clear information should be available to the public regarding the complaints procedures in the NHS. This information should cover all aspects of health service provision and should contain an explanation of what complaints routes to take depending on the grievance. For example; conciliation; compensation; service improvement; professional disciplinary action. This information should be provided in easily understandable form and should also be provided in appropriate languages. This information should also stipulate time limits for investigation and dealing of complaints and contain a requirement to provide a full explanation of outcomes to complainants.

2. In addition all complainants should have access to free, independent and confidential advice on how to complain and to support whilst processing a complaint. Many CHCs are already working hard in this area. However, they could fulfill this role far more effectively if they were given adequate training and resources.

3. All complaints should begin with an initial investigation to determine whether either conciliation involving discussion and explanation or a full enquiry would be the more appropriate and desirable course of action for the complainant.

4. Complainants should have a right of access to an "independent complaints investigation service", which although drawing on the expertise of the medical profession would be under lay control. This service would conduct an investigation before proceeding to an open hearing where the complainant and her/his supporter (advocate) should have the right to attend.

5. It should be a condition of the contract of all GPs and other medical staff that they should take part in these procedures.

6. Complainants should receive a full explanation of the outcome of any enquiries.

7. If necessary, the complaint and the results of the investigation should be referred to a compensation agency. This would not prejudice the complainants right of appeal to a Court if the compensation awarded were not satisfactory.

8. Additionally, where appropriate, the complaint and the results of the investigation should be referred to management or the professional body for appropriate disciplinary action. The complainant should be informed if such a referral is made, have the right to make an independent complaint and be informed of the outcome of any disciplinary action.

9. Any new system should include mechanisms to ensure the accountability of those administering it.

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

CONFERENCE: NHS COMPLAINTS PROCEDURES

11 October 1988: Regents College, Regents Park, London

INTRODUCTION

Cllr. Hywel Wyn Jones (Vice-Chairman of ACHCEW) introduced the conference:

As many of you well know CHC staff often have to help members of the public carry out their complaints, often with very little training and support relying usually on their own discretion, judgement and good sense. Discussing complaints could on the face of it be dwelling on the negative aspects of the service but proper procedures for dealing with complaints can serve a very constructive purpose and it is not merely a matter of redress and recrimination. Complaints will, alas, always be with us and we must make sure that they are used to reach higher standards of care and management.

FIRST PLENARY SESSION: Maurice Healy - Director of the National Consumer Council.

I think this is an important occasion and I would like if I may to congratulate ACHCEW on holding this conference. It is timely and I think very important to us all in our role as consumers of the health services. My role, I think, is to try to say how we in the National Consumer Council consider complaints in general - and not to be too detailed about complaints in the national health service.

I think the first point I want to make is that complaints ought to be a precious possession for the service being complained about. They are a way, if you are interested in improving your service of finding out some of the things that are going wrong and some of the things that may be going right. Let me give three quick examples.

Firstly, when I first joined 'Which?' I had a conversation with a man who was working for a mass food manufacturer, he said that for every complaint they got, in order to get some indication of dissatisfaction they multiplied the number by 500. Now that is not very scientific but the point it makes is that a complaint is almost certainly the tip of an iceberg about some more general dissatisfaction and I think that using complaints for quality control is clearly important.

Second story is about reputation. An American company did some research into what people who had complained about their products actually did. And they found that, if people had their complaint dealt with well and they were satisfied, their attitude to the product was reinforced, they became more positive about it and they told four people of their good experience. If they were

dissatisfied with the way the complaint was taken, their attitude to the product became very negative and they told eight people about it. I think this is particularly relevant to people using a service where they don't have a choice, because if they can't exercise their dissatisfaction by simply going somewhere else the temptation is to tell more people about their dissatisfaction.

Thirdly, the National Consumer Council is shortly to be visited by the Chinese Ministry of Supervision which seems to be charged with running the delivery of public utilities in Beijing. They have sent us a copy of their Code of Practice and the first thing it says is: "No formal reprisals should be taken against those who complain." Now that sounds very primitive to us but I think it illustrates an important reality that while complaints may be a precious possession to an organisation they are often threatening to the individual members of staff who receive them. This is a particular problem with medical services where staff have a very strong self-image about the value of the service they are giving and they may find particular difficulty in coping with the situation where people seem ungrateful. That creates difficulties on the consumer side too - deference to medical services is well-known. People perceive that others are trying very hard to do things for them often under extremely difficult circumstances, but there are still some people who are afraid to complain because they feel that the service they get may get worse.

Now, I would like to look at the processes a complaint goes through. I have identified five stages.

(i) The first stage is the perception of a grievance by a consumer - when somebody thinks something is wrong. At that stage quite a lot of things may happen. The consumer may do nothing, or they may tell somebody else other than the people they are complaining about. At this stage they may be suffering under some simple misunderstanding which can be easily put right.

(ii) For that reason it is clearly in the interests of those who supply a service to enable the second stage to happen which is the expression of that grievance by the customer to the person who is supplying the service. Many complaints can and should be settled here. All the customer may want is some word of apology or some indication that a procedure which seemed silly will be put right. The role of "gate keepers" in the system is very important at this stage. Senior people in organisations must ensure that complaints get through to them and are not weeded out by faithful junior staff. Complaints about gatekeepers themselves have a particular importance in the National Health Service where the image of - for instance - doctors' receptionists is not always totally positive.

(iii) The next stage is registering the grievance formally by the person who is supplying the service. At that point the complaint has been recognised as being of some substance and has to be dealt with in some way at a formal level which essentially means that one has to go through a process.

(iv) Attempts are made to resolve the problem. Both sides may need help to understand each other. The complainant and the people about whom they are complaining may be unable to communicate and the final stage clearly is a resolution of a dispute.

(v) A dispute is an unresolved complaint. At that stage it is clear that the two sides are unreconcilable and somebody has to make a decision about who is right and who is wrong.

I think it is quite important that one actually distinguishes those stages because the people who are involved in one stage may not be the appropriate people to be involved in the next stage. For example, the people who are involved in the conciliation of a complaint may not be the right people to make a decision about resolving the dispute. Some independent person is needed at that stage to make a judgement.

Moving on to some of the likely problems experienced by people wanting to complain about the National Health Service. It seems to me there is a huge problem of access. Who do you complain to? How many members of the public know that the Family Practitioner Committee is the place to make a complaint about a GP or a dentist? Who knows how to find out which health district they come under? A recent survey by the Royal Institute of Public Administration and Social Community Planning Research showed that two thirds of the people registered with a GP said that they wouldn't know how to go about making a complaint if they wanted to and, of those people who had been recent users of hospital services, only five per cent claimed to have been given any information on how to complain. We are pleased that the Government in its White Paper on improving Primary Health Care has suggested that complaints about GPs for example can be accepted by District or Regional Health Authorities and passed on. But how far does that really address the problem? Shouldn't the FPCs themselves be thinking of ways to publicise firstly their existence and secondly their involvement in complaints' handling.

The next point I would like to emphasise is that we ought not to talk about complaints as though they were all the same. Many are just calls for reassurance. Some simply want an apology. Some are simply interested in having a procedure that seems ineffective put right. Relatively few in any sphere of consumer complaints are seeking massive damages for an alleged wrong. The first and most important thing that any complaints procedure must do is find out what the person complaining actually wants. Systems that are set up to defend the supplier against the relatively few potentially costly disputes may turn away the vast majority of inputs. Let me finally suggest a number of criteria about the characteristics of any system for dealing with complaints through from the original recognition of a grievance by a consumer to the final resolution of a dispute:

(a) Visibility - the arrangements should be well known - and particularly to those who are likely to want to use them.
(b) The procedure should be accessible by the people who have a

complaint and they should be able, reasonably easily, to put the arrangements into operation.
(c) Speed - procedures should operate as quickly as possible. Justice delayed is justice denied.
(d) Expertise - those involved in the system should be sufficiently competent to tackle the issues in dispute.
(e) Fairness - procedures should ensure a just and fair outcome is achieved.
(f) An essential part of that is impartiality. There should be no conflict of interest on the part of those making dispute decisions.
(g) Authority - the system should ensure that an effective result be achieved. It should in the end resolve the dispute and lead to improvement for the future. It is very important that there is a mechanism to feed information back to those who can act on it for the future.
(h) Finally, cost effectiveness. The cost to the system should be as low as is consistent with its overall objectives.

Questions from the floor

Q: How do CHCs measure against your criteria?

M.H.: We have never studied CHCs in any systematic way, in relation to complaints. I think I would like to make one general comment - not necessary about the operation of CHCs. In the private sector now there are some very elaborate and consumer friendly systems for dealing with difficult complaints and disputes. I am thinking particularly of the Ombudsman which has been set up by the Industries of Insurance, Banking and Building Societies. There the businesses concerned voluntarily pay for the judgement of an independent adjudicator whose independence is guaranteed by the fact that he reports to a Council, a majority of whose members are independent of the industry. I don't see any systems as radically user friendly as that appearing in the health service or indeed in our public services generally. I think that the challenge for the public services is to produce a complaints procedure which is as good as those that are occurring in private institutions.

Q: How does the official Ombudsman Service in the NHS compare with private schemes just described?

M.H.: I think the official Ombudsman Scheme in the NHS and indeed in Local Government has, from a consumer point of view, one major defect. Consumers are interested in outcomes. They have suffered something, they want it put right and they want compensation if they deserve compensation. The Ombudsman system is designed to attack maladministration only. They are about behaviour. They want to say that these people behaved wrongly in some way. It may well be sensible to have a system which investigates maladministration and makes judgements about it and so on, but it is not the same as actually dealing with the consumer complaint and providing an outcome that the consumer wants.

REPORT OF WORKSHOP A: PROFESSIONAL ACCOUNTABILITY - THE GENERAL MEDICAL COUNCIL

WORKSHOP LEADER: **Jean Robinson** (Lay member, General Medical Council).

The GMC keeps the register of all trained medical practitioners and sets standards for those registered. Its powers are that it can decide to remove a doctor from the register. The criteria upon which such a decision is made varies over time e.g. before the Abortion Act many doctors were struck off for delivering this service. Removal from the register only occurs if a charge of "serious professional misconduct" can be proven. The criteria for professional misconduct are embodied in the rules and standards set out in the "Blue Book". These are a mixture of trade practices such as whether doctors advertise, and ethical practices such as sexual exploitation of a female patient's problems. Errors in clinical judgement are not an aspect of serious professional misconduct.

The Professional Conduct Committee (PCC) forms a subgroup of the Council which judges whether or not a doctor should be struck off. The PCC can decide to reprimand a doctor rather than remove him from the list, this is not a mild form of punishment, because of the public nature of the trial hearings.

The PCC now has two lay members (the GMC has a total of 11 lay members out of a total of 97). Judgements are made on whether the facts have been proven and whether the facts amount to serious professional misconduct.

Problems with the system

1. **Meaning of Serious Professional Misconduct.** The GMC should perhaps be able to put forward some sort of alternative charge, such as "unacceptable conduct" which would allow a wider number of cases to be considered, and where necessary, doctors appropriately penalised. Whilst the standard of 'serious professional misconduct' is high, it also muddles ethical and trade issues. There is no onus on doctors to report other doctors who are known to be causing patients harm. The GMC may treat complaints very differently from other bodies such as the UKCC, i.e. the deliberate changing of patient notes. It may be beneficial for there to be harmonisation between professional conduct committees changes and punishments.

2. **Sifting complaints.** Three quarters of complaints are weeded out at a preliminary stage. A number of these will be non-starters but not all and there is no monitoring of those complaints which are rejected.

3. **Linkage with FPC and hospital system.** The GMC linkage with these two systems causes two distinct problems. Firstly the GMC uses them as a sieve and refers people to take their complaint to the FPC or hospital even if this is not appropriate or necessary. Secondly, if an FPC hearing is found in favour of the patient and

the doctor is fined, it will be referred on to the DHSS who may then pass it on to the GMC. Months after the complainant thought their case was finished, a subpoena to attend an PCC hearing may arrive without prior warning. This can be distressing. If their case is referred in this way, the complainant does not receive a copy of the transcript if the doctor is found guilty.

4. **Lack of independence and unrepresentative nature.** As the GMC is so heavily dominated by medics, the public has little faith in its independence. An all lay-body for judging professional misconduct, which was advised by a medical assessor may be seen as more legitimate, such a system exists in Sweden. However, greater independence must be seen to be achieved. Women, younger people and black people are not adequately represented on the GMC, both amongst lay people and professionals.

5. **Practices of GMC not sufficiently known and understood by public and professionals.** The public can take on tasks such as disciplining doctors. It may require lay people to educate themselves on medical matters, however at present little effort is made by professional bodies to be open. Many of the GMC's practices are very secretive even members of the PCC are not given transcripts of 'trials' upon which they do not sit, unlike the UKCC which allows independent individuals to have transcripts. People may not be aware that the GMC includes a health committee which deals amongst other things with alcoholism. Doctors on drink driving charges may find themselves before the health committee of the GMC.

6. **Problems of 'evidence gathering'.** This is one of the greatest restrictions for the public in using the GMC. Many hospital doctors do not come before the PCC because the hospital complaints procedure, unlike the FPC procedure does not provide complainants with the evidence upon which their decision was made. Complainants who wish to bring a charge of sexual assault against a doctor may be better off going to the police rather than to the GMC as the police have wider powers and resources for evidence gathering. If the doctor is brought to court for sexual assault this will be made known to the GMC.

7. **The GMC has insufficient investigative resources.** The GMC has not got the ability to gather evidence, nor has it the ability to investigate aspects of management etc. where complaints arise. Such an ability might reduce the likelihood of an incident happening again.

Recommendations: CHC secretaries and members tended either to be inadequately informed about the working of the GMC, or if informed were cynical about its ability to adequately protect the patient. The workshop did not produce ideas for a working alternative, however it was recommended that CHCs share their experience of GMC responses to complaints and that these responses be monitored to provide a body of knowledge upon which to base future action.

RAPPORTEUR: HAZEL FISHER (ACHCEW)

REPORT OF WORKSHOP B: PROFESSIONAL ACCOUNTABILITY - SERVICE COMMITTEE PROCEDURES

WORKSHOP LEADER: **Tom Richardson,** (Secretary Oxfordshire CHC)

The grounds for complaint. In dealing with complaints about General Practitioners Tom said that it is essential to keep in mind the three items of service on the GP's contract to measure against the complaint. If the complaint did not show a breach of these then it stood little chance. The three items of service are that a GP should:

- render to all patients appropriate medical services as usually provided by medical practitioners.
- visit patients at their home when reasonably requested.
- refer patients elsewhere in the NHS and advise on other services provided by Local Authorities.

Even these terms of service do not provide a rigid yardstick since "usually" and "reasonably" are always debatable.

Lack of accountability. Tom said that professional accountability is clearly not evident and the Medical Service Committee seems designed to protect GPs. The Service Committee hearing is a mixture of complaint hearing, a fact finding exercise and a disciplinary procedure. Above all it cannot remedy patients' grievances because the hearing is designed to ascertain whether or not a GP broke his contract with the Family Practitioner Committee rather than with the patient receiving the service.

The BMA view of the procedure. Tom discussed the BMA's response to the Government White Paper. The BMA described the Service Committee as an "enquiry". However the patient cannot get access to their notes and so cannot discuss the evidence. Other FPC representatives present said that in their area this is always possible. CHC representatives welcomed this openness but could not believe it was widespread.

The BMA says the Service Committee is a fact finding exercise with considerable checks and balances for fairness. The CHC perception is that this is not the case and that the Service Committee seems designed mainly to protect GPs. However, the procedure could be better used and it may often be the case that a Service Committee hearing focuses on an excellent GP making the only mistake in his whole career.

The BMA response said that rudeness by GPs, a frequent cause for complaint, should be dealt with informally. Breach of confidentiality was discussed and a GP member of the group said that this was a clear case for the GMC or the Courts.

However, Tom said that in his experience it helps complainants if the FPC will at least take up the case at first because the GMC

has a poor record of dealing direct with the patients.

The BMA response also says that CHCs should assist and explain the procedure to patients but should not present complaints at hearings. However, from the CHC perspective there is a clear need for a CHC Secretary to be able to present the case of, for instance, a grief-sticken complainant.

Unfairness of the time limits. The statutory time limits in the complaints procedure make it inaccessible to many complainants. The initial 8 weeks time limit is unfair and whereas some FPCs are happy to waive the time limit when sufficient reason is given, others are rigid in adhering to it.

The GP is given four weeks to reply to the complainant's letter but in Tom's experience GPs rarely stick to the four week limit and are rarely upbraided for it. On the other hand patients have two weeks to reply to the GP's response and this is often enforced, sometime from the date of the letter rather than its receipt by the patient.

The date for the hearing is set usually without involving the patient in the negotiations for a suitable date and whether or not to have a hearing is decided upon by the Chairman of the Medical Service Committee.

There was some feeling that the decision whether or not to hear a case, based on which terms of service had been breached, prejudged the case before the hearing.

The result of a hearing is not always reported to the complainant but to the FPC and then only at the next FPC meeting which may be some weeks after the hearing.

The appeal is no fairer since usually the doctor has a barrister supporting him paid for by his insurance company but a complainant must pay for legal assistance from their own pocket. Also at present there is a long delay at the DHSS in resolving appeals.

Informal Procedures. There was some discussion about whether or not it is worth developing informal procedures. The informal procedure at least allows for a complaint to be heard on its own terms rather than in terms of a breach of contract. However, the success of the informal procedure can depend on the calibre of the lay conciliator, the informality of the procedure itself (some FPCs have a very formal informal procedure), whether or not the CHC Secretary can attend and whether or not the patient wishes to heal the breach with the GP.

There was concern that the informal procedure whilst allowing a patient to talk about his grievances may do no more than that. There is a consequent loss of accountability. The GP present suggested that the informal procedure should always have an agreed outcome to try to build in accountability.

Another difficulty with the informal procedures arises when the complaint is about a contractor who charges patients directly. In addition, dental complaints are difficult to deal with informally because dental work is so technical.

A major difficulty to emerge in the workshop was that there are huge differences between practice in one FPC and another, making discussion of general principles sometime difficult. For example, many CHCs reported that GPs often automatically strike a patient off their list when they complain. In an urban area this may not present a great difficulty but in rural areas patients often have no choice of practice.

Changes. The changes proposed by the workshop were that the contractor principal should be further debated in another forum. The contractor system makes it inherently difficult for the user to complain about the service received from a provider contracted not to the user but to another body.

A more immediate change would be to separate the two aspects which the Service Committee procedure attempts, and fails, to address. The complaints procedure should thus be separated from the disciplinary element of the procedure. The patient should be the focus of a new complaints procedure which should allow the patient a chance to complain about the service received and to receive an explanation for the problems.

Whilst the complaints procedure should be separate from the disciplinary procedure the two should join where it is seen that a complaint merits disciplinary action. Further, the disciplinary procedure should also cover a wider area; the terms of service should be extended (it was implied but not clearly stated that the extension should cover rudeness and attitude).

Some people said that members of Service Committees should be professionals from another area since many patients perceive the present system as inherently unfair, believing in the power of the old boy network.

RAPPORTEUR: LYNDA WIGLEY (Gt. Yarmouth & Waveney CHC)

REPORT OF WORKSHOP C; COMPLAINTS AS QUALITY CONTROL

WORKSHOP LEADERS: **MARTIN PAYNE** (Norfolk FPC)
MELINDA REPARD (Brighton HA)

The workshop began with a brainstorming session on 'what is a complaint' and then looked at types, methods, and sources in order to be comprehensive. A general discussion produced widespread agreement that people were not given enough information about how to complain or even encouragement to complain.

The first consideration was what does the LMC,FPC, CHC, DHA and RHA do with what it learns from complaints to improve quality control? There was a fair degree of ignorance, among those taking part, of the different complaints procedures run by different parts of the health service and the roles of various actors/organisations in it. With so much variation reported in different Districts regarding what are supposed to be uniform procedures, it was hard to keep the discussion from degenerating into an argument about what was appropriate/good/bad practice. It was generally agreed that there was little if any attempt to make the complaints procedures aid quality control. It was arguable whether there was much quality control in many sectors of the NHS. This too, sparked off a side discussion about different organisations' roles in enforcing/monitoring standards and their efficacy both with regard to 'erring individuals' and systematic problems.

It was suggested that on one level quality control required detailed quantitative methods and agreed standards. It was also argued that considerable gains in quality control could be achieved in areas where assessment was far more subjective.

One participant stated that quality control was a task of management. Others characterised managers as unable to act in their area on this subject. Someone suggested that since FPCs have no real power over practitioners, they could exert no power and very little influence. This was countered by a FPC administrator who explained the various ways that FPCs could act to affect practitioners' ways of working. Most present though had little experience of FPCs doing any of this. However it was felt that increased collection of comparative data would help FPCs pick out GPs who were under achieving.

A point was made by a CHC representative that FPCs should define and educate their local public about what reasonable expectations of service from practitioners should be. Without this definition it was felt that many members of the public had no idea how to judge the service.

Discussion continued on the recording of complaints, how they should be categorised and whether complaints could be used to formulate standards. The discussion repeatedly returned to the general public's ignorance of the complaints system and how to 'sell it' without encouraging too many complaints. For instance

comment cards in the back of admissions books.

Discussion continued on the question of the meaning of 'numbers of complaints' in determining whether the service in a given area was any good. One CHC delegate pointed out that there were cultural differences in the approach to this. Lack of complaints or non-pursuit of complaints was seen by some HAs as a sign of consumer satisfaction. It was pointed out that a great deal of complaints were about the way that certain managers failed to perform their duty in administering the complaints procedure!

A Health Authority representative explained how her progressive Authority's complaints sub-committee worked. How a small group including a CHC representative checked to see how complaints were being dealt with and looked to pick out problems which the Authority might seek to deal with. Few delegates reported that their DHAs had established similar procedures and there was little sign of any system of routine formal or informal reporting either inter or intra district of cases in a way which would discourage others from making the same mistakes.

CHCs too, had differing practices. Some collated and analysed complaints. Some allowed member involvement in complaints prior to their investigation by the providing Authorities, others banned such involvement and left assistance of complainants to the Secretary.

Two concepts - management action and education/dissemination of information - were discussed briefly. Two opposing views emerged; firstly that UGMs were the only people to deal with complaints and quality controls; secondly that UGMs were completely the wrong people to deal with complaints. This issue was not satisfactorily resolved. One FPC representative explained how his Local Medical Committee were circulated with individual narratives of complaints which they could act on and even circulate nationally if it was appropriate. One representative asked whether individual Authorities should not make more use of the information about mistakes made which were 'thrown up' in court reports of legal cases.

Conclusion The subject matter was probably too wide to be dealt with in a short workshop. Few participants appeared to have positive experience of complaints as quality control. A great deal more work needs to be done.

RAPPORTEUR: DAVID DAWSON (Rochdale CHC)

REPORT OF WORKSHOP D: HOSPITAL COMPLAINTS & THE INDEPENDENT PROFESSION REVIEW

WORKSHOP LEADERS: **Emrys Roberts** (Secretary South Gwent CHC)
Julie Cahill (Action for Victims of Medical Accidents)

Hospital Complaints are perhaps the most complex area of the NHS complaints procedure and the workshop began by going through the various official channels for dealing with complaints. In the main participants agreed that the outcome desired by the complainant usually determined the course a complaint would take.

Formal Complaints. Discussion centered around whether DGMs should always be the first point of contact for a formal complaint. Whereas delegates were unanimous that the GMC was a totally unhelpful mechanism for patients with a complaint, those delegates who had referred complaints to the UKCC (nursing complaints) reported that complaints had been handled seriously and sensitively. The UKCC will also take on board complaints which have not been through the official hospital procedure. The point was made quite strongly that if DGMs were to be able to use complaints to enforce management accountability, they should be the first point of contact for a complainant.

One of the main problems of the formal hospital complaints system was perceived to be the secrecy of DGMs once an error is admitted. Letters to complainants often say "appropriate action will be taken", but patients are not told what this means.

Ombudsman. Everyone agreed that the main problem with the Ombudsman was his refusal to deal with any complaint that might be, however loosely, related to clinical judgement. However, everyone except Emrys Roberts agreed that the Ombudsman system worked well.

Clinical complaints. The first stage of the clinical complaints procedure raises problems in that not all complainants want to sit in a discussion of their case with the consultant concerned. Additional problems arise because this first stage is completely voluntary on the behalf of the consultants - they can refuse to take part.

The greatest problem with the Independent Professional Review, it was suggested, is that it raises the expectations of complainants to believe that something will happen. Complainants do get the chance to air their grievances to a quasi-independent body and for many this does lead to satisfaction. However, delegates, particularly from CHCs questioned whether IPRs necessarily resulted in disciplinary action. Other delegates raised the issue of Health Authorities persuading complainants to sign away their rights to go to law before proceeding with an IPR. Whilst such disclaimers are not actually legally binding, they may serve as a deterrent to many complainants.

Legal Remedies. Julie Cahill spoke in detail about the benefits of encouraging complainants to seek legal redress for serious accidents or negligence. She explained that IPR was used by HAs as a means of stopping people going to law by making them believe that their complaints were being dealt with seriously. In particular the three year limit for legal action was often abused by HAs who delayed initiating IPRs until subsequent legal action would be ruled out of time. She went on to say that the medical profession clearly control the clinical complaints procedure and at all stages attempt to persuade complainants to drop their action - this is why they are reluctant to allow CHCs to represent patients.

She went on to say that CHC secretaries need more training on the medical issues surrounding negligence so that they can make an assessment of whether or not a mistake was avoidable. She said there was a great need to redress the imbalance of knowledge and information between the medical profession and the lay public - we need to know the kind of common mistakes doctors make.

The big problem with going to law is that it is very costly. Only 15-20% of complainants qualify for legal aid and there is a shortage of expert lawyers. For those people who cannot afford to take a legal case, it is even more important that CHCs are experienced at handling the clinical complaints procedure to help people make the best use of it.

One delegate raised the question whether it was CHCs role to get so deeply involved with individual complaints rather than advising on options. This view was not widely supported.

Conclusions.

1. There is a need for better procedures and increased public knowledge about how they work. Procedures should be far more independent with a much stronger lay input and co-operation in procedures amongst professionals needs to be put on a obligatory rather than a voluntary footing. The role of CHC secretaries as patients friend should be formally recognised.

2. Amongst CHC secretaries in particular and the public in general there needs to be far greater knowledge about what constitutes a medical accident or medical negligence.

3. Serious considerations need to be paid to a system of no blame compensation for medical accidents which is linked to proper accountability and formal review of the competence of medical staff.

RAPPORTEUR: SUZANNE TYLER (ACHCEW)

REPORT OF WORKSHOP E: THE ROLE OF THE PROFESSIONAL ADVICE WORKER

WORKSHOP LEADERS: **Joy Gunter** (Secretary, Dewsbury CHC)
Judy Thomas (Secretary, Bradford CHC)

Joy Gunter spoke on the general role of the CHC in advice giving to complainants. She emphasised the accountability of CHC staff to their members in reporting anonymously to the CHC detailed number of enquiries receive and identifying particular trends, where applicable. In certain circumstances, CHCs had established member-interest groups on complaints and advice. In most cases, however, it appeared that members were not keen on being too closely involved in the formal procedures of advice giving, and believed that this would be more appropriately dealt with by CHC staff.

Enquirers to CHCs were referred from a variety of differing agencies, including self-referral, other advice agencies, health and social Service professionals and those family practitioner Committees which had adopted the good practice of referring people to CHCs for support and advice.

Joy advocated a general approach of relaxed counselling in the first instance, followed by a formalising of the necessary information, where necessary.

When identifying the nature of complaints, a simple CHC check list of who, when, where, what, how and why could be used to ensure that, information required was obtained prior to offering a considered opinion on the course of action which a complainant might take.

In instances where it was important to write to Authorities, it appeared to be the normal practice of CHCs to draft letters and seek the observations of complainants prior to letters being sent. Joy emphasised that the 8 week timetable for receiving FPC complaints was very tight and, although there was opportunity to seek a waiver by an out of time application, those present at the Workshop confirmed that only half of these application were approved.

In identifying the course of redress for complainant, the necessary first priority was to establish what the expectation of the complainant would be. The role of the CHC worker would be to offer choices in any decision about courses of action.

In cases where monetary retribution was required, a large number of CHCs were now using the Association for Victims of Medical Accidents (AVMA), as they had gained more experience over the years and contact with professionals who can offer adequate medical opinion and legal advice.

Also of particular priority when giving advice was the need for the CHC workers to recognise their own limits, in order that real

choices might be established. To create an illusion of an outcome would merely compound the problem for a complainant. CHC advice workers need to recognise that Formal Procedures were only as good as those people who administer the process, and it is important to value the existing procedure in this way.

Judy Thomas spoke on the question of the existing values of procedures - what they are and what they should be. She questioned the role of the CHC advice worker in acting as an advisory or a counsellor, and emphasised the good practices that had been adopted by Health Authorities and Family Practitioner Committees in referring complainants to CHCs.

She especially noted the insensitivity of some professionals towards complainants in the question of bereavement and drew attention to the fact that many professionals find it difficult to cope with death.

She went on to express the lack of responsiveness by bureaucracy towards the views of carers and relatives.

The following points were raised by Workshop participants:

COMPLAINTS ABOUT GPs.

- an apparent reticence for complainants to come forward and challenge professional opinion.

- the monopoly of health care which exists in certain rural areas acting as a disincentive to complainants fearful of loosing access to care.

- The Formal Complaints Procedures appears to be very long-winded, which acts as a further restraint in obtaining redress through the existing complaints procedures.

- the vulnerability of patients in the decision process.

- there are a number of examples of CHCs acting as an interventionary force when problems arise between patients and professionals. Members emphasised that, in such cases, it was early identification of the difficulties which offered the greatest opportunity for positive remedies.

COMPLAINTS ABOUT HOSPITALS

- on the question of Health Authority complaints, emphasis was placed on the credibility of CHCs in their efficiency of response, as well as finding out how local procedures work in practice.

- one participant of the Workshop expressed the view that it was most important not to become closely involved with complaints at a personal level.

- participants particularly emphasised that the role of the CHC Secretary was one of having a good overview of local procedures and someone who should be the best person to recognise and identify good and bad practices which may exist in the local area.

- members also drew attention to the need for training of CHC and Health Authority staff in different ways.

- it was understood that some CHCs give a greater priority to advice and counselling activities than others and that, in any recognition of the CHC's duties, it may be important to recognise the varied needs and responses by individual CHCs.

- one aspect of good practice, which appeared to work in some Health Authorities and FPCs, was copying of complainants' correspondence directly to the CHC.

GENERAL POINTS

- Members considered that ACHCEW should be a focal point for the gathering of good practices on the question of advice giving and counselling within CHCs.

- A further point was made on the administration by FPCs of people seeking advice and the need for a common recording mechanism between CHCs for noting of enquiries.

- Consideration was given to the need for an annual publication by CHCs, summarising statistics and case histories.

IN SUMMARY

Members of the Workshop considered that the following points were of greatest importance in the future role of CHC advice giving:

* CHCs investigate local procedures for complaints at Districts, FPCs and Regions, and compare the written procedures with the way in which they are implemented.

* a known Code of Conduct should be developed between the individual CHC, FPC, DHA, RHA and Ombudsman's Office.

* A Good Practice Guide would be welcome, to include the limits of the CHC role and recognition of the role of Doctors in the monopoly provision of healthcare.

* a consideration of priorities for CHCs in offering advice to people who may seek general or detailed support/counselling.

* the role of CHC members requires more detailed clarification.

RAPPORTEUR: BARRIE TAYLOR (SOUTH WEST HERTS CHC)

SECOND PLENARY SESSION: Dr. David Williams, Chairman Statutes & Regulations Sub-Committee of the BMA's General Medical Services Committee.

Thank you very much for this opportunity to speak to this Conference on behalf of the BMA. I am in General Practice and I will slant my remarks in that direction.

When things go wrong patients should first take the matter up with their own doctor. That is in accordance with the principle which we heard this morning - first you go to the supplier. I feel sure that the vast majority of doctors would welcome the opportunity of discussing any complaint with their patients first before it went any further. Once a complaint goes to a formal service committee, the patient is committed to a frustrating emotional marathon from which there rarely emerges any satisfaction, reparation, compensation or tangible contribution to service improvement. The patient meets his first hurdle on the middle of the first page of "Notes on Service Committee Procedures", where the following words are underlined: "Service Committee Proceedings do not exist to remedy patients' personal grievances but to settle disputes about whether or not practitioners have fulfilled the terms of their contracts."

Complainants frequently maintain that they do not seek to attack the doctor - only to ensure that others do not suffer similarly. They often want to complain about a system that has failed to deliver. Instead their complaints are particularised, personalised and made adversarial. An analogy will show what I mean.

If you, as a customer, were to complain about the absence of meals on British Rail, you would be very surprised to be invited to present a case before a British Rail Committee against Rail Caterers Ltd., a sub-contractor, with a view to deciding whether Rail Caterers should have their remuneration reduced by the cost of the meal they failed to provide; the money to go, not to you, but to British Rail.

Just imagine the hearing. You present your case. "I was given a prawn sandwich with the words, "That's all there is, mate." The Chief Steward defends himself, "I offered the lady a complimentary prepacked lunch and apologised for the lack of variety. The shortage was due to food contamination outside the control of the staff. Other passengers did not complain. They appreciated the safety measures taken on their behalf. Yes, Chairman, we are specially trained to deal with difficult passengers. Yes, my three colleagues were all near enough to confirm the precise words and they are all word perfect." The whole hearing revolves round the precise words used on the train and your truthfulness. When you say there has been no dinner on other occasions and other trains, you are ruled out of order or out-of-time. Then the Chairman announces that, on balance, the committee prefers the Rail Caterers evidence and find in their favour on the grounds that, as you yourself had admitted, British Rail itself often provides a limited menu and Rail Caterers cannot be expected to

exercise a higher standard of skill, knowledge and care. Since your real complaint has not been addressed, you say you are not satisfied. The Chairman blandly explains that these procedures do not exist to satisfy passengers' personal grievances but to determine whether there has been a breach of the contract between British Rail and Rail Caterers. If you do not like the result, you can appeal to the Chairman of British Rail. But what is the point of that? He is the man ultimately responsible for the poor service. So you say you will write to the Press, only to be reminded that hearings are confidential. Game, set and match to British Rail.

The whole exercise succeeds in diverting the complaint away from British Rail Administration and focusing it on something said by an exasperated Chief Steward to an exasperated passenger on a particular occasion. If you want to revenge yourself on a particular Chief Steward, you will be outraged that you weren't believed, but if your object is to improve the standards on British Rail, you will be left in a state of frustrated and confused impotence.

When a patient tries to complain about his treatment in NHS general practice, he ends up as a party to a dispute over a contract between the NHS and a contractor. The NHS sits in judgement and decides, on a balance of probabilities, whether he, or the doctor or receptionist was truthful. And the appeal lies to the Secretary of State, the man ultimately responsible for the service. That may work if the patient seeks retribution on a receptionist or doctor but is frustrating, if his real intention is to improve standards in the NHS.

There is a very clear distinction in purpose between (a) simple complaints, (b) the search for retribution and (c) the search for compensation.

(i) Simple complaints lie in the field of audit, accountability to the public and service improvement. At such an enquiry, evidence can be assessed on a balance of probabilities and there should be no penalties and no formal attribution of blame. Everyone can try to learn from mistakes with the benefit of hindsight and any complaint can be considered. That is why the GMSC is in favour of encouraging the use of the Informal Procedure which should, in my view, offer an agreed outcome in terms of service improvement. The fact that it will usually be possible to preserve or restore the doctor-patient relationship is a bonus. The informal procedure is unsuitable for serious cases and they must be filtered out.

(ii) The search for retribution leads to disciplinary hearings in which there is an accused and an accuser. Legal safeguards are needed and facts ought to be established beyond reasonable doubt. The doctor-patient relationship is unlikely to survive.

(iii) The search for compensation is at present a matter for the Courts. Whether compensation ought to be based on establishing negligence, accident or proven need would provide material for

another conference!

It is extremely difficult in practice, to separate consideration of simple complaints from the disciplinary and legal consequences which may follow. In NHS general practice we operate a hybrid system which marries together the first two concepts and then uses aspects of the third to justify the anomalies and, of course, any medical complaint can also lead to a GMC hearing or to an action for negligence.

In discussing complaints there are three human failings we have to consider.

1. All human beings make mistakes. However, even minor medical mistakes can have very serious outcomes. All doctors in active clinical practice have made errors which have had serious consequences. Any doctor who denies that he has done so lacks the quality of self-criticism necessary to learn from their errors. Patients and their relatives also make mistakes. They may send for the doctor too late, omit medication or conceal symptoms through fear.

2. Most human beings, when they feel injured, experience a desire for retribution or compensation. Only the Saints amongst us try to forgive and understand.

3. Human beings, who are attacked, try to defend themselves. Doctors are no exception. They will feel guilty because they will always be able to identify something they could have handled better. Once, a personal conflict exists between doctor and patient, the relationship based on mutual trust is broken. It is usually quite unrealistic to expect the doctor to continue to treat the patient.

Because medical errors can be so serious, it is vital that they be discussed openly by doctors and patients. There must also be medical audit so that doctors learn from errors. However, as long as doctors feel vulnerable and personally threatened, these very desirable objectives are pie in the sky.

Why do doctors feel particularly vulnerable?

1. A full routine clinical examination and history takes about 30 minutes, but no doctor goes through the full half hour examination on every occasion. He has to decide how much to examine and how much history to take as he goes along. He is vulnerable because the adult with a head cold today can develop pneumonia tomorrow; because the child with a head cold today can develop meningitis or a cot death tomorrow. Once a patient has died, there will be little sympathy or understanding for the doctor who neglected to carry out a full clinical examination, take a full history and record every detail. Even though the DHSS workload enquiry revealed that surgery consultations last on average 8.25 minutes, and even though head colds obviously carry a low priority, to say this in defence when disaster has struck would neither satisfy the bereaved nor go far to convince the

judge. At best it could be treated as a plea in mitigation.

2. Most of the events which matter are on a one to one basis in the consulting room or on the telephone. Memories can differ widely and there is usually no corroboration. The doctor has no guarantee that he will be believed.

3. Medicine is a world of probability not of certainty. Diagnosis is by likelihood and is a matter of judgement. Judgement presents special problems and a I want to refer to errors of clinical judgement in some detail. They fall into three groups:-

(i) Legitimate Errors. These are the errors of management, diagnosis or treatment made in the course of careful and conscientious practice which all doctors can identify with hindsight. It is the area within which a doctor has a right to be wrong and a right to the support of the community. In practice, a minority of patients are prepared to take the inherent risks of modern medicine in order to get the benefits just so long as those risks do not materialise. If they, themselves are affected, they look for compensation and scapegoats and are increasingly encouraged to do so.

(ii) Bad Practice. This includes the isolated error no doctor should make at any time as well as the pattern of repeated minor errors which, on their own, would be forgivable. It may amount to Serious Professional Misconduct and be a matter for the General Medical Council. I estimate that about 5% or 6% of all complaints in general practice fall into this category.

(iii) Human Errors. These are errors of judgement in which a normally conscientious doctor lapses from his usual standards of care or skill; perhaps when tired or under pressure. I estimate that 22% of complaints against general practitioners fall into this category.

In almost every serious illness, there will always be something to defend; something which could have been done - or done earlier; diagnoses made later; treatment or referral delayed; administrative errors.

Because all human beings are bound to make human errors, isolated errors should be treated with understanding and ought not to be the subject of disciplinary proceedings. The gravity of an error ought to be considered in isolation from its outcome. When minor errors have serious or fatal consequences, it is usually quite impossible both to satisfy relatives and be fair to the doctors concerned.

The assessment of clinical judgement presents problems. Because clinical judgement embraces a wide area of latitude within which doctors may quite properly disagree about diagnosis, management and treatment, there is often considerable disagreement within the profession about whether a colleague has exercised his clinical judgement properly. What would be

regarded as acceptable by some practitioners could equally be regarded as an error by others.
Let me give three examples: (i) There is open disagreement about the significance of anal dilation in the diagnosis of sex abuse. (ii) In the past a patient with cardiac infarction was not allowed out of bed under 4 weeks. Now, the reverse is true. (iii) Today, some doctors believe they can help patients using homeopathy and acupuncture. Others attribute their colleagues' success to placebo.

A doctor who holds one point of view cannot be fairly judged by colleagues who vehemently disagree with him. That is why, in law, a doctor has normally discharged his duty of care and cannot be negligent if he has conducted his diagnosis and treatment in accordance with what a respectable body - not necessarily a majority - of medical opinion would regard as sound. What has to be decided, on the evidence presented by the parties, is whether such a body of opinion exists. It is sometimes suggested that clinical judgement can be independently assessed. Only the Courts can be regarded as genuinely independent and when medical opinions differ, it is open to the respondent to produce evidence to convince a Court that reasonable backing exists for the course of action taken.

This brings me back to the major problem. Complaints as Quality Control will be most fruitful when conscientious doctors are prepared to learn from their human errors. But, those same doctors will not practice good medicine and will be reluctant to agree to clinical audit as long as they are forced to practice defensively and expensively, forever tailoring their actions and records to a potential complaint, disciplinary hearing or action for negligence.

Paradoxically, it would be much easier to defend the conscientious doctor if the profession acknowledged and recorded the incidence of human error more openly. If the RCGP produced academic evidence that only 5% of their Members and 10% of their Fellows, woken at 2 am, were quite capable of answering the telephone whilst still asleep, it would be much easier to explain some of the bizarre events of which patients complain.

That brings me to a special area of professional judgement - the decision, made over the telephone that the patient's condition does not require a visit. Failure to visit is a frequent cause of complaint especially in the out-of-hours period and poses a particularly difficult problem. Since the NHS began, the practitioners' contract has been interpreted as imposing an obligation, in the out-of-hours period, to provide an emergency service. A majority of such calls are far from emergencies. Patients' demands and expectations are increasing especially in the evenings and weekends. The night visit rate has trebled in the last twenty years. But, to expect a doctor to decide, on the telephone, whether his patient's condition requires a visit, places him in a very vulnerable position. Sooner or later, he is bound to make an error yet, to expect him to attend every call would, in many areas, be an unsupportable burden.

So, what can be done to improve the Complaints Procedures?

1. A clear separation between non-judgmental audit, enquiry and complaint, on the one hand and disciplinary proceedings, which should provide full legal safeguards to protect innocence, on the other. There has also to be some degree of reassurance that participation in the first type of enquiry is not the prelude to the second or to legal proceedings.

2. Isolated human errors of professional and clinical judgement have to be accepted and understood as inevitable but bad practice has to be brought to the attention of the GMC or the NHS Tribunal, who must decide if the doctor is fit to continue in independent practice or in practice at all. We are not in any way defending bad doctors, they let the profession down.

3. The Doctor's out-of-hours obligations both in hospital and general practice need a complete review. The false "macho" image of the doctor with inexhaustible energy, expected to function night and day without making mistakes, has to be exorcised.

4. Lastly, the current emphasis on throughput must cease. Increased throughput in general practice and in our hospitals is only achieved at the expense of lower standards. Time to listen, time to examine, time to investigate and time to record is the secret of good medical practice. When patients choose to go privately, they buy time not expertise.

The reality of the NHS is the conflict between throughput and standards. Pressure for higher standards may well be successful in causing doctors to limit their work rate so as to acquire the time need to achieve those standards. But, if it does there will be high standards for those who reach the consulting room but nothing at all for those left waiting. The values underlying the NHS ought to require us to share medical time equitably on the basis of need even if that means lowering standards. The drive by management for increased throughput has caused and will continue to cause a fall in clinical standards. The profession has no intention of being cast in the role of scapegoat. Any complaints procedure ought to be capable of identifying the shortcomings in management, politicians and funding as well as those of the clinical staff.

I began with an analogy about British Rail. The man responsible for standards there is the Chairman and, in that analogy, he was also the final judge of standards and heard the appeals. So he could avoid accountability. In the real world of the NHS, the Secretary of State hears the appeals and so avoids accountability for what happens to individuals. Perhaps, in that respect too, we need reform.

PANEL DISCUSSION

PANEL MEMBERS:

Chris Ham: Policy analyst at the Kings Fund Institute
Jean Robinson: Lay Member General Medical Council
Arnold Simonowitz: Director - Action for Victims of Medical Accidents
Derek Prentice: Member of West Lambeth Health Authority
David Williams: General Medical Services Committee of the BMA

Chris Ham: The Panel has been given the job of trying to bring the disparate themes of today together and to try and make some sense of them, so that ACHCEW can take ideas from our discussion forward. So far lots of different themes have emerged. With the help of the panel and participation from the floor I hope we can develop some of those.

I think what has come out for me so far is the complexity of the procedures that we are talking about. There are many different routes for pursuing a grievance or a complaint: some formal; others informal; some involving the search for compensation; others involving people who simply want an explanation of what went wrong. If we go back to Maurice Healy's criteria it seems to me that the NHS procedures don't stand up very well. They are complex. They are fragmented. They are very difficult to understand, both for individual patients and for people involved in the Health Service. They are slow and they are lacking in independence, which is one of the key criteria we should have in mind when designing complaints procedures.

Should we, on the one hand, reform the procedures quite radically, to overcome those deficiencies or should we tinker with the system to try and make the existing procedures work more effectively?

*** Separating the procedures**

I want to begin by latching on to the issues which David Williams spoke of and I want the panel to respond to David's point about the need to separate the procedures for investigating 'simple' complaints where the aim is to look at what happened and try and find out what went wrong, from the procedures for disciplining doctors and try to get some kind of retribution or in some cases, compensation out of the system.

Jean Robinson: I am not sure exactly how this is meant to happen. There are various aspects of what David Williams was saying that I was very unhappy about and one was his constant use of the word retribution. This to me is typical of the difference between the medical and consumer approaches to complaints. Consultants often say that people who make complaints are

vindictive. I do not think any of us who have worked for years to try to help people who have a complaint see them in those terms at all. That kind of perception is totally wrong. People want to know the truth, and see some kind of change. A few of them are turned into wanting retribution by the complaints procedures and by the dishonesty of the response when the doctors lie. Before we go on to systems I would like to change medical perceptions.

Arnold Simonowitz: Victims of medical accidents certainly do not want retribution. Jean used the term 'justice', I would use the term 'satisfaction', which encompasses all the sorts of things that they want - not only money. They want an explanation, they want an apology. Dr. Williams said that you have got to separate this and doctors have to be reassured that if they participate in the one they won't leave themselves open to attack in the other. In other words, they will not co-operate in trying to give apologies, explanations if it leaves them open. The whole thing is about accountability, and that is where we have got to begin to find out what happened, why it was done, what went wrong. Then if it transpires that some one needs to be disciplined, discipline them and if money has to be paid, pay the money. Don't have some secret investigation into what when wrong in which the doctor will only take part as long it is kept secret. It is a lack of understanding of what victims and what patients want.

Derek Prentice: I think it is the process itself that makes patients and those with a complaint against the system vindictive. The person making the complaint doesn't go out in the beginning to get that person disciplined. They have a complaint against a service provider. If that complaint is justified it is then for the employing authorities to decide whether or not that person as an employee, or as a contractor should be disciplined. No-one would actually believe that people receiving services could be treated in the way that complainants are treated in the NHS. It is an outrage that people should be able to say as we have heard today that doctors are prepared to take part in a procedure but only on the basis that nothing else will happen to them if they agree to that particular procedure.

David Williams: I am sorry if I choose the word wrongly - retribution. I was trying to point out the difference in purpose between what I described as a simple complaint and the complainant who says, "I don't think this doctor is fit to practice". Perhaps I should have said the complainant wanted 'disciplinary action' to be taken against the doctor. The very fact that the thing is so personal and so emotional does make the doctor terribly vulnerable. People who feel vulnerable are not going to co-operate. If as a doctor you know that the consequences are serious of a complaint made then you will not wish to co-operate voluntarily and you will want it to go either to a disciplinary procedure where you can be protected by law or not at all. Our difficulty is to persuade doctors that their vulnerability will be taken account of. After a death, for example, people all feel guilty and they have to move the guilt on to somebody else. This often places the doctor in a very

difficult position. He feels he is having to defend the death and yet that defence may be difficult. The very vulnerability of the doctor is going to make it very difficult for us to persuade them to participate genuinely in audit without some degree of protection. We want people to sit down honestly and openly to discuss things and unless they have some degree of safeguards they are not going to do it. We can't persuade them any more than you can.

C.H.: Can we pursue the issue of vulnerability? Would a no-fault compensation scheme or a patient compensation scheme help?

D.W.: I think it would help in the hospital service particularly. I don't think that in the general practitioner service it is so much the fear of the legal procedures, as the fear that they might be brought before a service committee. In the case of a death the doctor may be found in breach of his contract.

C.H.: But if a doctor has made a mistake or caused a death or serious injury, surely, it is appropriate that there is disciplinary action?

D.W.: It may not be appropriate that disciplinary action should take place. A doctor, who has had a conscientious practice for many years, and makes a minor error, which leads to a major catastrophe may need sympathy rather than discipline.

C.H.: So rather than an error in a particular case it is a doctor's record that is important. One particular poor example of his practice that gives rise to a difficulty is excusable but not a record of bad practice.

D.W.: No. A fairly minor error might have catastrophic consequences.

Questions and comments from the floor?

*** Needs of the user**

Any complaints procedure must actually have as its underlying principle the rights and the needs of the patients, and also the need to improve the service for other patients. The issue of what happens to the doctors is a separate one. That's why I think it is important that we do have two separate procedures and the first procedure must take account of the needs of the user of the service and have their complaints satisfied.

*** Ensuring professional co-operation**

Dr. Williams said that GPs would be reluctant to come into any system which might lead to a disciplinary procedure. However, it could actually be written in to the terms of service of a GP that they had to co-operate.

David Williams: I think it would be possible to write it into

the terms of service that doctors participated in this sort of procedure but you would not necessarily get willing participation. What we want is to have a system where doctors discuss openly, the errors they made with patients and with the public. To get that system, you have to have their agreement and willingness to participate. It's done by persuasion and one of the things you have got to be prepared to do is to give some protection, so that when they do participate, the things they say are not going to be amplified into other complaints of a disciplinary nature. If you find some major disciplinary problem arising out of a complaint then clearly you can't ignore it.

A.S.: I would like to come back to the very first point that was made which is that we should be talking about a system that will satisfy patients. Unless all the issues can be discussed openly you are not going to get a proper complaints system. A special pleading on behalf of the medical profession that this is somehow different from other consumer situations because personal factors are involved, I don't accept.

J.R.: I am worried about this assumption that if the doctor does not feel threatened then you are going to get the information and co-operation. Look at what happens to the Ombudsman enquiries. Case notes still disappear or get altered. The same happens with the Regional Medical Officers complaints procedure, actually designed by the joint consultants committee of the BMA. They won't even take on a case unless there is no chance of you suing. We are here to look at a system that works for patients. There is an enormous amount of conciliation work to be done in medical complaints and I would like to see the development of skilled conciliation work.

*** A new kind of system?**

Arnold Simonowitz: I think the fundamental requirement for any system is that it should be simple and there should be one point of complaint. Complaints should be investigated by a team which is aware of the problems of the doctor and also aware of the problems of the patient but is not beholden to the medical profession. You have got to have an independent enquiry system, advised by the medical profession, if necessary, but able to make decisions, on the broad issues involved. For example, we don't have a single doctor in Action for Victims of Medical Accidents but our case workers are able to identify the issues and to take them on to tell people whether they have got a claim.

J.R: I think the first thing is to find out what the complainant wants to achieve. Doctors would be surprised at the variety of things people want and often it is very simple. Often they say "I would like to sit down in the same room with the person who did x or y, the midwife, doctor or whatever and be able to talk about what happened, ask them why they did it and get it resolved." The needs of complainants differ. In some cases they need the services of a skilled conciliator. They need to have access to the truth and that means access to case notes. I think we need training for all health care professionals in how to deal

with complainants and their own feelings about complaints otherwise we will get nowhere.
D.P. The first thing is to bring about a change of attitude about what complaints are. People have to realise that complaints are a good thing for any organisation. They are one of the best management tools and can tell you more quickly what is going on and what the consumer concerns are in your organisation. We want more, not less, if we are really going to find out what makes this service tick, and what's wrong with it as far as the users of the service are concerned. Most people, as we have heard today don't want retribution. They want to know what's gone on and what happened. We need openness and that means access to records. We need liability admitted quickly. The classic way of getting a complaint to go away is to deal with it the way the health service does - make it take six years - don't respond to the letters quickly. People don't go seeking massive compensation claims unless they actually need it to look after themselves or their dependent relatives. So, we need complaints committees in hospitals that are independent, that have their own budgets, that have the right to admit liability immediately when things go wrong.

D.W. Most doctors when faced with one complaint get so upset about it that it affects their practice considerably. If complaints are to be a continual part of practice then you will change practice very considerably. What you will get is a formal defence in the case notes. When a doctor sees a patient, he will automatically write down everything that will perhaps defend him against a complaint. That takes an enormous amount of time. You will also get an enormous amount of investigation that shouldn't be done.

Questions and contributions from the floor?

*** GP training**

It is not so much that doctors need training in how to deal with complaints, but in how to deal with their own fallibility and the fact that they may be making errors throughout their career. We constantly find that doctors do not have any re-training.

*** Existing failings**

I was hoping that we would touch a bit on those areas where the current complaints procedure fails. For example, the case that the FPC refers to the GMC, the GMC to the police and the police say it is nothing to do with them.

Institutional negligence

I think there is another important issue that has to be looked at here: institutional negligence. Negligence due to mismanagement and negligence due to shortage of finances. How does the patient get any satisfaction at all when you can't pin the complaint on to any individual. For example, Health Authorities are making cuts, closing wards and in the CHCs we see the result of these cuts.

Derek Prentice: I think that this is an issue which is rightly raised. Indeed I think one of the things about encouraging complaints is to make people realise in fact that they have paid for the service and they do have a right to complain about what the institution in its broadest sense is doing. It comes back to a far wider issue of consumer involvement in the health service. One isn't only talking about complaints about medical negligence but about rudeness, or the state the ward is in, or long waits for an ambulance, or lost notes. At the end of the day, it is management who should take the buck and not the doctors. It is management who should decide whether a medical person is going to be disciplined or not, not the doctors themselves. Management should have the power to take responsibility for the whole service, when it goes right and also when it goes wrong.

A.S.: I think it is important to have regard to the fact that there are complaints not against doctors, but against institutions. But we have got a big difficulty there, because there will be some complaints relating to the institution, lost notes for example, which may not relate simply to the institution. There will always be a member of the medical profession in the background and someone wanting to protect that member of the medical profession. Dr. Williams talked about doctors getting upset if complaints increased and not co-operating and putting their defence in their notes. What I want to know is who is going to teach doctors not to do that. What happens to a doctor when an accident takes place? He contacts an insurance company that has nothing to do with the morality of the issue. They are only interested in the legal aspect. The medical profession should produce some ethical body that would help the doctor right from the beginning: as a medical student learning to deal with his or her fallibility and how to handle complaints right up to the time when a complaint takes place.

D.P.: The first thing that has to be done is that General Managers are made responsible for all the medical actions in their hospital. Clearly, everyone makes mistakes but General Managers should be taken to task if the system is so inadequate that it allows clinicians to make mistakes. Secondly, I actually think it is over-rated that we make medical staff take out insurance - it gives them the excuse that they can maintain a certain clinical freedom. But there are other people in the health service that can damage patients. Cleaners leave a polished floor, where there shouldn't be polished floors, or whatever and patients trip over and hurt themselves. We don't make them take out insurance, and I think that if we take on our staff and if we employ our staff, we should be responsible for them in every sense including insurance. We have to persuade the lawyers for Health Authorities that they are there to represent the consumer. I believe the major problem lies in the early 1952 or 1954 circular that requires health authorities to co-operate with these medical defence organisations because it prevents honesty and openness and it delays the system.

*** Removal from GP's list**

While I think it is admirable to encourage patients to make complaints against their GPs, I think it is totally unrealistic given that a doctor has the right to remove a patient from his list. Every time our CHC gets a complaint we have to explain this first and suggest changing GP. I think this right that GPs have to remove the patient without giving any reason to anybody is invidious.

Jean Robinson: I agree that doctors have a right to remove a patient from their list, just as we have a right to leave. However, the implications of this are becoming more serious as the size of practices grows to cover substantial geographical areas. It is not just the complainer who is struck off the list it is all his or her kin and this means that everybody has got to traipse off to another GP surgery. I am worried about the size of group practices which are allowed. If you have two group practices of four GPs, then patients have got a choice, but if you have got one practice of eight they have not. On the role of management I am interested not just in the ethical behaviour of doctors or nurses but the ethics of management. On whose behalf are they administering the service and with what ideals and with what standards? We pay for the service and we have a right to demand certain ethical standards on behalf of the health authority and on behalf of the lawyers whom they employ. The Ombudsman cites cases of people who were threatened with libel actions by people writing on behalf of the health authority when they made legitimate complaints. Do no Health Authorities believe there is any value in truth for its own sake?

*** Role of the professional advice worker**

Chris Ham: Can we be sure that CHCs are doing a good job in looking after users and patients interests in helping them find their way through this very complex system that we have heard about. Who investigates complaints against CHCs? How can we ensure high standards of advice work and support from CHCs?

Points from the floor.

We do have problems in CHCs primarily in that complaints take up an awful lot of time. We have a lot of duties to fulfill. Complaints take up a disproportionate amount of my time and quite frankly as much as I might like to do more, it is physically not possible and we have not got the resources, monetary, statutory and staffwise to do more. CHC secretaries and members are generally not trained in any sort of advocacy. I have taken this up with my regional health authority and they have no plans at all for helping us.

Because the existing complaints procedures and the range of ways in which patients can get any sort of satisfaction are so

complicated and so complex, giving patients advice has become a professional job. Local Citizens Advice Bureaux are increasingly referring all health complaints to CHCs because they are aware it is a very complicated area. However, there are gaps; CHCs have never really come to grips with the Mental Health Act and the Commission and the complaints in those areas. CHCs have largely self-taught expertise and need to build on that.

CHC members don't automatically get paid time off work and some CHC Secretaries do worry about members if they have had no training being involved in complaints. Only a minority of any CHC's members actually have time to receive training in the range of issues that CHC members have to come to grips with. The Regional Health Authority should acknowledge the responsibility to train CHC staff.

Derek Prentice: Given the range of CHC activities and the kind of budget and the staff resources they have, I really believe that they are only scratching on the surface. I don't think that it is important that consumers/patients have someone outside the service to go to. I would like to see within the health service, well trained professional consumer advisors appointed to do this service. To act on behalf of the patient. It works extremely effectively in many American acute hospitals, where there are patients' representatives, who are very powerful indeed.

J.R.:I think the CHCs have made an enormous difference simply because there was somebody in the community who was monitoring complaints. The strength of the CHC is that it is there. People can go along and say, "Have you had any more complaints about Dr. X or ward Y or such and such a hospital?" I am amazed that with the staff they have they manage to do as much as they do and I think they have a legitimate demand for resources. Some CHCs, I am sorry to say do the job badly and I have had my CHC directory marked with ticks and crosses.

*** Role of ACHCEW?**

Chris Ham: Is there something that ACHCEW should be doing, for example one of the groups talked about a Good Practice Guide gathering the experience of different CHCs?

Toby Harris (Director ACHCEW): The needs for training are very widely recognised. There is a shortage in terms of the training resources available for CHC staff and members. As far as CHC staff are concerned there are I think a handful of Regional Health Authorities which provide some training for CHC secretaries. The Society of CHC Secretaries provides a number of courses which are open on a voluntary basis to CHC staff but this is no substitute for there being a recognised training budget of a sufficient size so that people are adequately equipped for this wide ranging role. As far as members are concerned, I think again there has to be a recognition of the role of members. If CHCs are to fulfill all the many jobs and duties which are thrust upon them, then CHC members have to play a big part. The

National Health Service Training Authority has recently produced material for training Health Authority members and FPC members and we are going to have some discussion with them about a similar package for CHC members. What it will ultimately come down to is how much the Government and the health service are prepared to recognise that CHCs have an important role, that they are the bodies to advise and assist people, and how much resources they are prepared to allocate.

*** No Fault Compensation**

Chris Ham: Would a system of no fault compensation bring about important improvements? If so, what else should we do as well as changing the compensation arrangements, particularly to strengthen the accountability of doctors.

A.S.: Dr. Williams said no-fault compensation would reduce the vulnerability of doctors and would make them co-operate. The experience in New Zealand is that this just has not happened. So don't look to no-fault compensation to improve the attitudes of doctors because it is not going to happen. At the very minimum any system of no-fault compensation should contain a parallel accountability system.

J.R.: I am very suspicious of no-fault compensation. It would not have met the needs of any single complainant I have ever dealt with. Have you ever had somebody come to you with a complaint and said "I want money that's all I want." At one time the medical profession said to us "Sue or shut up" now they are going to say, "Take the money and shut up." That is not the answer. First of all we have to think about accountability. "What when wrong?" "Why?" "What can be done to change it?" if money is required fair enough. Under existing conditions Court decisions can establish patients' rights and can, in fact, improve medical practice. No-fault compensation by itself, does not.

D.P.: No-fault compensation is not the panacea that many of us thought it might be. I have one question for Dr. Williams. If he thinks that no-fault compensation is a way out, would he agree to the introduction of such a system but maintaining the right of the patient to sue for negligence?

D.W.: At least one system of no-fault compensation does maintain that right. My worry about no-fault compensation is that it seems to me illogical that compensation for damage should depend on negligence. Many medical errors are not negligent errors. Therefore, patients are going to lose out if they don't have a system of no-fault compensation. However, there are many things for which people need compensation, like birth injuries, yet these people do not get any compensation under either system. We have to look at whether compensation should be based on negligence on accident or on simple need. My personal preference is, of course, for simple need. The question about whether a doctor can be sued for negligence seems to me to be a separate one and I see no reason why he shouldn't be sued separately.

E N D

NOTES ON SPEAKERS

Maurice Healy

After University and National Service, Mr. Healy spent three years at the Board of Trade as Assistant Principal and then entered a long distinguished career in consumer representation, firstly at the Consumers' Association where he worked on 'Which?' and stayed there from 1960 to 1976 working on Which magazines as Editor in Chief and Head of the Editorial Department. He then joined the National Consumer Council as Head of the Consumer Policy division in 1977. He was appointed Deputy Director in 1984 and Director from January 1987. He has broadcast and written on consumer matters.

David Williams

He is a General Practitioner in Holywell in Clywd. He has been a GP since 1954. In 1968 he became a member of the British Medical Association Medical Services Committee and was a member of the BMA/Ministry of Health Working Group which devised the current criteria for prescription charge exemptions. From 1979 until 1982 and from 1985 to the present day he has been Chairman of the Statutes and Regulations Sub-Committee of the GMSC. He is currently chairing a group discussing changes in the Service Committee procedures with the Department of Health.