LETTER FROM WESTMINSTER

Ordeal by ombudsman

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The agonised writhings of the City of London as it adjusts to self regulation and strives to avoid the statutory embrace of parliament are a matter of wry amusement to those accustomed to medico-politics. The close interest that politicians take in safeguarding the people's wealth is second only to their concern for the people's health, which is regarded as too important to be left to doctors.

At the moment there are nine medical bills of some sort in progress at Westminster, despite this session being meant as a holiday from health legislation. They range in alphabetical order from the Access to Personal Files Bill to the Unborn Children (Protection) Bill.

Almost unnoticed among them is the Parliamentary and Health Service Commissioners Bill, a government measure being piloted through by Mr Richard Luce, Minister of State, Privy Council. The office of parliamentary commissioner—the ombudsman—is exactly 20 years old. The inclusion of the health service in his terms of reference came in 1973. The new bill is a further extension to bring several quangos within the ombudsman's jurisdiction.

Forgotten now are the doubts of 20 years ago about importing so alien a concept into our constitution. Today the ombudsman has all party support and the government's blessing from Mr Luce, who said, "The experience of the last 20 years has shown the great value of his role in protecting the individual against administrative abuse."

Let us consider how the health service commissioner has been absorbed into the constitutional process and assimilated by the National Health Service. Like the constitution itself the ombudsman shares the merit of being almost invisible until he is needed. His presence bears mostly on the hospital medical and nursing services by investigating shortcomings reported by patients or their relatives. But matters of clinical judgment or diagnosis are outside his remit.

In relation to the six million inpatients a year, or even their 9000 written complaints, the ombudsman handles only a small proportion—around 900. Of these, nearly 800 do not go the distance and last year he issued reports on only 137 cases—in half of which the complaint was held to be justified.

These are further refined to a chosen few which are examined by a parliamentary select committee. This is the point at which the ombudsman meshes into the constitution, and it is terrible to behold, as those brought before the select committee will testify. For chairmen and staff of health authorities it can be an ordeal.

They are commonly subjected to a public inquisition into some unfortunate mistake made years before, the lessons of which have been learnt, and an apology given. Having already been found guilty by the ombudsman (who enjoys the powers of a High Court judge) those arraigned are patently contrite and at a clear disadvantage. Only the benign chairman of the select committee, Sir Antony Buck, stands between them and MPs who are out for blood, especially if it is to be drawn from an erring consultant. Last year the select committee called for names to be entered on a national register of misdemeanours reported by the ombudsman.

That probably won't happen, but there is evidence that the strictures of the ombudsman and the select committee do strike home with salutary effect, directly on the health authority concerned and indirectly on others as word of an errant's deeds travels the medical grapevine. General managers or regional medical

officers ignore the ombudsman's reports at their peril. The drawback can be that clerical care supersedes medical care, with every telephone call having to be logged just for the record. On balance, however, the advent of the ombudsman is well regarded.

The present broad consensus about his role, however, is coming under pressure from two directions. The Labour party would give him more powers. As stated by front bench spokesman Mr Frank Dobson in a recent debate Labour would allow the health service commissioner to investigate clinical matters, extend his jurisdiction to family practitioner committees, and allow him to initiate investigations when no specific complaint has been received.

The other sidewind, the Hospital Complaints Procedure Act, could have the opposite effect of diminishing the ombudsman's role. That act, passed in 1985, is due to come into operation soon with a directive from the Secretary of State. It will introduce a new statutory procedure for disposing of complaints on the spot, monitoring trends, and applying the lessons.

The act had its origin in a long period spent as a patient in hospital by the Conservative MP who introduced it, Mr Michael McNair-Wilson. He envisages that it will gradually pre-empt many of the nursing complaints that now go to the ombudsman. What would he do then? Either his job would become less important, or, says Mr McNair-Wilson, it would be redefined to cover clinical complaints, perhaps as an alternative to litigation, on the basis of no fault compensation. All of which clearly leaves scope for more legislation.

Boost for MRC research

Meanwhile, one of the quangos being brought under the eye of the ombudsman is the Medical Research Council (MRC), whose chiefs gave evidence last week to the high profile inquiry by the social services select committee into the problems associated with the acquired immune deficiency syndrome (AIDS). The MRC was plainly elated by the government's willingness to fund an ambitious programme of research to develop an AIDS vaccine, at a cost building up to £10 million a year. Since this would be extra money it means that AIDS research should not be at the expense of other medical research.

Said the MRC: "We believe that the UK has the scientific capability for making a decisive contribution to the development of an AIDS vaccine provided that a political lead is given and that substantial extra funding, outside the science vote, is forthcoming."

Soon the Whitelaw cabinet committee will go on to consider how far to introduce screening of the general population in order to monitor the prevalence of human immunodeficiency virus (HIV) infection, which the MRC believes could now spread like a classical venereal disease. Should testing be confined to volunteer groups, should there be blind screening, or should people be told of a positive result?

Recognising the difficult ethical and legal problems involved, the MRC stated: "The problems posed by the epidemic are too serious for doctors alone to take the responsibility of deciding what is or is not ethically or socially acceptable."

As Sir James Gowans, MRC secretary, put it, "It is too important for doctors alone to decide. The public needs the information. It needs a debate as to how to get it."

It is not often that MPs are told they are needed. It worked wonders for political egos around the table.