COMMENTARY

The Health Commissioner: no cause for complaint

RUDOLF KLEIN

When the first Health Service Commissioner, Sir Alan Marre, took up his post on 1 October 1973, there was considerable apprehension both among the medical profession and in the NHS at large. The legislation creating the post had been introduced only in the face of considerable opposition from, and after long negotiations with, the various organisations representing NHS staff. Equally, however, there was much criticism, in and out of Parliament, that the concessions made to professional opinion—in restricting the Health Commissioner's terms of reference—had effectively drawn his teeth and resulted in little more than a piece of legislative window dressing.

Achievements so far

Who was right? The Health Commissioner has now produced three annual reports¹⁻³ and, most recently, a summary of 47 individual case histories.⁴ So it is now possible to draw up a rough and ready balance sheet of what the Health Commissioner has achieved and what his activities tell us about the NHS. The exercise is all the more relevant, since the question of the NHS complaints machinery is still on the political agenda. In particular, the Secretary of State has referred the most controversial recommendation of the Davies Committee on Hospital Complaints Procedure⁵ to the Select Committee on the Parliamentary Commissioner for Administration. This is the proposal for setting up regional investigating panels to deal with complaints which involve the exercise of clinical judgment and which are thus specifically excluded from the Health Commissioner's current remit.

Against this background, the most significant conclusion to be drawn from the Health Commissioner's reports so far is that lifting up the NHS carpet shows a remarkably clean floor. In other words, setting up a complaints machinery does not necessarily generate public distrust. On the contrary, it may even enhance public confidence in the professionals providing the Service.

This generalisation requires qualification. On the one hand, the Health Commissioner has uncovered no scandals and, to this extent, his reports have provided reassurance. On the other hand, he has drawn attention to a great many examples of petty administrative mismanagement and failures in human relations. The point may be illustrated by analysing the 47 case histories in his most recent report.⁴ In over half of these, he makes some criticism of the health authorities, but in none of them does he find any major transgressions of the kind which would undermine public confidence in the delivery of health care. A handful of cases apart, it is tempting to read his

report as confirmation of the thesis that setting up a complaints machinery only encourages the manufacture of minor grievances.

One of the biggest categories, accounting for about one-seventh of all the cases, involves delays in the arrival of ambulances. Complaints about poor communication or lack of information account for much the same proportion. Yet other complaints involve such matters as a dispute about who should meet the cost of toughened lenses in spectacles; the quality of hotel services to a patient in a private bed; and delay in dealing with a claim for compensation for the alleged loss of a £5 note, a plug for an electric razor, a cigarette lighter, two lighter fuel refills, one can of beer, and a set of keys.

Not all the complaints were as trivial as these examples. Some involved allegations of neglect or inadequate care, particularly by nursing staff. Others raised serious issues such as the qualifications of a surgeon for carrying out a specific operation and failure to explain the nature of a particular operation to the patient (though in these particular instances the complaints were not upheld). Furthermore, as in previous reports from the Health Commissioner, the management of waiting lists and delays in outpatients feature prominently.

Dealing with complaints

When added to the material in the annual reports, these case histories seem to suggest several conclusions. The first is that the most important justification for the Health Commissioner's existence is that his activities are a check on the way in which the NHS field authorities deal with complaints. Many of his criticisms are directed against the failure of the local administrators to deal with complaints effectively, or to take the steps (such as writing courteous and prompt letters of explanation) which would have averted the complaint in the first place. Since the Health Commissioner does not normally deal with any complaints unless these have first been considered by the health authorities, the very fact that trivial cases escalate up to him implies a weakness in the existing machinery of dealing with grievances. To this extent, his reports strengthen the case for implementing the recommendations of the Davies Committee for improving the local machinery at the level of individual hospitals and authorities—though there will always be some people who will never be satisfied by any inquiry or explanation, however thorough or convincing.

The second conclusion is that dealing with complaints is expensive. One of the most impressive aspects of the case histories is the punctilious thoroughness with which complaints are investigated: those concerned are

interviewed by the Health Commissioner's officers, while the relevant files are examined. Such punctiliousness is as essential for protecting the staff against what may be unjustified allegations as it is for the satisfaction of the complainant. But it does mean that the Health Commissioner's budget probably represents just a part of the total cost of his activities to the NHS. To it must be added the staff time taken in dealing with his questions.

The third conclusion, following on from this, is that the Health Commissioner's reports could profitably be used as teaching material during the training of health professionals. For they underline the extent to which the same picture may be perceived differently by health care professionals and patients or their relatives. Matters which may seem trivial from the perspective of the providers (and which indeed are so in terms of the technical treatment of patients) may be vitally important from the point of view of the consumer of medical care. Off hand, unconsidered remarks by an overworked doctor or nurse can fester in the minds of the patients; misleading impressions may all too easily be created and false hopes aroused. In short, the investigation of complaints should help to shape attitudes and policies which may prevent their future occurrence.

This point has wider implications still. It suggests that complaints should not be seen, and resented, merely as negative criticism. Some may fall into that category and may be more revealing about the complainant's state of mind about the NHS's standard of performance. But others can have the positive function of indicating where things are going wrong from the patient's perspective. The patient's point of view is often incomplete and ill-informed. But so is that of the doctor and other health care professionals. For if patients lack the expert technical knowledge of the providers these, in turn, usually lack the subjective experience of what being a patient means. When it comes to commenting on what it feels like to be at the receiving end of medical care, it is the patient—not the doctor or nurse—who is the expert. If relatively trivial matters can affect the patient's sense of security or well being then it may well be that these matters should be treated seriously. And if, as the Health Commissioner's reports confirm, some patients have an excessive expectation about the availability of services or the ability of medical science to deal with their ills then this would indicate not that their grievances should be ignored but that it might be sensible to spend more effort on educating them to the realities of the situation.

In all this, the Health Commissioner's own case histories can play only a small part in informing doctors and others about the problems of the patients, and vice versa. His

importance is that he acts as a check on the effectiveness of the complaints system as a whole. While the Health Commissioner gets about 500 complaints a year, over 12 000 are annually logged up by the health authorities.⁶ If the complaints machinery is thought of as part of the NHS's information system then it is local accessibility which is crucial—as is local ability to process complaints.

Furthermore, the Health Commissioner can investigate fewer than half of the complaints he receives. In 1974-5 he rejected 354 out of 493 complaints received as being outside his jurisdiction²; in 1975-6, the equivalent figures were 360 and 504, respectively.³ The main reasons for rejection, as the Health Commissioner has explained,⁷ are that 25% of the complaints had not been first referred to the appropriate health authorities; that 20% were about family practitioners; that 17% raised questions of clinical judgment; that 11% were about non-NHS authorities; and that 8% were out of time.

Clinical judgment

These figures raise some intriguing, if speculative, questions. Firstly, they suggest that the Health Commissioner might not be swamped (and the medical profession would not be greatly threatened) if complaints involving clinical judgment were included within his jurisdiction. Only some 50 cases a year would be involved on current form, though the unknown factor in this calculation is the extent to which the official inclusion of this category would generate extra complaints. Secondly, they suggest that the machinery for dealing with complaints against family practitioners may not be working as well as it should, though ignorance as well as dissatisfaction may help to explain the number of cases affecting GPs referred to the Health Commissioner. This seems to support the case

for changing the current family practitioner committee procedures for dealing with complaints, along the lines proposed by the Council on Tribunals,⁸ by introducing independent, legal chairmen and neutral clerks.

The resistance of the medical profession to changes in the machinery for dealing with complaints—illustrated in the initial suspicion towards the Health Commissioner concept—is not surprising. No other profession indulges in so much self-criticism or offers so many opportunities for redress to the consumer. What is more, there is a legitimate concern lest a complaints machinery be used not just to deal with lack of competence but with the inevitable mistakes which everyone—and, in particular, professionals working under pressure—are bound to make. This concern is further reinforced by the fact that all the evidence suggests that consumers of medical care are not equipped to make well-directed criticisms of technical competence, and are as likely to judge a doctor by his manner as by his performance.⁹ It would clearly be against the public interest if strengthening the complaints machinery were to lead to an expensive, rule book style of practice.

Protection for professions

As against these arguments, the experience of the Health Commissioner would suggest that a judicious style of investigation offers as much protection to the health care professionals as to consumers. Furthermore—given the financial pressures on the NHS—it may well be that it will be to the advantage of medical and other professionals to have an independent machinery for establishing whether any mistakes made are the result of individual lack of competence or a collective lack of resources.

If the medical profession itself could devise a system of its own for dealing with this

problem, then many of the present proposals for extending the scale and scope of the complaints machinery might become redundant. But so far it has failed to do so. The profession's own committee charged with finding a solution¹⁰ came up with several proposals which will undoubtedly raise long-term standards by encouraging a continuing programme of self-assessment and self-education. But none of its recommendations deals squarely with the specific and immediate issue of who should be responsible for identifying and dealing with those individual practitioners who allow their own standards to slip—and who, perhaps because of their isolation from their colleagues, are thus least likely to join in any self-assessment or self-education programme. So long as the medical profession invites criticism on this score pressure for extending the NHS's complaints machinery may well grow.

References

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- ⁵ DHSS, *Report of the Committee on Hospital Complaints Procedure*. London, HMSO, 1973.
- ⁶ *Hansard*, House of Commons, 5 July 1976, col 433.
- ⁷ *First Report from the Select Committee on the Parliamentary Commissioner for Administration*, Session 1975-6. London, HMSO, 1976.
- ⁸ *Lancet*, 1976, 2, 680.
- ⁹ Klein, Rudolf, *Complaints Against Doctors*. London, Charles Knight, 1973.
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Welsh working party on devolution

A group of doctors in Wales have been considering the devolution bill. Representatives on the working party were drawn from the BMA Welsh Council, the Welsh Committee for Hospital Medical Services, the Welsh General Medical Services Committee, and the Welsh Committee for Community Medicine. Their conclusions, which are given here, are to be presented to the parent committees in the near future.

- The subject committee of the Welsh Assembly as proposed is not a suitable institution to manage the health services in Wales.
- The Bill does not adequately safeguard professional and service standards within the Welsh Health Services as compared with the rest of the United Kingdom.
- An assembly in the form proposed merges executive and legislative powers in a constitutionally improper way and is liable to undermine the rights of the citizens of Wales.
- It is essential to develop a Health and Personal Social Services Commission serviced by staff derived from the redeployment of staff from those services. This would effect con-

Dr G Murray Jones, chairman of BMA Welsh Council, chaired the working party.

siderable savings by reducing the extra number of civil servants proposed in the Bill.

- Only two tiers of management authority are required, the commission and a lower level which should be arranged flexibly in such a

way as further to integrate services to the individual while maximising economy. The pattern of the lower tier of administration should be that of service patterns and conterminosity with local authority boundaries should be a secondary consideration. This administrative pattern should merge even if there is not an acceptance of the Bill's proposals.

- A single question referendum on the proposals following Parliamentary debate is essential. It is the only way to produce a result capable of accurate interpretation.
 - One feature of an acceptable assembly would be for its members to be elected by a system of proportional representation.
 - It may be suitable for certain grades of staff to determine terms and conditions of service on a local basis. In the interests of the services in Wales and for the maintenance of the standards of recruitment within Wales, however, the terms and conditions of service of doctors should remain the same throughout the United Kingdom.
- These conclusions were unanimously reached by a group which contained doctors both for and against the principle of devolution.