

*The Work of the Ombudsman**

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I esteem it the greatest honour to have been invited to deliver this Inauguration Lecture. It is not only the distinction and importance of this College and its members which make the invitation one to be proud of: I have the additional pleasure of being well acquainted with your new and distinguished President. Having worked with him on tasks closely associated with the welfare of the whole medical profession, I know from personal experience how deep is his learning, how clear his understanding and how abundant his common sense. As an outsider I would respectfully venture to congratulate the College on its choice.

Of the complaints I received last year as Health Service Commissioner less than 5 per cent related to any aspect of psychiatric medicine. I do not seek to draw any conclusions from this fact except to say that it does probably mean that few of you here will have had any occasion to come into close contact with my Office. I intend, therefore, to start with a few words on the development of the role of Ombudsman and an explanation of my jurisdiction and how my investigations are conducted. The picture I see of the Health Service through the complaints I receive is not, of course, representative of the 50 million or so contacts between patient and hospital doctor which take place every year in the United Kingdom and which go unremarked. I hope, however, that I can take a balanced view of the Health Service, particularly because, before I became Health Service Commissioner, I had already had some experience of the Service, both as a consumer—as to which I have every reason to be grateful for the dedication of individual doctors and nurses—and as a participant in a number of inquiries into the Service, notably the Royal Commission on the National Health Service. These varied experiences have led to a keen awareness of the many problems the Service is facing today. I am well aware of the difficulties and therefore sympathize with those who face them. But this does not mean that I see no room for improvement. There are, I believe, lessons to be learned and conclusions to be drawn from a study of the work of my Office, and in the course of this talk I hope to point out some of these lessons, both those relevant to the Service as a whole and, in particular, those which have special relevance to the field of psychiatric medicine.

But first, to set the scene, a little history. You will know, I expect, that the Office was established in 1973 to look at complaints, almost always from patients, of failure or maladministration in the Service. This was the second Ombudsman post established in the country, following that of the Parliamentary Commissioner for Administration in 1967. So

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the whole institution is a fairly new one. For centuries there were only two institutions protecting the rights of citizens, the courts and Parliament. Through the courts an individual can defend himself against the actions of a public authority by seeking damages or an injunction, by asking a court to compel an authority to perform its duty or asking it to quash a decision. But whatever is complained of must be *unlawful*. However, not all bad administration *is* unlawful, and in those circumstances all an aggrieved person could do was to seek, through his elected representative, an explanation or redress from the Minister in charge, and in exceptional cases have his grievance debated by Parliament. The role of Parliament has always included a check on the Executive in administrative matters, and both the courts and Parliament are formidable weapons. So why therefore was there felt to be a need for something else? The answer lies, I think, largely in the massive nature of these weapons. Legal action can be extremely expensive and to most laymen the process of law is complex and cumbersome. Someone who feels that the Inland Revenue have mishandled his tax affairs is not lightly going to decide to take them to court, and similar considerations apply to the role of Parliament as a defender of civil liberties. Often a letter from a complainant's MP to a Minister will produce a satisfactory outcome. But if not, there may be some suspicion that the Department is acting as a judge in its own cause. I am not seeking to minimize the role of the courts and Parliament, which deal with cases of great injustice; the Ombudsman's role is certainly not to supplant them, but among the innumerable actions and decisions taken daily by Departments and other authorities it is inevitable that some will be bad. What I exist to do is to examine and scrutinize cases where such 'bad' actions are believed to have been taken and where neither courts nor Parliament, nor any of the statutory tribunals or other mechanisms which exist, provide suitable machinery for dealing with the complaint. Such actions are rarely of major significance, but they can be of great importance to the individual concerned.

The Parliamentary and Health Service Commissioners were both set up to do the same basic job, that is to investigate allegations of maladministration on the part of Government departments or health authorities causing injustice or hardship to individuals. On the health side, there is an added responsibility to look specifically at alleged failure in a service or failure to provide a service in the first instance.

Examples of the kind of complaint covered are:

- (a) the way in which a policy decision was reached (e.g., to close a hospital);
- (b) the administration of a hospital department (e.g., the organization of a waiting list but *not* the priorities within it);

- (c) the provision of ambulances;
- (d) staffs' attitudes to patients and relatives;
- (e) the standard of nursing care (other than clinical);
- (f) failure to provide regional secure units or drug addiction clinics;
- (g) loss of patients' property, management of patients' money;
- (h) lack of liaison between health and social services;
- (i) failure to keep patients informed;
- (j) the handling of complaints by the authorities themselves.

But my jurisdiction is circumscribed in a number of ways and a substantial proportion of complaints examined have to be rejected. Some are easy to reject, such as the man who wrote: 'While in hospital I was given an IQ test and failed' and the request to: 'Kindly investigate the cause of my death in Male Ward 6'.

Nearly one-third of rejections involve actions taken solely in the exercise of *clinical judgement*. I cannot question any professional decision of this kind but I will consider whether it was taken in full knowledge of all the circumstances and, while matters like priorities on waiting lists again involve clinical judgement, I will look at the way lists are managed, whether they are reviewed regularly, and generally whether an adequate service is being provided. I know that the issue of clinical judgement raises strong views among both supporters and opponents of the extension of my jurisdiction into this area. I do appreciate the concern of those in the medical profession who believe that this step would inhibit their clinical freedom. But there are also those who believe that some independent voice in the complaints machinery is the only way to preserve public confidence in the Service. The pressure from patients for explanations when something goes wrong is considerable and I welcome the new complaints machinery which is to come into operation in the autumn. I sincerely hope it will be successful and certainly it is manifestly better that the profession should provide its *own* solution rather than have one imposed upon it.

The next most common reason for rejection is the requirement that a *complaint should be made first to the authority involved*. This is a sensible bar, as there is no point in an investigation by me if the matter can be satisfactorily resolved at local level. The handling of complaints in the first instance is a management job for the NHS itself. A rejection on these grounds is conditional, but very few complaints rejected for this reason find their way back to me. This leads me to the conclusion that very many complainants are satisfied with the authority's own investigation of their grievance.

Nearly as many complaints are turned away because they concern *actions of family practitioners, dentists, opticians or pharmacists* who are not employed by but are contractors to Family Practitioner Committees (FPCs), or because they concern actions of the latter under the Service Committee and Tribunals Regulations. However, I *can* and do look at an FPC's initial handling of a complaint and at any informal

procedure they may have adopted to deal with it. About 10 per cent of complaints are rejected because they deal with *NHS personnel or contractual matters*—these are outside my jurisdiction on the grounds, questionable grounds I believe, that other mechanisms exist to redress grievances of this kind, for example trade unions. Other reasons for rejection include the existence of a *legal remedy*. People who are seeking damages should go to court. But I can waive this requirement if legal action is not a reasonable proposition. And as I said at the beginning, it would often be unreasonable to expect people to exercise this right to go to law. In addition, many do not want to do so and are only seeking an explanation, not monetary compensation or public vengeance. There is a similar exclusion in my role as Parliamentary Commissioner, and as a general rule I do not normally investigate any complaint where an alternative remedy exists in the courts or by way of an independent tribunal. There is also the *time bar*. Complaints should be made to me within twelve months of the complainant becoming aware of the grievance. This is a practical limitation, as it can be virtually impossible to establish exactly what was said or done months or even years ago. One woman complained to me about her three-week detention in a mental hospital in 1940! But I have discretion to waive the time limit if I think it right to do so.

With the exception of complaints referred to me by NHS staff on behalf of patients, complaints must normally come from the aggrieved person, although if the complainant cannot act for himself I can accept a complaint from an MP, relative or other agent. Sometimes complainants are doctors and nurses themselves. But I cannot accept a complaint made by a pressure group or by a Community Health Council on its own behalf. Nor can I start an investigation on my own initiative. I cannot, for instance, look at events surrounding the appointment of bogus doctors until something has gone wrong. This is something I would like to have done a couple of years ago when I received a complaint from an organization that a former master butcher had managed to get employment as an orthopaedic surgeon and had carried out a number of operations. But, as it happened, none of his patients were any the worse for wear and I had no individual claiming hardship who was entitled to ask me to investigate.

How a complaint is actually investigated is much the same on both sides of my Office. A total of some 90 staff produce about 120 health and 225 parliamentary reports a year. When a complaint is received it is first screened to see whether it is within jurisdiction. If not, and I see each one, the complainant or MP is informed of the reasons. If the complaint is *within* jurisdiction, a summary is prepared and sent to the appropriate health authority and to *any individual* named in the complaint so that they can present their case in writing. On the health side interviews are almost always held with the staff concerned. All records are examined, including medical records, ward reports, waiting lists, appointment

lists, etc., and once a complete dossier of information is built up a report is prepared. Each report is seen by me. The draft report is then sent to the authority to allow them to comment on the factual accuracy and balance of presentation in the report, and to ensure that no information prejudicial to the complainant is included: also to obtain their acceptance of a proposed *remedy* where appropriate. The report is then issued, with a copy sent to the health authority, to the complainant or his representative, and to any member of staff identified in the complaint and said to have been at fault.

I have substantial powers to secure the information I need for my investigations—the same as the High Court of Justice. I can compel the production of any papers that I consider necessary for my investigation, however secret. The only door closed to me is that of the Cabinet Office, and on the few occasions that it has been necessary for the Ombudsman to see Cabinet papers he has been permitted to do so. I am able to compel the attendance of witnesses, including Government Ministers, and to administer oaths. Wilful obstruction of my investigations is punishable as if it were a contempt of court. I would not expect to have to use the sanctions I have at my command to secure the production of evidence, but their existence generally ensures speedy co-operation. It is often necessary to the understanding of a particular complaint to see sensitive medical reports, but I am extremely careful how these are treated and the health authority always have an opportunity to see my report in draft and can suggest that I exclude medical information which the patient's consultant considers it would not be right to include. I always arrange to obtain the views of the consultant in charge of the relevant department and any member of staff identified in the complaint.

The process of investigation by my Office is detailed and exhaustive. Few investigations are completed in under four months, and many take over a year. It has been suggested that this is a Rolls Royce system for Mini complaints. I am not complacent about the time taken, but it is difficult to see how one can classify complaints into those needing full investigation and those for which some lesser effort would suffice. Complainants have a right to expect that I will do the very best I can for them, and some complaints do have wider implications, such as the complaint from a woman who had an accident while employed by a hospital that her medical records had been released to the authority's legal adviser with neither her knowledge nor the consent of the consultant treating her.

Of course, I receive a very wide variety of complaints. But in a great many of these the main component is an allegation of a breakdown in some form of communication. I consider that the quality of information the Health Service provides its patients with is particularly important. For aggrieved patients and relatives, theirs is the only case. But for busy doctors and administrators it is one in thousands. Explaining unexpectedly disappointing clinical outcomes does take up time and energy, but people naturally want to

know what has happened to them or their relatives and are entitled to be told as much as it is practicable to explain to them. I have had several cases recently, for example, where medical and nursing staff knew a patient was terminally ill but for one reason or another failed to tell the patient or relatives. This can be particularly distressing when a husband or wife was absent when their partner died and the death came as a complete shock. Sometimes, though, I recognize that attempts are made to explain to relatives a patient's condition but the truth is not accepted at the first time of telling. If this happens, it may then be necessary for staff to go over the same ground again and again to be as sure as possible that the message has got through. The burdens on junior staff in dealing with people at times of great stress in their lives can be very considerable, and therefore it is not surprising that sometimes there is a failure. I believe that the importance of clear guidelines and adequate training of junior staff in how to handle these difficult situations cannot be overestimated. I was pleased to learn of an experimental course in communications as part of nurses' training.

Of the cases which I do see concerning psychiatric medicine, few contain the kind of serious allegations of ill-treatment for which there has been considerable publicity over the past few years. Given this amount of interest, I might possibly have expected more cases of this kind. It may be that people do not know that I might be able to help, and, of course, there has to be an individual complainant to me who may have suffered hardship or injustice. I cannot conduct a general inquiry into conditions at a hospital. When people do come to me with a complaint of ill-treatment, they have often looked elsewhere for help first as well as complaining to the health authority, and the trail may well be very cold. But we do our best to find out what happened. I have on occasion had cause to criticize standards of care in particular mental hospitals but have never found any case of serious ill-treatment made out. One conclusion I have drawn from this kind of complaint is that it is vitally important in the interests of both patients and staff for proper records to be kept of a patient's physical condition and particularly of any special nursing authorized, or periods of seclusion. Several times recently I have been unable to determine the exact course of events related to a complaint because records were missing or inadequate. Staff in one instance thought that a patient had been put in formal seclusion on a few occasions but were unable to produce the seclusion book in which any such period should have been recorded.

Another aspect of psychiatric care has come to my attention recently which I find rather worrying. This concerns the extent to which it is possible for a mental illness to mask symptoms of a physical condition requiring treatment. I recognize that sometimes psychiatric patients will pretend to be physically ill in order to secure attention, and in such circumstances it will, of course, be difficult to differentiate between this behaviour and a genuine physical complaint.

But it is very important to bear in mind the possibility of physical as well as psychiatric causes for unusual patterns of behaviour. I found in one case recently that a hospital had allowed a young man to walk about with a fractured femur for nearly three weeks before it was diagnosed, partly because they did not believe his complaints of pain. He had not been X-rayed.

I get a number of complaints from people who allege that they or their relatives have been improperly detained in psychiatric hospitals, usually by order under the Mental Health Act 1959. Sometimes they are extremely anxious to remove what they see as a social stigma. The actual decision to make an order detaining a patient is not one for me to question, since it is made clearly on the basis of the doctors' clinical judgement. But I can, and sometimes do, investigate to ensure that all the proper procedures have been carried out and that relatives have been kept properly informed of what is happening. I also do my best to reassure complainants that nowadays there is no disgrace in being the subject of an order and that someone taken to hospital with a mental illness is just as sick as someone who has to go into hospital with, say, pneumonia or a heart attack.

I was interested to note the title of one paper which was given yesterday called 'Aspects of burden, intolerance or burden and the emotional relationship between key relatives and their elderly ill'. That struck a chord with me because a very common theme in the complaints brought to me arises from the care of elderly people in hospital. A typical pattern is that an elderly person becomes too ill for relatives to cope with at home or has some relatively minor complaint which necessitates admission to hospital. Later, often after the patient has died, the relatives complain to me that the elderly person was not properly cared for in hospital—perhaps that he or she was not fed properly, was allowed to become cold or dirty, or was bullied into walking before ready to do so. There may also have been, at some stage, a dispute about whether or not the patient was fit to be discharged home or not. I often perceive a strong element of guilt in these complaints, whether justified or not, in that the relatives feel that they failed to take care of their elderly ill and failed to ensure that their last days were pleasant and comfortable. After the patient has died, the relatives often pursue very minor complaints in order to prove to themselves that they really were concerned. Often I find that the medical care given was adequate, but, of course, the same individual attention cannot be given to a patient in a busy hospital ward as if the same patient was being looked after at home by loving relatives. Quite unrealistic expectations of hospital care are sometimes expressed to me and I have to point out the limitations of a service provided from public resources.

When I find administrative failings, I will ask the authority to provide an appropriate remedy. Remedies vary according to the circumstances of the case and might be: an apology; the introduction of revised procedures; the reconsideration of a policy decision not properly taken; a review of facilities;

the overhaul of waiting lists; restitution for lost property or the cost of transport; the issuing of fresh guidance by departments for use by all health authorities.

Remedies do not necessarily affect the complainant directly but they do serve to ensure that the same mistakes or failings are not repeated. More often than not an apology is the only appropriate remedy. This may not sound much, but it provides the complainant with an acknowledgement that he did not receive the degree of care or attention he had every right to expect. Almost always the health authority accepts the remedy proposed. But where it does not, I have a powerful backup in the form of a Parliamentary Select Committee of all parties which considers my reports. It is sometimes said that the Ombudsman lacks power to require an authority or department to provide the remedy he thinks appropriate. Those with a predilection for surrogate violence tend to complain that I have no 'teeth': they would like to see me 'rend' my victims limb from limb. I have no wish to act in such a manner. It is true that in strict terms I cannot enforce a remedy. But what I can do in cases where an authority or department decline to accept my findings—and they are very rare—is to report that fact to both Houses of Parliament. It is then for the Select Committee to consider the facts of the case. They can call responsible Ministers to account, and if not satisfied can so report to the House. The final sanction might be a debate in the House. There is a less direct relationship on the Health Service side than on the Parliamentary side in that the direct management of the Service is in the hands not of a Minister but of health authorities. But the system works well enough and an alternative which put the power of compulsion in the hands of one man would be unacceptable in a democracy.

The Office of Health Service Commissioner has been in existence now for more than seven years. What has its value been? Nothing earth-shattering has been achieved, but that was not the intention. A large number of ordinary people have had their grievances examined impartially by someone wholly independent of Government and health authorities and have in many cases received some sort of remedy. That is the obvious achievement. But I think the value of the Office goes wider than that in two respects. First, the Office has over the years drawn attention to problems which are not exclusive to a single health authority and has prompted action to prevent the same mistakes arising elsewhere. Similarly, it has drawn attention to weaknesses in systems or in practices, with the result that the issues concerned are reviewed on a national basis. And, although this is said so often it has become almost a cliché, I am convinced that one of the greatest values of having an Ombudsman is that he is there. I cannot estimate the number of complaints which have never reached me because a hospital administrator, aware that his or her actions might one day be investigated by me, has taken a little more time and trouble in dealing with someone's affairs. I suspect, however, that this would be quite a significant number. The powers of the Ombudsman

to obtain information are very substantial, and my ability to seek out the truth wherever it may be found gives weight to my recommendations. Public estimates of the usefulness of my Office seem to vary a great deal, and while I would not go so far as to echo the views of one complainant who wrote: 'Only Almighty God or yourself can help me', I can understand what prompted another person to write: 'I understand that you are the conscience of the Government, the Civil Service and any other blunders that may come along.'

In conclusion, I would just like to mention a phenomenon which appears from time to time in complaints to my Office and which I find intriguing. Like all complaint-handling organizations, we have our share of the eccentric, obsessive and disturbed. Often, we are able to tell that a particular complainant will be in this category as soon as we open his or her letter. Typically, the complaint will be written or typed very closely, using up the whole page and with few paragraphs to guide the reader. Passages which the writer considers particularly important will be picked out in capital letters, often in red and often underlined, frequently several

times. I call this the 'underlining syndrome'. Faced with such a letter, which may be many pages long, our hearts tend to sink. The current record stands at 300 pages. Another clear sign is the eminence of those to whom the letter is copied, which often include one or more to the Queen, the Archbishop of Canterbury, the Lord Chancellor and the Prime Minister. But someone who is disturbed may also have a genuine complaint, and we have first to sift through the material to see if there is a grievance there that we can look into. However, even if there is, I usually find that the person is dissatisfied with the results of my efforts and will often attempt to carry on a correspondence long after my report has been issued. Eventually, of course, I have to say politely but firmly that I will answer no more letters. But I am sure most of you here will understand that such complainants are not easily dissuaded. No doubt this phenomenon is only too familiar to you and you have long ago analysed or classified it and given it a name. Perhaps one day my Office will be occupied by a distinguished member of this College. I am sure that he would be eminently fitted for the task.

Unemployment: A Psychiatric Problem As Well?

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The spate of suicides and riots in unemployment-stricken towns has recently brought to public attention a feature of joblessness which had not figured in the minds of those that thought that it would only have financial and probably minor social consequences. Since then, a flurry of interest has been spurred by the media; they regularly report on studies that show some association between unemployment and ill health, quite often, and not surprisingly, to make party political meal of a long-term problem that is bound to have implications for health provision in this country, at least over the next two decades. As psychiatrists we all know the central role played by regular, satisfying employment in the mental health of our patients, and I am sure many of us are affected by our total inability to secure adequate rehabilitation alternatives on which we are sure our patients' future, and that of their families, depend to a great extent. Some of us may also have been aware of the increased demand on mental health resources over the past few years and of the worrying tendency for admissions into psychiatric hospitals to be prolonged because of the time it takes for an ex-patient to re-enter the labour force.

Despite this, and until recently, unemployment has been virtually ignored by the British health care professions as a possible pathogenic force. This is surprising when one considers that other major life changes, mostly involving loss, appear to be associated with alterations in psychological and physical well-being. Studies have shown how, for example, bereavement, immigration and loss of limbs are followed by psychological phases of adjustment and sometimes long-

lasting emotional and physical problems. Other writers have found that when these loss experiences are unresolved they may be at the core of many psychosomatic disorders, such as asthma, ulcerative colitis and psoriasis. This neglect is all the more surprising when one finds that evidence has slowly been accumulating since the 1930s associating unemployment and increased morbidity. Marie Jahoda¹ and Eisenberg and Lazarsfeld² described the three psychological phases following unemployment which have been corroborated by later researchers and which follow a similar pattern to other experiences of loss. Briefly, the first phase amounts to a denial of the situation, a feeling of relief and sense of holiday, with an increase in the activities which had had to be postponed because of the work routine, such as house repairs and decoration, car maintenance, etc. The second phase is experienced with increasing distress as the ex-worker is confronted by the seriousness of his situation when he successively fails to regain employment and with the prospects of poverty and inability to provide for his family. Job seeking during this time is done in earnest. In the third phase the ex-worker is broken and resigned, adjusting to an unemployed style of life, dropping his efforts in job seeking and curtailing his social interests, spending most of his time at home, in front of the TV set and even isolated from his family circle.

These phases are obviously an abstraction, and there are many exceptions to the rule. One or two of them may be entirely missed or they will vary in length and degree according to, among others, the worker's past job record, previous