

## OMBUDSMAN'S ADVICE TO NEW FELLOWS\*

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I begin by offering my warm congratulations to all the new Fellows of this Royal College. In his work *Of the Advancement of Learning* book 2 chapter 10 and section 2 the Lord Chancellor Francis Bacon wrote 'The weakness of patients and sweetness of life and nature of hope maketh man depend upon physicians with all their defects'. I have gained some insight into man's and woman's dependence upon physicians in the course of my work as the Health Service Commissioner or Ombudsman and I hope to offer to you now some words of advice derived from that insight and my experience of their defects. My themes are communications, openness, record keeping, and how to handle complaints.

The Health Service Ombudsman acts in the same way as any other ombudsman 'to adjudicate between disputing parties without the expense of going to court', in other words as a middle man between medical attitudes and patients' perceptions of those attitudes. The characteristic of an ombudsman is that he or she is impartial in investigating the cause of a complaint. If there is justification in the complaint the Ombudsman will seek to put right the situation which has given rise to it. This should ensure that the organisation or public body which has allowed the circumstances to arise which generated the complaint will take steps to prevent the same fault from occurring again. In that way the actions of the ombudsman ought to benefit not just one complainant but all those who use that service by making those who provide the service conscious of ways in which they can improve it. Not all complaints are justified but, if they are, redress may simply be to explain to the patient whose perceptions may have been inadequate the reason for the medical attitudes and the course of events which led to the complaint. It may add to such an explanation an apology. It may even produce some monetary recompense. It may improve standards of care in the future.

Mrs Murgatroyd in England and Mrs McGinty in Scotland expect their complaints to be treated seriously, to be investigated thoroughly, and to be kept in the picture when it takes time to answer all the points they have raised. They hope that their complaints will prevent the same failures in service being repeated. They like to be told what is going on in language which they can understand. Those who care for them have their sensibilities blunted by having to treat thousands of patients. The episode of care may be humdrum to the physician: it is unique for the patient.

It is just possible that you new Fellows may in the course of your subsequent career have to deal with a complaint about yourselves or about a colleague. You may be invited to act as a professional assessor in an independent professional review of another physician's actions or be asked to be an assessor in a court case or to join the General Medical Council. In passing may I say how much I welcomed the GMC's issuing new guidelines last month on *Duties of a Doctor*, even if the guidelines replicate some of the remarks I had already prepared for this occasion. You should realise that everybody's complaint should matter. If there is a reason for complaint because of medical attitudes or because of what

\*An address given at the College on 2 November 1995.

patients see as medical attitudes, it is always the best policy for the complaint to be dealt with quickly, locally and as informally as possible. The level of complaints against the NHS is still remarkably low when judged against the huge numbers of admissions to hospitals for in-patient or day treatment. My experience is that in a very high proportion of cases complaints are caused by a failure in communication.

Here is one simple example. In a telephone call a nurse failed to communicate to a doctor the full extent of a patient's pain so that the clinical assistant, a GP, prescribed a drug but did not visit the patient for a further twelve hours. He immediately diagnosed an embolism and called for an ambulance to transfer her to another hospital 'as soon as possible'. The nurse did not use a priority category when telephoning the ambulance service to indicate that the ambulance was needed urgently and it did not arrive for three hours. And, finally, the patient's daughter was not told of the serious change in her mother's condition and lost the opportunity to see her again before she died.

The patient is not always right. But the patient likes to be told what is going on in language which is understandable, not medical jargon which may be seen as obfuscation. It helps to make your meaning clear: three examples of ambiguity which I gathered while walking through the streets of Edinburgh today illustrate that:

'This building is alarmed'.

'Gas explosion—man serious'.

'Brides—12 1/2 per cent off'.

Another failure in communications can arise through assuming that other members of the caring team—another doctor, a nurse, a hospital porter, a radiographer, a secretary—have done what is necessary. Assumptions are the root of all evil. There should be clear instructions and good communications, for example between a hospital discharging a patient, the patient's general practitioner and the patient's family and the patient and the community nurse. In the 15th century we learn from the Paston letters how John wrote to Dame Margaret for medicine. It was not for himself but for the King's attorney. He asked her to send a large plaster of flos unguentorum 'for all his disease is but an ache in his knee ... but when ye send me the plaster, ye must send me writing how it should be laid to and taken from his knee; and how long should it abide on his knee unremoved; and how long the plaster will last good; and whether he must lap any more clothes about the plaster to keep it warm or not; and God be with you'.

That was a good example of a desire for information in order to make the remedy work. Now to give an example from my experience about a simple failure in communications. An anxiously worried patient who has been asked to come in for a consultation arrives at hospital and finds that nobody knows anything about the arrangement, time is wasted and anxiety is increased. The house officer assumed that the consultant's secretary had done the necessary, but the consultant had had to go abroad and there was little system for running his clinics. In another kind of failure of communication, a geriatrician inadvertently wrote *left* instead of *right* about a patient's leg and assumed that an x-ray of the knee also covered the ankle. That produced the result that an elderly patient with a broken ankle was encouraged by nurses to exercise on the wrong leg. The elderly woman's perception of the geriatrician was made more acute by the pain.

Medical and nursing staff have their sensibilities to some extent blunted by having to deal with a succession of thousands of patients: but the episode of treatment is unique for the patient. Does a new Fellow of this Royal College have regard to accuracy, to communications and to the patient's wishes? Parson James Woodforde wrote in the 18th century about his contacts with the medical profession. He and his sister Nancy followed a dietary regime graphically described in his diaries which could not be approved by any modern doctor least of all those paying heed to the advice from a body aptly described by its acronym, COMA. To deal with her indigestion Nancy usually took tincture of rhubarb, but on 22nd March 1797 her brother noted 'Nancy continues still to get better by drinking plentifully of port wine, at least one pint in a day'. How do you get your patient to follow a healthy diet without causing offence?

What distinguishes some of the complaints to the Health Service Ombudsman from complaints to other Ombudsmen is that they are about matters of life and death. Many patients seem to have in mind the dictum of that great physician Thomas Sydenham 'To imagine nature incapable to cure diseases is blasphemy; because that would be imputing imperfection to the Deity who has made a great provision for the preservation of animal life'. Another literary quotation is from the Reverend Francis Kilvert who recorded in his diary a visit on Christmas Eve to a farm in Wales where a child, little Davie, had died. The Parson records 'The father seemed greatly distressed and indignant because he thought the child's life had been thrown away by some mistake of the doctor'. I receive many complaints about failure to resuscitate very old patients whose own view may be that they would prefer to slip quietly away. It is cool self-interest on the part of a physician and his staff caring for such patients to note any agreement that had been made with the patient or with the family about whether or not to resuscitate such a patient. The ethical problems can be severe, but some of them may be eased by having a written agreement of what care will be given or withheld in circumstances of collapse. Again the GMC's *Duties of a Doctor* gives helpful advice on this topic. As for the death of a child, the parents whose son died of bone marrow cancer wanted to discuss his treatment with the consultant but the records could not be found, a meeting was put off and the chief executive felt that it would be unfair on the consultant to hold the meeting without the records. When the parents complained to me, my investigation revealed that, when their son had been sent to a second hospital, his records were sent with him but that fact had not been recorded. As a result of my investigator's work the records were found and a meeting arranged. That could have happened months before and a lot of time, expense and distress could have been saved with a proper record keeping system.

Parliament gave me responsibility earlier this year to monitor a Code of Openness of Information in the National Health Service just as in 1994 they gave me the same responsibility in relation to Government Departments and all the many bodies within my jurisdiction as Parliamentary Ombudsman. What is at issue is giving adequate information. That may be of three kinds. The first may be strategic information. By that I mean due information and consultation about a decision to close a hospital or a unit or a ward or to open a home for those to be discharged from psychiatric hospitals in a residential area. The second may be audit information—waiting times, and rates of mortality. The third kind may be personal information to ensure that the patient and the patient's family do not

feel either ignored or treated as teaching objects or kept in undeserved ignorance of what is going on. The GMC's *Duties of a Doctor* encourages doctors to give patients the information they ask for or need about their condition, its treatment and prognosis. (Prognosis is a word Mrs McGinty doesn't use—she couldn't tell prognosis from a prosthesis—but she wants to learn what is likely to happen to her). But it is important to seek and give information aptly. I quote from an article in the BMJ of 9th April 1994 'A friend was on the trolley on the way to theatre for an elective Caesarian section when the dismayingly young surgeon leaned over casually and asked if she was planning to have another child, adding that he really had to know immediately as this would affect how he cut her open. The 30 seconds he allowed her to make this major life decision under conditions of stress, pre-med and semi-naked horizontality, was of course generous by modern hospital standards. However the worry over this man's skills as far as human relations are concerned soon yielded to the conviction of a likely exemplary technical competence'.

#### *The values of complaints*

The first is to encourage everyone in the Health Service to improve abilities to communicate orally; not to assume somebody else is passing on their views or asking for an X-ray to be arranged or arranging the ambulance for discharging a patient to a hospice or a home. Since so much care is team based, internal communications matter just as much as external communications.

The second value is to encourage the caring professionals to make adequate records, intelligible, timed and dated, signed by the person who made the record, carefully kept, not tampered with and made available on time when the patient comes for a consultation.

The third value is to inform those at the top of an organisation, be it a Health Board or a National Health Service Trust or a special health authority, about performance and to enable them to learn lessons from what has gone wrong in other cases. A complaint properly handled can provide an external quality audit into areas which may not otherwise have light shone on them.

The fourth value should be to make those delivering care year in year out pause and think how they are perceived. Would they treat their own mother or wife or husband or partner like that? How can you justify not reading letters that have come to your clinic from patients or GPs? How can you justify not telling a patient that he has cancer, but expect the nurses to deduce that from the clinical notes and inform the family? What perception can the family have of such a consultant?

The fifth value should be to make those who deliver care remember that what is perfectly routine to them is unique for the patient and for the patient's family. An explanation and a kind word can help.

Sometimes an episode of care has given rise to one small element of complaint. The way in which that complaint is handled locally can colour the perception of the whole episode of care. There may be a glossy leaflet about complaints being treasured and a timetable set down for dealing with complaints. If that timetable is wholly ignored, elements of the complaint are badly handled and the final letter is couched in abrasive terms, the public will regard the glossy leaflet and the whole process of looking at complaints as a sham or simply as a public relations exercise. That is particularly so when there is an unsatisfactory or conflicting explanation. Let me give one example. A man had an operation on

his bladder and was fitted with a catheter. When he left hospital the catheter became blocked two weeks later. His GP arranged for him to be taken to another hospital where he waited in the accident and emergency department for over an hour. Then a consultant told him that the staff could not change the catheter because he was under the care of another consultant. He was transferred to a urology ward. There after a further wait the catheter was changed. When he plucked up courage to complain he was told that he had had to be transferred to the ward because the urologists had asked that their patients' catheters should not be changed by the staff of the accident and emergency department. There had also been delay because of paperwork and in transferring him to the ward. He complained to me after going to the Trust that ran the hospital that the delay caused avoidable distress and that he had been given differing explanations which he did not find satisfactory. I found that he had been given no advice on what he should do if the catheter became blocked. His family doctor had not been told that he could contact the urologists directly instead of sending his patient to the A and E department. There was no communication about this between the hospital doctors and the GPs in the area. The written explanation given in reply to the complaint by the hospital had been based on a thoroughly unsatisfactory investigation. No inquiries had been made of any of those involved in attending the man and the reply to the complaint read 'I did not see you but I know from the records what happened. You came in at 11.07 am and was [sic] seen at 12.12 pm not the 2 hours you stated. Because the request of the urologist surgeons is that the A and E department do not change their catheters, contact was immediately made with the consultants' assistants and then there was some delay over paperwork in getting you up to the ward'. In this case the profession was perceived as not getting its own act together and not providing relief for considerable pain because of what resembled a dispute among boiler-makers rather than plumbers.

My individual reports are not all published in detail but every six months I publish summaries of cases I have investigated. These identify the NHS Trust and Hospitals involved but do not name individuals whether the complainant or the complained against. I invite Fellows to read them because much can be learned from them about how to avoid making and repeating mistakes and how to improve the standard of service to the patient. The Government have proposed to extend the jurisdiction of the Health Service Ombudsman next year to cover clinical complaints and complaints against general practitioners. Where cases involving clinical judgment are concerned, the Ombudsman will recognise professional concerns about double jeopardy and also the emotional stresses which beset practitioners when unresolved complaints hang over their heads. I shall make certain that professional advice and assistance is available to ensure that the findings of the Ombudsman are properly informed. I am having helpful discussions with professional bodies about how to obtain and use such advice. I am taking their minds on the problems of how or whether to avoid publicly identifying GP practices which have been the subject of complaints to me.

In 1591, Richard Hooker wrote in *The Lawes of Ecclesiasticall politic* the words 'He that goeth about to persuade a multitude, that they are not so well governed as they ought to be, shall never want attentive and favourable hearers'. I hope that you will be able to derive some guidance for your future careers from what the Ombudsman has found out through his investigations. In the friendliest possible way I conclude by saying to the new Fellows that I hope that professionally we may never meet again.

## MEMORIES OF A SURGEON-LIEUTENANCY EDINBURGH 1941-43: PART III

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DER ZWEIÄDRIGE DOLMETSCHER (THE TWO-WHEELED TRANSLATOR)

'SURG LT T LAYTOR REQUIRED PEEBLES HYDRO TOMORROW SUNDAY 0930 HOURS STOP PLEASE CONFIRM ENDS'. This signal from the Officer Commanding the Army Hospital, Peebles, was received by the Naval Officer in Charge, Leith & Granton, and confirmation was immediate. What seems to be the medical officer's name in the signal as received was an unintentional encoding. The signaller at the hospital had misread 'translator', taking 'Trans' to be the officer's first name and 'Lator' to be his surname, the two parts having been divided between two lines on the signal form that he was given. The 'y' may have been added to rationalise the spelling.

At 0645 on Sunday T Laytor's naval transport duly cast off from Granton Harbour at the start of his sail to the Hydro, where he planned to arrive at 0915 hours by the shortest route, just under 26 miles (see *Proceedings* 1996; 26: 164-6). By this third year of the war the transporter had become shabby but remained functional within its design limits. It had a back-peddalling stern brake and a frightening bow brake that worked by vertical pressure on a solid front tyre. The original saddle of this relic of the 1914-18 war had disappeared during the interwar years in an admiralty store; its replacement was a once well-shaped, solid piece of timber that at some time had split lengthwise and been resecured by a too hurried screwdriver, leaving a ridge that tended to shed splinters into unwary riders. The rear tyre was pneumatic and doubtless cushioned the roughness of the ride. There were no gears, just an exercise-giving low ratio chain drive.

The worst parts of the journey from Granton to Peebles were the long climb from the harbour to Edinburgh's Queen Street and then the succession of hills between Princes Street and Kaimes. Once well out of the city and into the fresh countryside the hills became less taxing. The road to Peebles was longer then than now, hillier and more curved and on the whole narrower. After the two to two-and-a-half hours' ride it was good to reach the Hydro, though its long uphill driveway was a final challenge that must be met without the Senior Service arriving dishevelled and out of breath. But why did the translator not travel by train? The railway ran to Peebles until 1962. The answer is that the navy and army could not agree about which party should pay for the translator's ticket, particularly as he was an officer, travelling in uniform, and therefore required to go first-class. It seemed to the officer concerned that he could end the silly squabble by taking seriously the originally facetious suggestion by his Senior Medical Officer (SMO) that the Sick Quarters' bicycle was there to be ridden.

The main purpose of those visits to the Hydro was to help the anglophone doctors and their German-speaking patients to communicate accurately on clinical matters—taking histories, advising treatment, discussing prognosis. Occasionally, the *Dolmetscher* could help over personal matters other than health—religious

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