

## The parliamentary scene

### Complaints and clinical judgment

Even the most routine minor operation – for varicose veins or the repair of a hernia – carries some risk for the patient. The inescapable mortality from major operations – prostatectomy, heart valve replacement, fitting an artificial hip joint – is around 2 per cent. When something goes wrong and the patient dies or is left with some permanent disability, the natural question for relatives to ask is, who was to blame? Whose fault was it?

Asked that question, doctors know that an honest answer can be given only by a medical insider. Some deaths and disasters are unavoidable accidents; but others are due to incompetence or negligence. The patient's relatives can rarely know exactly what happened. Sadly, an accidental death may give rise to recriminations while the relatives of a patient treated negligently may be embarrassingly grateful. Times are changing, however, and with the public questioning medical decisions more readily and with North American distrust of doctors beginning to permeate Britain, there is growing pressure for some formal system of inquiry to be set up to examine deaths and other complications among patients treated within the NHS.

At present the Health Service Commissioner cannot investigate these incidents. His jurisdiction includes complaints from anyone who claims to have suffered an injustice or hardship as a result of alleged failures or maladministration on the part of a health service authority, but matters of clinical judgment were specifically excluded when the post was created. The Select Committee that looked at the work of the Parliamentary Commissioner for Administration recommended that the regulations should be changed to include complaints arising from the exercise of clinical judgment. The Joint Consultants Committee – which includes representatives of the medical Royal Colleges and the BMA and which negotiates with the Department of Health on behalf of NHS doctors – recommended that an informal inquiry system should be set up. If the consultant in charge of the case could not satisfy the inquiring patient or his relatives, two independent consultants would be asked to examine all the documents and talk to the staff concerned. They would then make themselves available to the patient for a full discussion of the grounds for concern.

These proposals, published early in 1980, did not

satisfy MPs; and in March Mr Jack Ashley introduced a Bill to give the Health Commissioner power to investigate clinical matters. Mr Ashley, who had all-party backing, argued simply that people who had suffered damage or disaster had a right to know what had gone wrong and why. The scheme suggested by the Joint Consultants Committee would, he said, leave aggrieved patients with no alternative but to 'shut up or sue'. If the reassurances provided by the two independent consultants did not convince the patient, he would have no choice but to go to law.

Mr Ashley's Bill was not intended as legislation (since there was no time for it to go through the required stages). It did, however, show that many MPs believed that some way should be found to extend the Health Commissioner's remit.

The Commissioner himself seemed less certain when his annual report appeared in late summer. 'I am particularly concerned' he wrote 'about the difficulties which appear to me to be inherent in a parallel jurisdiction between my office and the courts with respect to medical negligence. There is an obvious danger that if my jurisdiction were to be extended to include clinical judgment then a person dissatisfied with some aspect of the medical treatment he has received might take advantage of my office to obtain a "free" investigation into the merits of a possible case against a Health Authority.' A favourable report might, he explained, be used as a basis for obtaining legal aid.

Mr Patrick Jenkin has now told the Joint Consultants Committee to attempt to draft new proposals that will go further towards satisfying the demands of patients' groupings. The committee will not find that an easy task.

The stumbling block, plainly enough, is the fear among doctors and health authorities of a growth of litigation by patients to North American proportions. At present, so long as there is any possibility that an aggrieved patient (or relatives) may sue for damages, the medical staff concerned will be told by their legal advisers to say as little as possible. If the Health Commissioner (or some other body) were given legal powers to examine the case notes and interrogate the medical and nursing staff the doctors concerned would have lost the safeguards provided for defendants by the English legal system.

Indeed, one of the most questionable developments in the 20th century has been the multiplication of statutory bodies and officials who claim

the right to question individuals and to impose financial or other penalties on those who refuse to cooperate or are judged to be at fault. At one time only the courts of law had such powers: now many other quasijudicial bodies can make important decisions without the checks and appeals developed by the legal system over many centuries.

Unfortunately the courts have become too expensive for them to be much use to private litigants – except those poor enough to qualify for

legal aid or rich enough not to need it. The great mass of the population in the middle cannot afford to go to law, so it seeks its remedies through tribunals, complaint procedures, and officials such as the Health Service Commissioner. These may provide alternative solutions for the aggrieved: all too often they do not offer natural justice to the targets of the complaint.

TONY SMITH