

**CROOKSHANK LECTURE:
MEDICAL ATTITUDES AND PATIENTS' PERCEPTIONS**

by

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In this lecture I propose to quote from three Lord Chancellors - two of England and one of Great Britain. I do not regard it as inappropriate in addressing members of one of the learned professions to quote from practitioners in another. I begin with the Lord Chancellor of Great Britain, Lord Mackay of Clashfern, who happens to be a Scot like me. In the course of his Hamlyn lectures he referred to Ombudsmen schemes as having gained the confidence and imagination of the public. He said "A characteristic all the Ombudsmen schemes have in common is their potential to adjudicate between disputing parties without the trappings or expense of going to the court." I myself have stressed the advantages which an inquisitorial, as distinct from an adversarial approach, without the possible glare of publicity accorded to certain court and tribunal proceedings and other enquiries, brings for a citizen who needs his or her complaint impartially investigated. An Ombudsman's investigation is relatively informal, the Ombudsman is accessible to the person who wishes to make a complaint and there is no expense involved in using his services.

The Health Service Commissioner acts in many ways "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 the complaint. If he finds that there is justification in the complaint, he will seek to remedy the situation which has given rise to it. In the interests of the person who has complained, he will try to ensure that the organisation or public body which has allowed the circumstances to arise which

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generated the complaint will take steps to ensure that the same fault does not occur again. In that way his actions ought to benefit all those who use that service by making those who provide the service conscious of ways in which they can improve it. 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 being lodged. Some patients may be more demanding. One wrote to me on 21 January as follows: "Dear Sirs, I enclose correspondence dealing with my case and the handling of it by Mr. A and by B Hospital, which is self-explanatory. I would be most grateful if you would take appropriate action and inform me of your decision. I would also be most grateful if you could examine the possibility of appointing a suitably qualified independent observer to be present during my operation, scheduled to take place on 6 April, in order to assure fair play and the greatest medically possible chance of success. Yours ..." Unfortunately for that complainant I did not oblige, not least because I am confined by statute to examining what has happened, not what may happen in the future. Medical attitudes and patients' perceptions may both be stimulated by the publication of league tables, whether of the results of clinical audit or of hospital waiting times. If such publication is to take place - and there are valid arguments both for and against such action - my view is that it is preferable to give a rounded and complete picture. One of the desirable features in such a picture would be the volume of complaints, the reasons for such complaints and the way in which they are tackled.

My four predecessors as Health Service Commissioner for England, for Scotland and for Wales discharged their duties before the days of Citizen's Charters and Patient's Charters. The creation of Charter documents was an exercise intended, to use the jargon, to "empower the citizen". It was given stimulus in 1991 when three of the main political parties in this country each issued a charter document with that in mind. We now act under the present Government's charters and, despite the Royal College of Nursing's view expressed in April that what is in the Charters is inadequately known, I consider them of great relevance both to medical attitudes and to patients' perceptions. In saying that I am adopting an entirely neutral stance, as is proper for an apolitical officer of the House of Commons. I do not intend to become embroiled in the contentious aspects of charter documents. Instead I want to indicate the benefits which I believe they confer on the public

and how they ought to enhance the standard of service delivered by all kinds of public bodies and professions to members of the public. The Patient's Charters - for there is more than one - are relevant to the title of my lecture.

In the first place, the charter document sets out for those who are delivering the service an indication of what the service aims to provide. It may be helpful if a local charter document sets out the limits to what it will aim to provide. Secondly, it enables those who are using the service to understand what they can expect from the service by way of standards, delivery of service and best practice. Third, the charter document has been produced in a decade which has been characterized by a livelier interest by consumers in what they consume in what I have called a querulous and questioning age. The charter sets out how the consumer, in this case the patient or his family, can make a complaint if dissatisfied with the standard of service; and the charter document also sets out to whom that complaint may be made. There are national charter documents and there are local documents setting out what a health authority or a health trust or a hospital or a general practice seeks to offer to patients. If because of medical attitudes or patients' perceptions there is ground for complaint, it is always the best policy for the complaint to be dealt with quickly, locally and as informally as possible. It is noteworthy that 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 arise through failure in communications.

Such failures in communication can arise from a great variety of sources. In one *simple case*, the secretary of a specialist, let us say a radiologist, will not have told the specialist's colleagues when she or he is going to be away on holiday or study leave. A patient who has been asked to come in for a consultation finds that no one knows anything about the arrangement, and time is wasted. In another type of simple failure, a geriatrician may inadvertently write Left instead of Right with the result that an elderly patient with a broken ankle is encouraged by nurses to exercise on the wrong leg. The patient's perception is made more acute - and so was the pain - by regarding his or her case as unique and indeed it is; but the medical and nursing staff have their sensibilities to some extent blunted by

having to deal with a succession of thousands of patients. In a *more complex case*, complaint may arise through an inadequate explanation of treatment. Why has such a inadequate explanation been given? Is it because the medical attitude assumes that the perception of the non-medical hearer does not matter? There was that noteworthy remark, reported in Byrne and Long's work published by HMSO in 1976 and entitled *Doctors Talking To Patients*: "I see no reason at all to explain a patient's condition to him. If he asks an intelligent question I might offer some simple explanation, but on the whole I prefer not to." That was twenty years ago. It is likely that such an attitude, maintained as a matter of principle, would be very rarely held nowadays, but in an investigation I completed this year I criticized a consultant who had not told a patient or his son that he suspected cancer, had not briefed the nurses about it but said they could have deduced it from the clinical records and they - not he - could have passed on the diagnosis. Another type of inadequate explanation may arise from a medical attitude that the patient does matter and it must be good to explain what is wrong. However, the explanation may be in such great technical detail that the lay person will not understand.

Earlier, I said that it was not inappropriate to quote from practitioners in the legal profession. What do you make of this *public* advertisement?

"The Lord Ordinary on the unopposed motion of the Pursuer and Real Raiser recalls the sist: finds him liable in once and single payment only of the fund in medio; holds the condescence annexed to and described in the Summons as a true condescence of the fund in medio; appoints all persons claiming an interest in the fund in medio to lodge their condescences and claims thereto by May 3, 1993; appoints the solicitor for the Pursuer and Real Raiser to publish the import hereof by way of advertisement in each of *The Scotsman*, *The Herald* and *Dundee Courier* Newspapers in Scotland and *The Los Angeles Times* and one other Newspaper circulating in the locality of Seattle, USA and to lodge an execution of said advertisement in process."

May I give you by contrast an example of one of the clearest and simplest pieces of communication in the English language? I invite you to note the use of monosyllables and the avoidance of any technical terms. It is from the speech given by Mr. Churchill on 13 May 1940 and it reads briefly "You ask what is our policy? I will say: it is to wage war by sea, land and air with all our might and with all the strength that God can give us: to wage war against a monstrous tyranny, never surpassed in the dark, lamentable catalogue of human crime. That is our policy." I do not think that Churchill would have approved the now politically correct statement: "The Health Authority has produced a new mortuary policy under the Chair of a Hospital Chaplain".

Then again, what is used by way of shorthand in one profession may not be understood by the lay person. One man's acronym is another's mystery. Even the simplest example may not be understood by the layman. Everyone in my audience knows what an A and E department is. Members of the public may not even understand what A and E stands for - or D and C. The public who have read certain press articles may understand that A and E is an accident and emergency department - that part of the hospital which is characterized by cold, draughty corridors on which some patients lie on trolleys for six hours unattended with no refreshment being offered, no explanations given and nobody cares. In an A and E department you may be asked to see the triage nurse. My audience will know the meaning of that technical term. The patient's perception is that it is a mystery not calculated to put him at ease. If he asks and finds out that, as a result of seeing the triage nurse, he will be relegated to wait while more urgent cases are seen, he will take against the order of priority allotted to his accident. Sometimes a nursing record may be made but it is meaningless. It says "All care given". It does not say when, it does not say what, it does not say how much, it does not say how often. It may not say by whom, especially if it is not signed. That is an abrogation of responsibility.

Some complaints are not dealt with very well at local level. They may therefore be referred to me. I do not accept a case for investigation unless it has been first put to the body against which the complaint is lodged and adequate time has been given to that body to make its own investigation and provide its own explanation to the patient. If, however, the

patient is still dissatisfied or if the patient's family is dissatisfied, they may come to me and ask me to investigate. It is because of the investigations that I undertake and the anonymized accounts which I publish of those investigations, because of the recommendations I make for improvement of service and the wide knowledge I gain of medical attitudes and patients' perceptions that I assume the great honour has been conferred on me of being invited to give this lecture.

Let me return to charter documents. Many patients write to me complaining about what they see as failures to meet published charter targets. In my other capacity as Parliamentary Ombudsman, I have set out what my view generally is in relation to such complaints. "If targets are expressed as mandatory ones, or if a promise has been given that the citizen has an expectation to compensation should those targets not be met or should they be missed by a specified period, the case for compensatory redress is strong. Otherwise targets are to be taken as indicators of a satisfactory or unsatisfactory performance rather than as a firm commitment that a specific performance will be achieved in every individual case. They will be persuasive indicators, but they are not positive guarantees. On the one hand it will not automatically follow that, just because such a target has been missed, the body providing the service will necessarily be at fault and compensation will be due. On the other hand, it will not automatically be the case that, simply because such a target has been met, the body's performance will necessarily have been fault-free or that an argument for considering redress can be ignored. Cases need to be considered on their individual merits and in the light of their individual circumstances". I have to say that some patients' perceptions can be different.

Perhaps the most fruitful source of complaints to me in that connection as Health Service Ombudsman derives from cancelled operations or extended waiting times or misunderstandings over extra-contractual referrals, that is those referrals made to a body with which the patient's local health authority does not have a contract to provide a service which the patient urgently desires. There are similarities between complaints about a shortage of operating theatre time and complaints about the time taken by trials in court. The public expects an exact science, the professional cannot produce one.

When I propose as Health Service Ombudsman to conduct an investigation into a complaint, I have to inform the health service body concerned - and any other person who is alleged in the statement of complaint to have taken or authorized the action which has given rise to the complaint - an opportunity to comment on any allegations contained in the complaint. I conduct my investigation in private. I allow those who give evidence to my investigating officer and me the opportunity of being accompanied by a friend or professional representative. I may require any officer or member of the health service body concerned or any other person who can supply information or produce documents relevant to my investigation to give that information or produce that document. I have the powers of the High Court to require such evidence to be given to me. When I have compiled the report of my investigation results, I ensure that the facts are checked for accuracy with the body complained about. If I find a divergence between the evidence given by the staff of the health authority and the complainant, I make further investigations and try to ensure that I arrive at the truth or at least what, on the balance of probabilities, appears to be the truth. In many cases it is common for the patient or the patient's family or the person in the bed across the ward to have an apparently clear recollection of events, giving rise to a complaint, which occurred many months, even years, in the past. You might think that remarkable but the event, perhaps an operation or a scan, will be etched in the memory of the person for whom it was a unique event. To quote patient perceptions from another of my investigations (W.242/92-93): "The family did not know what sort of scan was involved, how urgent it was or when it would be done. By the time seven to ten days had passed the patient said that the delay was apparently because three or four radiologists were on leave. The family tried to find out what was happening but there were always different medical staff on duty, they were never given any real information and there seemed to be lack of medical leadership." What about the nurses, the ambulance men, the secretary to the consultant, the senior house officer, the locum anaesthetist, the complaints officer, the unit general manager, the mortuary attendant? For some of those witnesses on the other side of the fence it may be etched in the memory - perhaps because it occurred on the first day in a new job at the hospital; but for most it will be unremarkable because it was one incident among countless others. Will it be possible to recollect anything? If there are some records, it may be possible. There is a quite fascinating account in D.C. Morrell's John Fry Trust Fellowship

lecture of 1993 "Diagnosis in General Practice: Art or Science?" which I have sought and obtained permission to quote. "If a general practitioner is presented with the name of one of his patients who has been registered with him for a period of years, and is asked to describe what he knows about the patient, he will probably provide minimal information. If he is then given the patient's address, he is likely to be able to expand his knowledge, recalling the patient in familiar surroundings. If he is then placed face-to-face with the patient, prompted, perhaps, by just a glance at the patient's records he will probably speak eloquently about the patient, his past medical history, with anecdotes about his medical care and his family. It appears that a series of prompts are necessary to open up new areas of information stored in the doctor's brain." That observation illustrates how necessary it is for me when I begin an investigation to let the complainant have the summary of complaint I am going to look into; and it is essential for my investigating officer to obtain all the relevant medical and nursing records and to ensure that the same summary of complaint is available to each and every witness. In that way patients' perceptions and medical attitudes can be placed in a common framework. So when a particular medical man was questioned by my investigator and expressed irritation by saying "This is the third complaint I've had to deal with today - can't you let me get on with my work?", that told me something about his medical attitude and it should have made him realize something about himself.

What is in my jurisdiction? I can investigate a failure in a service provided by a health service body; a failure of such a body to provide a service which it was the function of the body to provide; and maladministration connected with any other action taken by or on behalf of such a health service body.

What is maladministration? It is not defined in statute but it is relevant to the purposes of this lecture to indicate what I regard as maladministration. Some examples characterize medical attitudes. Some characterize patients' perceptions of those attitudes. They are:

- rudeness (though that is a matter of degree);
- unwillingness to treat the patient or the complainant as a person with rights;

- refusal to answer reasonable questions;
- neglecting to inform a complainant on request of his or her rights;
- knowingly giving advice which is misleading or inadequate;
- ignoring valid advice or overruling considerations which would produce an uncomfortable result for the person overruling those considerations;
- faulty procedures or the absence of any procedures;
- failure by management to monitor compliance with adequate procedures;
- showing bias whether because of colour, sex or any other grounds.

My second Lord Chancellor is Sir Thomas More. In book two of *Utopia*, he wrote "These hospitals be so well appointed, and with all things necessary to health so furnished and, moreover, so diligent attendance through the continual presence of cunning physicians is given, that no man be sent thither against his will, yet notwithstanding there is no sick person in all the city that had not rather lie there than at home in his own house". That was written before the days of care in the community. It was written before cunning physicians had annual leave or study leave or had to hold clinics in three or four different hospitals and did not have post opened in their absence or forwarded to where their next clinic was to be held. Another quotation from an investigation (SW.61/92-93): "The cardiologist told my officer that, since the complaint, he had held a meeting with the secretarial staff at which he had emphasized that requests for medical records were urgent. He now date-stamped letters on receipt and had started to date his requests for medical records and to monitor responses to requests to ensure that nothing was overlooked." I do not believe that Utopian hospitals employed the House Officer who wrote: "An entry in the records not to resuscitate was usually made as a joint decision between doctors and nursing staff. The doctors were usually junior medical staff ... I do not believe there was a defined resuscitation policy at the hospital. I was certainly never given specific instruction on this matter. Without exception, I do not recall a patient being consulted to ascertain their own resuscitation wishes." It is not easy these days to maintain that a patient should not have been asked to indicate her wishes.

When you go into some hospitals with a long tradition, you may be confronted with boards setting out the benefactions on which they depended for their existence and early maintenance. Many doctors and many patients and Leagues of Friends are still anxious to increase the resources available for the care of the sick. Yet here too there may be conflict between medical attitudes and patients' perceptions. In my report for 1990-91 I observed that patients and their relatives are entitled to expect that their wishes for confidentiality are respected. In a case which I investigated I found that the consultant involved in a patient's care had intentionally released to the press detailed information about a patient, but not her name, in order to heighten public awareness of the needs of the therapeutic programme which he regarded as inadequately funded. He wanted to get more funds. His release of information led to investigative journalism. That in turn resulted in needless distress to the patient's family. In another case where a patient complained of a breach of confidence in respect of her records being used in a research programme, it was quite obvious that medical attitudes were in favour of promoting the research. The relevant Health Authority agreed to produce a policy on disclosure of information for research and to refer to their responsibilities in relation to clinical research when giving information to patients.

Patients may complain for wholly altruistic reasons. They may not be wanting anything but an assurance that what went wrong in their case will not be repeated with other patients. If that is so, they are likely to be comforted and assured if the resultant medical attitudes are positive. The converse will be the case if they feel they have been given the brush off, ignored or treated with disdain. The medical fear of litigation unfortunately can produce a defensive, unhelpful response to a perfectly innocuous request for information. Patients may complain for reasons which are not at all altruistic but for self-interest. Possibly the most difficult to deal with are those complaints which say "If only my Dad/my Mum/my baby/my husband had received treatment when promised - if the biopsy results had not been lost, if the ambulance had come to the right address, if the recall appointment letter had not been mislaid, if the specialist had not been in America that week, if the nurse had understood what I was saying, if the oxygen cylinder had not been empty, if the surgeon had had the right gadget, if the hospital ward had not been closed at the weekend, if somebody

had really been in charge, if I had been told in advance I would have to pay the fees at the nursing home it wouldn't have been necessary to complain."

During my preparation of this lecture, I read with considerable interest the report of the Ashworth Hospital Inquiry Working Group published by the Royal College of Psychiatrists. In it I found two references of particular use. One comes from the charter and bylaws of that Royal College. It states that members of the College on election as such should sign a declaration which includes the following words: "I pledge myself in the practice of psychiatry, ever to have regard to the highest standards of professional service to patients and to the honour of the College." The next reference was from the recommendations on the training of specialists by the Education Committee of the General Medical Council. Those recommendations refer at one stage to skills in sensitive and effective communication with patients and their families, professional colleagues and local agencies, and the keeping of good medical records. They go on to emphasize the need for an understanding of the special needs of terminal care. On the maintenance of attitudes and conduct appropriate to a high level of professional practice, they refer to the recognition that good medical practice depends on partnership between doctor and patient, based upon mutual understanding and trust; "the doctor may give advice but the patient must decide whether or not to accept it."

Then in the context of the content of training common to all, reference is made to communication skills: "Trainees in all specialities should be able to communicate clinical information accurately and precisely, both orally and in writing, to medical colleagues and others involved in patient care. They should learn to keep concise, informative and well-organized records. Good communication requires time. It also calls for understanding by the doctor of his or her own temperament [The inscription at Delphi read ΓΝΩΘΙ ΣΕΑΥΤΟΝ - 'know thyself']. It involves the capacity to take a good clinical history, to listen to the patient in a way that enables the patient to talk openly and the ability to explain concisely and sensitively, in simple language, the salient features of the patient's illness and any risks or disadvantages inherent in the treatment proposed. It also requires the capacity to assess the patient's understanding of the explanation so that he or she can, where appropriate, decide

whether to proceed. ... Some aspects of communication may be non-verbal, such as the doctor's manner during the consultation." I proceed from that quotation to one of the Soundings in the BMJ for 9 April 1994 - it was headed "Morale and Mistakes". It began: "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." That kind of example is paralleled in some of the complaints investigated by me. Was a pacemaker being fitted as part of the NHS service or as a privately paid for enterprise? That question was asked under conditions of stress, pre-med and semi-naked horizontality: the answer was not perceived by the patient who asked it as being clear beyond all reasonable doubt.

As regards record-keeping, I provided the NHS Training Directorate with a preface to *Just for the Record*, a guide to record-keeping for health care professionals. The preface reads: "At the root of most of the complaints put to me lie failures in communication. One way of ensuring that communications are improved and that patient care is not flawed is to make good records. At its lowest level, keeping good records is a matter of cool self-interest. If I am told by a health professional that care was given expeditiously and according to a plan agreed by all the team members involved, but the records are scant and provide no documentary evidence that such care was delivered, what am I to make of that? Clear, contemporaneous records serve to rebut alleged failings. There is a much more positive reason for keeping good records. A multi-disciplinary approach, increasing complexity of care, development of specialist skills and diverse specialties and the separation of professional roles are factors which make a shared understanding and effective communications more important than ever. Shortcomings in records can have serious repercussions for patients and cause real distress to them and their families. All too often I find that the quality of care - for example in relation to attending to pressure areas, to giving appropriate supervision to a disturbed patient, to arranging discharge from hospital - has been

damaged by failures to pass on or record important information." It is ironical that in my early days as Health Service Commissioner I had to investigate a complaint that there had not been a failure of records but, rather, there were too explicit records where a man found that his mother, an elderly patient in hospital, had this marked on her medical records: "Not for the 222s" - in other words, she was not to be resuscitated should she suffer a heart attack. In the light of my investigation, I passed to the Chief Medical Officer of the day, Sir Donald Acheson, my concern that there appeared to be no general guidance on resuscitation policy. I was not trespassing on clinical judgment but I thought that it was a matter for some concern that there appeared to be little coherence or general guidance given on a matter which is of such concern to patients and their families. The absence of guidance is likely to perpetuate misunderstanding; such misunderstanding can be a fertile source of complaint that there has been a failure in service.

I know that the Chief Medical Officers brought this problem widely to the attention of consultants and post-graduate deans. However, in the *Journal of Medical Ethics* of December 1993 there was a letter from a medical registrar in a district general hospital. He reported that when, on a single day in March 1992, the notes of all medical in-patients were examined to ascertain which type of patient had been deemed unsuitable for cardio-pulmonary resuscitation, it would not have been clear to an outside observer who had made the decision in eight entries: "Not for 333s", or on which specific day or hour that decision had been entered; that the nursing staff in 50% of the cases did not know of the medical decision; and that there were nine patients who were deemed suitable for resuscitation despite having a terminal illness who would, at least initially, be put through the trauma and indignity of the resuscitation procedure in the event of cardiac arrest. The writer of the letter observed that the random survey showed that reasons for a policy not to resuscitate were not actually documented in the notes and that, at times, decisions had apparently been left to a pre-registration house officer. Although consultant advice may indeed have been sought by such a house officer, that was not clearly documented in the notes. The matters I have just mentioned may not typify medical attitudes but I include them because they illustrate an area in which patients' perceptions are of prime importance.

One of the delicate areas of relationship between a doctor and a patient is research. Can the doctor encourage a patient by indicating that, even if a cure cannot be achieved, the observation of and the treatment of that patient can serve to promote research in the interests of others? That explanation has to be given with delicacy. Confidentiality and the preparation of appropriate guidelines or protocols are of high importance and when they are neglected that can give rise to complaints and feelings of misuse and invasion of privacy. I was very glad to see in a letter in *The Times* in January that Dr. Jill Bullimore, Vice-President of this College, wrote sympathetically and effectively about the need to develop a system that will record, in the routine management of a patient, the type of cancer, its extent, the clinical management and the outcome of treatment such as cure rates and long-term side effects.

I have concentrated on the need for good communications so that patients' perceptions are not affected adversely, but there is a great deal to be done still in tackling the handling of complaints. Some complaints are dealt with by the clinical complaints procedure, which consists of three stages, involving medical attitudes or competence and patients' perceptions. The final stage - independent professional review - involves an assessment by two members of the relevant specialty who have not been concerned in the treatment of the patient. They assess the performance of the medical staff who were involved in the treatment. The two are nominated by the Joint Consultants Committee. They are not there to see the whole history of treatment for they cannot judge the actions of nurses or members of professions allied to medicine - such as radiographers. These limitations are unsatisfactory, for they can create artificial or unhelpful boundaries and leave the patient profoundly mistrustful about professional judgments and frustrated that nothing can be done about the contribution of non-medical staff. Sometimes the way in which the procedures in handling such clinical complaints are used gives rise to complaints to the Health Service Commissioner and there are great disparities in regional handling of such complaints. In the context of the whole profession, complaints against members of this College are rare, but I have found fault too often with aspects of those procedures. I do not underestimate the problems confronting the two independent specialists. They have to overcome the criticism that they are examining only the clinical decisions and the knowledge that, if they find no fault, the patient or relative may perceive their findings as whitewash. They have to recognize that, unlike the GMC in

some of its actions, they have no lay assessors and may be thought to lack street-credibility. They may have to ponder the problem of assessing, by the high standards of latest practice in a modern teaching hospital where clinicians have been trained in technical excellence and in communication skills, the performance of a colleague in a remote District General Hospital who qualified thirty years ago and has not made full use of postgraduate training.

The Wilson committee under the chairmanship of the Vice-Chancellor of the University of Leeds has taken a fresh look at complaints procedures in the NHS. The report was published in May and is out for consultation. As the *Health Service Journal* observed on 19 May: "Dealing decently with complaints is an art which vast tracts of the NHS have never quite mastered. The Health Service has its roots in an era and a culture when patients were expected to be grateful for the attention they received, not to find fault with it. Down the decades that attitude became institutionalised and largely impervious to change in society at large. Today its most conspicuous manifestation is the thoroughly discredited NHS complaints system or systems, variously condemned as complex and inaccessible and damned by the Health Secretary as 'fragmented, confusing, cumbersome and slow'." The *Journal* mentioned the numerous cases in the reports of successive Health Service Commissioners down the years in which clumsy and insensitive responses to complaints have aggravated the initial grievance out of all proportion or else have heartlessly exacerbated the distress of patients and their families. We must all hope that, as the report indicated: "if a complaints system is to work, it must be seen to be fair to staff as well as to patients. That will mean providing staff with adequate training in handling complaints and giving them appropriate support when they have complaints made against them." Two of the more contentious recommendations are: that the Health Service Commissioner should provide the lay element seen as necessary to be added to independent professional review and that he should become involved in examining complaints against general medical practitioners. Whatever emerges from the Government's consultation about these recommendations, it looks as if I may find myself exposed to medical attitudes and to patients' perceptions over a wider area.

It is commonplace nowadays to say that death is the last taboo. My experience as Health Service Commissioner teaches me that those who are bereaved will act out of

character for a period after a relative's death has taken place. One of the saddest of patients' perceptions occurs when a son or daughter who has cared at home for an aged parent reluctantly agrees that hospital care is needed. After being in hospital for a matter of days or weeks, the parent dies. The son or daughter may be so thrown off balance by bereavement that the only conclusion the child can draw is that the hospital staff "killed my mum. Had I been caring for her, it is unthinkable that she would have died." It is very hard for the staff who have cared for the parent in her decline to know how best to deal with the resulting complaint. An independent investigation, possibly by the Health Service Commissioner, coupled with the passage of time, *may* help to resolve the complaint and assist the process of grief. Perhaps it is because religious beliefs have become less fashionable and less practised than in the past that many patients try to hold on to life and their families regard death as caused by the incompetence of the medical profession. It is perhaps unfortunate that there is no allowance made for a person acting out of character for some weeks or months after the relative's death. Contrast W.S. Gilbert's "Is life a boon? If so, it must befall that Death when'er he call must call too soon" with what the poet William Cowper wrote:

No present health can health ensure
For yet an hour to come.
No medicine, though it oft can cure,
Can always balk the tomb.
Whence has this world her magic power?
Why deem we death a foe?
Recoil from weary life's best hour
And covet longer wo?

This afternoon I have given a somewhat gloomy recital to those who have just been admitted to this Royal College's Fellowship. I do not apologize for centring my remarks on complaints because I hope to have achieved two purposes. The first will be to make you, as leaders in your own profession, more aware of the expectations of the patients and their families with whom you will have dealings and how to adjust your own attitudes to deal in as caring and uncontentious a manner as possible with your patients. The second purpose will have been to let you know that, if you wish to study in more detail accounts of how things

can go wrong and how they can be made to go better, you have only to read the annual and six-monthly reports of this afternoon's lecturer to see how to avoid the pitfalls of some of your predecessors and some of your contemporaries.

If any of you have been counting, you will have realized that we have had two Lord Chancellors down and one to go. I conclude, therefore, by quoting from Francis Bacon who wrote in *The Advancement of Learning* the following: "And because founders of Colleges do plant and founders of lectures do water: it followeth wel in order to speake of the defect, which is in Publique Lectures: namely in the smalnesse and meanesse of the salary or reward which in most cases is assigned unto them: whether they be lectures of Arts or of Professions." I have to acknowledge that Francis Bacon is no guide to today's proceedings since I have been given a very warm invitation to dine this evening, with my wife, as guests of the College. If I have been able to give you some food for thought on how to avoid stimulating complaints from patients or how, if they nevertheless complain, to deal with them effectively, I hope that I will have earned my forthcoming entertainment.