AIMS' COMMENTS ON NHS COMPLAINTS PROCEDURES

1. WHAT IS AIMS?

1.1. The Association for Improvements in the Maternity Services is a voluntary organisation, established in 1960. It is the only pressure group which is solely concerned with maternity care. We:

* **Help parents with enquiries about how to get the kind of care they want.**
* **Give information about obstetric and midwifery practice.**
* **Give assistance with complaints.**
* **Liaise with other organisations, including similar groups overseas.**
* **Give talks to midwives and health authority staff and present papers at conferences in Britain and overseas.**
* **Respond to requests for information from health authorities and health professionals.**
* **Monitor obstetric and midwifery journals and text books, produce information leaflets and a quarterly journal.**
* **Have local groups in England, Scotland, Northern Ireland, Wales and Eire.**

1.2. We know that for most women the outcome of pregnancy is a happy one. We know that there are good hospitals and caring and sensitive obstetricians and midwives. Indeed, we spend a great deal of time referring women to midwives, doctors and hospitals who are more likely to meet their needs. However, we believe that our 30 years experience of the difficulties families have with maternity care and the complaints system gives us a great deal of experience of the positive and negative effects of the current system, and we welcome the Government's review of the NHS Complaints Procedures.

1.3. At any one time AIMS deals with well over 100 serious complaints (I, personally, have over 80 current cases in my own files), many are self referrals from the parents, or close relatives, who will have obtained our address or telephone number from popular magazines or childbirth books. Some have been referred to us by other organisations, or by midwives, doctors or other health professionals.

1.4. **While I, and Jean Robinson, tend to deal with the more serious complaints, two other committee members deal with serious complaints in their area, and every Committee member (of whom there are thirteen) and every group secretary (of whom there are eight) assist with the everyday, and less serious, complaints; or the complaints where the complainant is not willing to take their complaint any further than the initial stages.**

1.5. **AIMS has no paid officers, and all our work is done in our free time. We do not receive any funding or grant from any Government department and we are finding the time we have to devote to complaints an increasingly difficult task, which is additional to our other work.**

1.6. **Our objective in assisting complainants is to obtain the best result for them. This means that we will give them advice and information, and explain the complaints system and how they can best result for them.**

1.7. **I, personally, have been involved with maternity care since 1974. I was a member of East Berkshire Health Authority for three years, and am currently a lay member of the Midwifery Committee of the United Kingdom Central Council for Midwifery, Nursing and Health Visiting. I also regularly teach midwives, nurses, doctors and administrators, and spend some time assisting midwives, and occasionally doctors, who have been the subject of complaints, sometimes from their own colleagues, as a result of having spoken out about the shortcomings in the service.**

2. HOW THE COMPLAINTS SYSTEM FAILS THE COMPLAINANT

2.1. **a. The present system is far too complex, and complainants have little information about how the system works.**

b. Complaints about a number of individuals can mean that the complainants are required to relate their experiences many times.

c. The complaints system is intimidating and encourages a "them and us" attitude.

d. The time limits are far too short for the majority of parents.

e. Complaints are dealt with by individuals, who are employees, and may have an interest in ensuring that the complainant takes the complaint no further, rather than dealing effectively with the issues raised.

f. Complaints are not perceived as a valuable auditing tool, which can provide a barometer to the quality of care.

g. The complainants have little information about what steps have been taken to rectify any shortcomings identified.

2.2. We have cases where women have experienced bad GP care AND bad hospital care. Many find it difficult to complain at all when they are depressed, and some are caring for handicapped babies also. To cope with two types of procedure is impossible and, not infrequently, having been through one complaints procedure the women are too exhausted, and sometimes even further traumatised, to take on yet another complaints procedure where they will have to relate their story all over again. This is iniquitous and it does not help them come to terms with what has happened, heal the tauma, and get on with their lives.

3. COMPLAINTS ABOUT GENERAL PRACTITIONERS

3.1. **The present system of FHSA complaints system is totally unsatisfactory. It fails to address the needs of the parents, or deal adequately with any GP shortcomings, and has a time limit which excludes many potential complainants.**

3.2. **For some women, their problem may stem from a GP's failure to act on a specific symptom during the pregnancy which may result in difficulties with the birth, and the mother may not realise, for some time, that the two were related. In a recent case, the GP's failure was clear. A mother contracted a high temperature during her pregnancy and asked the GP to attend, she was not examined and the GP prescribed painkillers. Eventually, some days later, the mother referred herself to hospital, where she was diagnosed as having chronic pneumonia. She miscarried. Eventually, she complained to the FHSA who rejected her complaint as it was out of time.**

3.3. **Many of the complaints we receive about GPs concern their attitude and behaviour. In a recent case, the GP collaborated with the midwives to pressurise a woman throughout her pregnancy to have a hospital birth. This pressure escalated to the point when, during the labour, the GP turned up at the house, univited, tried again to persuade her into hospital and then, having upset her, contacted a psychiatrist and persuaded him to attend and commit the woman under the Mental Health Act. To his credit, the psychiatrist considered that the woman was perfectly sane and refused to co-operate. A subsequent complaint to the FHSA was rejected on the grounds that the GP had not breached his contract! We find it extraordinary that the FHSA has no power to deal with GPs' behaviour.**

3.4. **On the rare occasions when a GP is found guilty of breach of contract and fined, we are dismayed to find that we cannot get the doctor removed from the obstetric list. It appears that once a GP is put on the obstetric list, s/he is there for life without requirement for refresher courses. We have a number of cases on our files, and we know from our discussions with local Community Health Councils, that some GPs have a number of complaints against them, yet they are still on the obstetric list. There is no means of preventing a GP from continuing to give maternity care unless s/he is removed from the Register, or such conditions are attached to his or her practise by the GMC. But it can take at least three years before the case comes before the GMC, and the GP may continue practising in the meantime. Complainants wish to safeguard others, and we feel there should be provision for suspension - either from practice or maternity practice - in certain cases.**

3.5. **As long ago as 1984 we were complaining about the lack of an adequate mechanism for removing a GP from the obstetric list. In our files we have a letter, dated 27th September 1984, from the Royal College of General Practitioners which states:**

"You may be interested to know the criteria for admission of general practitioners to Family Practitioner Committeee Obstetric lists are at present under review by the DHSS. I think it likely that they will incorporate clear guide lines for retaining the names of doctors on the list."

3.6. **How long do we have to wait before effective action is taken on this issue?**

3.7. **The Code of Practice for Midwives ensures that the Supervisor of Midwives has the power to suspend immediately any midwife whom she believes is a danger to the public. We believe that this power should also be extended to GPs. We are deeply worried by the experience of Lewisham and Southwark FHSA which took three years to sack a GP who had been accused of sexual abuse, and in the meantime they were unable even to suspend him from practice.**

3.8. **We have been pleased to note that here is a mechanism for dealing with rude or abusive obstetricians. In a recent case of a woman who complained about the behaviour of her consultant the Ombudsman investigated and criticised the consultant's behaviour. The Select Committee on Health called the health authority managers before them, censured them and required changes in practice.**

3.9. **People can only complain about things they know they are entitled to complain about. Most women do not realise, when they sign an agreement that a GP should provide them with full or partial maternity care, what the GP is supposed to deliver under the contract. We receive many complaints about the lack of care women receive when they report a threatened miscarriage, for example. They are completely unaware that GPs are paid an extra fee for doing this, or for postnatal checks (which again many do not get, or do not have done adequately). If women were issued an information leaflet as to what the GP is supposed to provide, more cases of faulty care would be identified.**

4. HOSPITAL CLINICAL COMPLAINTS PROCEDURE

4.1. **The present hospital complaints procedure fails to address the needs of the complainants, and in many cases actively conspires against their interests.**

4.2. **I have accompanied parents on many occasions, acting as a friend. Although I have noted, in some health authorities, a very positive and supportive approach I do not believe that this is a widespread phenomenon. We always advise complainants to take a friend with them, and if an AIMS member is not available suggest that they contact a CHC representative who may attend.**

4.3. **While the initial informal meeting offers an opportunity to discuss the complaint, many of these meetings present the following problems:**

a. The parents, and often the mother goes on her own, find that they are faced with a group of professionals. In one case the woman arrived alone expecting an informal discussion, only to find the room filled with doctors and midwives (over 30 of them). She was subjected to a two hour grilling, and left even more traumatised than she was to begin with. She said that she felt that she was on trial, not the staff.

b. These meetings are often held with the complainant having little idea of who is going to be present. On the one hand, there is no compulsion for the staff to attend, and often we find that the very member of staff about whom the complainant has the strongest complaint is not present. The complainant then feels that she has been denied the opportunity of confronting him or her and hearing their justification for their actions. On the other hand, some complainants cannot face meeting the very person who treated them so badly, and can become very distressed indeed at even the idea that they may be present. What is needed is a system which offers them a choice, where they can discuss and decide what course of action is best for them at that time.

c. I have attended a number of informal meetings where the complainants attempts to get an honest and open answer to their questions was as difficult as drawing teeth. Many complainants have viewed these meetings as a complete waste of time and have decided not to take their complaint further, others have gone on to see their lawyers angered by the obstruction they faced.

d. In a current case the family wished to meet the staff, and particularly the paediatrician, to discuss the circumstances leading up to the death of their baby. Two and a half hours before the meeting was due to be held the hospital telephoned to say that it was cancelled, because the paediatrician was ill. The family said that they would still come and collect the case notes, and were met by the district manager, the hospital administrator, and the senior midwife. They decided to discuss their case and asked that the meeting with the paediatrician would be held later, as the majority of their complaints were directed at the paediatric care. The family considered the meeting a waste of time,

as they did not have their questions answered. They subsequently received a letter from the hospital stating that they saw no point in a further meeting as "any further meetings would be counter productive".

e. Occasionally, a member of staff, usually the administrator, will make it perfectly clear that they are unsympathetic to the complainant. Unfortunately, there is no disciplinary procedure, or professional organisation, available so that complaints about administrators can be addressed adequately. We have seen cases where the administrator has been severely criticised for his behaviour only to be promoted shortly afterwards!

f. There have been circumstances where the administrators have offered an apology on behalf of the health authority. Many complainants are extremely disappointed by this. What they often want is an apology from the particular individual involved. An apology on the subject's behalf is considered by many as no apology at all. In some circumstances the complainants are left wondering whether the guilty party was even approached or knew about the complaint.

5. THE INDEPENDENT PROFESSIONAL REVIEW

5.1. In our experience the independent professional review is not helpful to the parents, and we do not recommend it. Hence more of our parents are being referred to experienced lawyers via AVMA (Action for Victims of Medical Accidents). There is in fact no adequate clinical investigation of what occurred - in the sense that the Ombudsman's staff investigate - interviewing witnesses and reviewing documents. The consultants usually merely review case notes and have one meeting with the complainant. Even when it is hinted at the meeting with the reviewers that care was less than ideal, this information does not appear in the letter the complainant eventually receives. Nor is the complainant entitled to see the reviewers' final report.

5.2. Obstetric complaints almost invariably have a midwifery component as well as a medical component, and there may be other aspects of the complaint which include nurses. But there is no midwife and/or nurse on the review team and - of course no lay person.

5.3. Many "clinical" complaints are mixed up with non-clinical complaints (e.g. consent issues, which are a major part of our work) which would come in the remit of the Ombudsman if they were not attached to "clinical" issues. This artificial division is a nonsense.

5.4. What we need is a panel which can hear all the evidence, in the presence of the complainant, in serious cases. Reviewing case notes is inadequate. We have had many experiences of case notes not recording

important information, being inaccurate, or even deliberately falsified. On a number of occasions we have reported midwives to the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) for falsification of case notes; failure to keep accurate notes is an offence under the UKCC code of conduct - though not under the General Medical Council's (GMC) code.

5.5. **There is an enormous variation in the quality of response to complainants in different districts. It is common for complainants to receive responses from hospitals which do not answer their questions but give them pages of details about their experience, most of which is not relevant and not at issue. This waste of type and paper gives the impression that the woman has had a full response to her complaint, but the crucial issues are left unanswered. Unless the woman is being advised by AIMS, or another organisation that has some experience of complaints, her most likely response will be to give up. The ensuing silence is interpreted by the health authority as yet another satisfied complainant, nothing could be further from the truth.**

5.6. **We are concerned that increasingly complaints mechanisms are geared towards informal meetings with those complained about. This may be helpful for some complainants but it is not for all. Many of our women are traumatised and having nightmares (more than a year later) about events in the delivery room and the behaviour of a particular midwife or doctor. Memories of labour and birth, both good and bad, are particularly vivid. Some women may want and need an eventual meeting, but when these meetings are urged on them and they cannot cope, they drop out of the complaints process, and are then thought to be uncooperative or satisfied and not needing to pursue the matter further.**

6. ACCESS TO CASE NOTES

6.1. **The current legislation allowing all patients access to their case notes is welcome, and has provided many complainants with the opportunity of understanding better the circumstances surrounding their complaints. It is because of the easier access to case notes that we have been able to explain to many complainants what happened and why. Many have decided not to pursue their complaint further once they had a full understanding of what probably happened. They are often more willing to listen to what AIMS has to say on the subject because they recognise that we will speak out if we find shortcomings but will also be honest when we see that the staff have done all they could in specific circumstances.**

6.2. **It is a pity that access to case notes is restricted to notes written after 1st November 1991. For many, access to earlier notes is important. In**

1991 AIMS' attention was drawn to women who had been conscious during a caesarean section under a general anaesthetic. As a result of the publicity received by the first case which reached the High Court, and AIMS' research, a total of 80 women contacted AIMS with details of their experiences. Most did not wish to take legal action. One woman told us of her experiences twenty years earlier, she had no support from anyone she told. Her sufferings, both emotional and physical, were dismissed, and it was only last year, with the encouragement of AIMS, that she finally managed to persuade a sympathetic psychiatrist to obtain her original notes. She then found out precisely what had happened and was able, at last, to resolve her emotional problems, and finally receive appropriate treatment for her physical ones.

6.3. It is unfortunate that most health authorities make a charge for copies of the case notes. Many families, particularly those who have lost a baby, find it a further injustice when they have to pay for the records. In one case, the family was charged £176.00, although this was reduced to £126.00 following the intervention of the family's MP. This amount of money was far beyond this family's means and they have had to obtain a loan to pay for the notes.

6.4. Although the legislation makes access to case notes easier for more recent cases, some health authorities are extremely reluctant to hand over the notes. Some give the mothers a single sheet summary, and when the parents realise that this is not what the Act entitles them to, they conclude, rightly or wrongly, that the authority has something to hide.

6.5. From many years experience at reviewing case notes we are dismayed at the failure of health authorities to ensure that there is a clear record of the names, status and qualifications of those who are writing in the case notes.

6.6. In practically every record we have examined there are signatures, or at worst a scrawl, with no indication of who the individual is. In one of our most recent cases we asked the hospital to supply a list of the professionals who had entered comments in the case notes. They refused to do so.

6.7. Because of the complexity of the complaints system any complainant, who has a number of complaints, or potential complaints, about specific individuals is seriously inhibited by lack of information about those who attended her. In one particular case the standard of care in the hospital was so poor that the complainant not only has complaints about the quality of care, but also about the decisions made by various, as yet unidentified, individuals.

6.8. **If hospitals will not supply names of those who cared for patients, complainants are unable to pursue the matter with professional bodies like the GMC or UKCC.**

6.9. **Clearly, if a consultant makes a clinical decision about your care which subsequently turns out to be wrong it may amount only to a clinical error. If the same decision is made by a junior house officer acting far beyond his clinical competence that decision may amount to serious professional misconduct; and if the complainant is denied information about the status of the staff present they may not realise that their complaint may be far more serious than they first thought. Similar scenarios apply to midwifery and nursing practice. We were so concerned about the health authority's refusal to co-operate we referred this important issue to the Ombudsman, and we await his decision.**

6.10. **We believe there should be a sheet in the front of all case notes which everyone completes at the time of their first entry in the notes. They should be required to enter their signature, their name and initials in capital letters, their status, and their qualifications. In this way future examination of the case notes will ease identification of the signatures of those who have made entries.**

6.11. **Those families who wish to obtain information about their care prior to November 1991 have to take legal action to obtain the case notes. For those who have children with particular problems or disabilities, it is unfortunate that they have to resort to legal action merely to find out as much as they can about their child's condition in order to ensure appropriate care and treatment.**

7. LOCUMS

7.1. **In general practice the bizarre rule that when a locum has failed in his/her duty the complaint is directed at the employing GP applies. This is a thoroughly unsatisfactory state of affairs. While we acknowledge that the GP has a responsibility to ensure that his/her locum is adequately qualified, it is not reasonable for the GP to take full responsibility for the locum's shortcomings.**

7.2. **We are equally concerned about locums employed in NHS hospitals. We have seen many cases where the locum has been sacked but has immediately taken a post in another health authority. As s/he is now outside the health authority's jurisdiction s/he cannot be compelled to attend any hearing, or respond to the complaint. Furthermore, the health authority cannot take any appropriate sanctions. Although the employing authority has the power to refer the case to the General Medical Council we have yet to find an authority that has done so.**

Indeed, it is remarkable how few hospital doctors are reported to the GMC.

7.3. It was entirely due to the investigation mounted by AIMS that the cases of women being conscious during caesarean sections under general anaesthetic became public knowledge. In every single reported case we received the women had told a health professional of their experience. No action was taken by anyone. Two women themselves reported the anaesthetist responsible for five cases to the General Medical Council. The Council refused to investigate these two complaints, and it was only when four women put in their complaints at the same time that the GMC finally bowed to the pressure and referred the cases to the Professional Conduct Committee.

8. TIME LIMITS FOR COMPLAINANTS

8.1. The time limit set for complainants is unreasonably short, particularly for maternity cases. It is our experience that the more traumatic the mother's experience the less likely she is to complain, and the thirteen week time limit for GP complaints is particularly short.

8.2. While complaints about hospital care can be dealt with within a year, this is also too short for many women, particularly those with very traumatic experiences. It is not uncommon for women to have sent letters of thanks to the hospital after a birth - even when the birth was horrifying and they were traumatised. Although they are deeply depressed, it takes them months or years to deal with what happened. We appreciate the difficulties the staff may have in dealing with a complaint that may be a year or more old; staff will have moved and many of those involved may have no memory of what had happened.

8.3. In 1991 we dealt with a case of a woman whose GP had warned the hospital that his patient had a history of depression, anxiety and lack of self confidence, and he warned them to "take extra care". The woman had written a birth plan and particularly wanted the midwife to leave the cord to stop pulsating before it was cut. When it came to the birth the midwife held the scissors, the mother said "please don't cut the cord" to which the midwife replied "no, I won't" and then promptly cut it. The mother, having had a direct instruction totally ignored was devastated and, not surprisingly, became depressed once again. Her complaint to the hospital which was never answered.

8.4. A year or so later, she approached AIMS. We encouraged her to write another letter of complaint, and fortunately, this time, there was a new Director of Midwifery Services who took the complaint very seriously. She sent an experienced senior midwife to talk with the mother and explain what had happened at the birth, and why. At the end of this

discussion the mother felt very much better having had the opportunity to discuss seriously her complaint and accepted that the hospital could not act against the midwife, as she was now employed elsewhere, but she was very pleased to see that her complaint had been taken seriously and the hospital staff had done all they could the acknowledge and put right the damage. This resulted in the mother's postnatal depression improving and a considerable amount of personal growth in a woman who had not felt very assertive or confident.

8.5. For the mother who is coming to terms with the death of her baby, or the mother of a brain damaged or otherwise handicapped child, there are other more pressing priorities than addressing the failures in care. It is unusual, in our experience, for a traumatised mother to be able to deal with complaints within three months of the birth. Indeed, women frequently suppress the negative aspects of their care and very often find that they have to deal with it once they become pregnant again. For the severely traumatised mother this can be two or more years later. It is not uncommon for us to be approached by a very upset mother who does not wish to give birth in a particular hospital. We encourage her to tell us the reasons for her aversion. Invariably, we find that she has had a traumatic birth and grounds for complaint, but had not been able previously to deal with it. Now that she is pregnant again, the previous experiences can no longer be ignored.

9. OUTSIDE THE SYTEM

The Armed Forces

9.1. We receive complaints about care from mothers whose husbands were serving in the armed forces (sometimes overseas). The quality of maternity and paediatric care for families of the armed forces is of great concern to us, in view of the serious nature of the complaints we get. Women tell us that they cannot complain "because if you do your husband gets moved somewhere dangerous, like Northern Ireland".

9.2. Because of the rigidly hierarchical structure of the armed forces, the complaints often involve the wives of junior ranks or junior officers complaining about senior officers. We know of cases where the junior ranks and junior officers have been told in no uncertain terms that if they don't "encourage" their wife to withdraw the complaint they will find their careers seriously jeopardised.

9.3. We believe that often the care given is dangerously bad, and below that offered in most of the NHS. But because there is no independent complaints system, and for fear of reprisals, and because there is a shifting population in each centre, users of the service have no effective voice.

Prisons

9.4. We have received complaints about the care mothers have received in prison, and have had examples of care which also was dangerously bad, and below the standards offered in most of the NHS. Like the armed forces there is no independent complaints system, and fear of reprisals, a shifting and the disenfranchised population in each prison, ensures that the women have no effective voice.

9.5. There should be an independently administered complaints system for the armed forces and for women in prison, and CHCs should be allowed to visit medical facilities operated by both.

10. INDIVIDUAL PROBLEM PRACTITIONERS

10.1. Many members of the public will feel there is little point in complaining if when serious problems are identified nothing is done. We sometimes find that a particular obstetrician, or midwife we have a complaint about is know by management to be a problem, but nothing has been done, or nothing effective has been done. However pleasant and helpful the administrators who deal with the complaint, however prompt and efficiently worded the replies, and even if there is an apology at the end, the knowledge that little or nothing has really changed, in the end, leads to cynicism and the belief that the only way to get results is to sue, so that it will be too expensive to employ dangerous and unsatisfactory practitioners.

10.3. Confidential Enquiries into maternal deaths, perinatal deaths and perioperative deaths have, over and over again, revealed that a major cause of avoidable death is junior doctors dealing with complex cases which should have been done by consultants. (These Enquiries do not cover avoidable major morbidity, which is much more common). Any one hospital will probably have only a few cases a year, and they do not see the scale of the problem. We can, of course, pursue complaints which may have serious consequences for the junior doctor. But our main aim is to prevent such tragedies and to change the system. Whilst individual trusts and health authorities, or their lawyers, deal with the complaints, and a cause has been identified, it seems that the present pattern is too well entrenched to be changed within a reasonable time scale. Even if the NHS does deal more effectively and fairly with individual compaints, it is not necessarily going to reduce their number unless the information is used.

11. THE NEEDS OF THE COMPLAINANT

11.1. a. The majority of complainants want an honest explanation of the reasons for their experiences.

b. They do not want what happened to them to happen to anyone else.

c. If there has been fault on the part of those attending them, they want an assurance that appropriate steps have been taken, either to discipline them, or retrain them.

d. They require an apology, preferably from the person or persons at fault.

11.2. Unfortunately, the present complaints procedures fail to meet these objectives. Many complaintants are faced with procedures that are bureaucratic, duplicatory, unnecessarily lengthy and heavily weighted in favour of the professions.

11.3. While some complainants do obtain an apology, many feel that this is little less than tokenistic and an example of the staff "going through the motions", probably in order to fend off what they perceive as a potential litigation case.

11.4. We are concerned that increasingly complaints mechanisms are geared towards informal metings with those complained about. This may be helpful for some complainants but it is not so for all. Many of our mothers are traumatised and having nightmares (more than a year later) about events in the delivery room and the behaviour of a particular midwife or doctor. Memories of labour and birth, both good and bad, are particularly vivid and stay with women for the rest of their lives. Some women may want and need an eventual meeting, but when these meetings are urged on them and they cannot cope, they drop out of the complaints process, and are then thought to be uncooperative or satisfied and not needing to pursue the matter further.

11.5. While we would support a system which deals with complaints in a less formal manner, and where apologies are made in appropriate circumstances, we should warn that an insincere apology is easily recognised and can have the opposite effect to the one desired. If an apology is given it must also be accompanied by clear evidence of remedial and, where appropriate, disciplinary action.

11.6. We are also very concerned that these informal meetings will develop into an exercise is smoothing over the problems, reassuring the parents, and closing the case. What is needed is a thorough investigation into all aspects of the complaint and a mechanism whereby disciplinary action can be taken in serious cases. Too often we find that the parents' complaints have been dealt with in a superficial manner and the root of

the problem has not been addressed and, as mentioned earlier (para 4.3.d) the meeting can be used as an excuse to prevent any further discussion, thereby leaving the family frustrated and angry. Informal meetings also result in no written record of what was said, other than the notes each side may have taken.

11.7. We recognise that the FHSA formal procedure has an advantage of being linked to further disciplinary procedures via the GMC, and gives complainants the opportunity of questioning the doctor concerned. This is a small step in the right direction. However, with hospital doctors there is no similar mechanism and we find it almost impossible to ensure that those who fall below acceptable standards are appropriately dealt with.

11.8. One of the major shortcomings of the present system is the failure to conduct a proper investigation, establish the facts, interview everyone involved and obtain a clear idea of what happened, and why. We deplore the restriction of the Ombudsman's powers, so that he is unable to investigate clinical aspects of the complaints referred to him.

11.9. We find it unacceptable that the present complaints procedures are primarily designed by professionals for professionals, and if there are to be any worthwhile changes they have to be restructured in a patient-centred way. There is a view that the complaints system is fine in principle, but does require a certain amount of fine tuning. We would vigorously oppose this view. We cannot stress strongly enough our view, from over thirty years experience, that the complaints system is thoroughly unsatisfactory and, in its present form, can increase the distress of a family. In almost every case which has proceeded to litigation the family has taken that course because they have felt outraged and patronised by a system which has not acknowledged the seriousness and validity of their complaints; and has shown little evidence of any action being taken to rectify the problems or discipline those whose standards have fallen below acceptable levels.

Beverley A Lawrence Beech
Honorary Chair - AIMS
30th October 1993