

Warning: Outdated lecture Notes!! Do not rely on after 2003

Medical Law

Topic 4, Lecture 1 (of 2):

Complaints and Systems of Accountability Within the NHS

Aim:

To outline how a patient may seek redress (which, probably, does not generate compensation) for maladministration and/or sub-standard care within the NHS, not by resorting to litigation but by pursuing one of the principal systems of accountability within the NHS.

Objectives:

After careful study of this topic you should be able to:

1. Evaluate the 'new' systems of accountability in terms of the locus of power in the doctor-patient relationship;
2. Distinguish complaints procedures and disciplinary procedures in relation to GPs providing general medical services under the NHS;
3. Explain the composition and powers of the GMC, paying particular attention to s.36 Medical Act 1983.

Complaints Systems: an introduction

Effective complaints systems sift and channel complainants legitimate questions and allegations relating to maladministration, and/or substandard treatment, to the appropriate source(s) for a definitive answer and/or appropriate remedy. The processing of a complaint appears, *prima facie*, to acknowledge the provision of sub-standard service and/or treatment.

A comprehensive system of accountability focusing on a patient's concerns will address:

- i. who may complain;
- ii. what they may complain about;
- iii. to whom the complaint should be made known;
- iv. within what time the complaint should be brought to the attention of the appropriate person/authority; and
- v. what remedy, if any, may be provided.

Complaint or Claim?

When a claimant seeks information, without declaring his objectives, it won't be known whether he's pursuing compensation or (say) merely seeking an apology. This may promote an uncooperative, defensive stance amongst those who had had clinical care of the patient, forcing the complainant into litigation as the means of securing a satisfactory outcome. Yet this should be avoided on the basis that the complainant's objectives, or motive, should not detract from the nature or comprehensiveness of an investigation.

Sub-standard Service(s) / Treatment

As to what is regarded as a satisfactory standard of *service* within hospitals or from a GP, appears to be defined, ultimately, if necessary, by the **Health Service Commissioner** who 'has an unreviewable discretion as to whether to pursue a complaint' (*per Brazier, Medicine, Patients and the Law*). However, until recently, the Commissioner had no jurisdiction to investigate matters of *clinical judgment*: here the standards were, and continue to be, set by the medical profession applying the *Bolam* standard.

Accountability of Doctors to Patients Other Than by Way of Court Action.

'[S]uing doctors in court ... is merely one way of seeking to hold them accountable for their conduct' (*per Kennedy*). With regard to some other ways of ensuring accountability, however, the law, prior to April 1996, had permitted the medical profession to exert considerable influence on the setting and maintaining of appropriate standards of conduct to which doctors must adhere. This was evidenced by the initial attitude to professional self-regulation in the form of (i) medical audit; and in (ii) the composition and *disciplinary* powers of the **General Medical Council (GMC)**.

(i) Medical Audit

Medical audit has developed from an informal means of monitoring standards of practice amongst doctors by way of *peer review*, i.e. it involves doctors regularly assessing their practice in discussion with colleagues. Whereas some early initiatives may have been organised on a local basis, (say) within a hospital department or for GPs in group practice, more formal structures became evidenced on a national scale in, for example, the *National Development Team for Mentally Handicapped People*.

The contention of **Hoffenberg (1987)** that the medical profession had shown considerable reluctance to the concept of audit is now long-since relegated to history since '*medical audit*' was the subject of *Working Paper 6* which derived from the 1989 white paper *Working for Patients* and a requirement to participate in medical audit is now included in a GP's terms of service. Each *Health Authority (HA)* establishes a medical audit advisory group consisting of doctors and other staff to monitor audit procedures in its area. The advisory group is responsible for the standard of these audits. The consequences for a GP deemed unsatisfactory may be severe - especially if he is reported to an *NHS Tribunal* which, under the **NHS (Amendment) Act 1995**, may disqualify him from practising, or to the *GMC* who may, under the **Medical Act 1983**, erase his registration for serious professional misconduct. (See p3)

(ii) The General Medical Council (GMC)

Whereas the GMC is the body which has *disciplinary* powers over all registered medical practitioners, whether GPs or hospital doctors, this introductory note simply puts in perspective how the medical profession was perceived to have been granted almost free reign to determine the standards of medical practice – perhaps to the detriment of patients.

{The determination of whether one of its fellow practitioners should be disciplined for inappropriate behaviour (i.e., 'serious professional misconduct') is the focus of lecture 2}.

History

A 'General Council', the forerunner of the GMC was established by the *Medical Act 1858*. One of its objectives was to identify reputable medical practitioners, i.e. As *Knight (Legal Aspects of Medical Practice)* says "to distinguish properly trained doctors from 'quacks'."

The title '*General Medical Council*' came into being when changes to the composition of the council were made in 1950. The current structure of the GMC stems from the *Merrison Report of 1975* which recommended, inter alia, the election of a majority of members directly by the medical profession. The GMC now consists of 104 members made up of:

54 *elected* members - all registered medical practitioners;

25 *appointed* members - all fully or provisionally registered medical practitioners, representing universities and other bodies in England, Wales, Scotland and Northern Ireland which have the power to grant a registrable medical qualification under the Medical Act 1983; and

25 *nominated* members - of whom the majority must be non-medical personnel.

Thus, potentially, 91 out of 104 members are registered medical practitioners. This remarkable imbalance has arisen because the law has, in effect, given control of the medical profession to medical practitioners.

The sense of grievance experienced by patients who failed to achieve, as they saw it, a satisfactory outcome from a complaints procedure that would only be 'effective' if the doctor was convicted of *serious professional misconduct* was easily understandable – particularly as this was a disciplinary function divorced from a compensation procedure. Accordingly, a scheme other than litigation needed to be devised for the more informal pursuit of complaints. It needed to be simple, easy to access, separate from disciplinary matters, quick and thorough. Such a system has, supposedly, been in place since April, 1996

Health Authorities and the Investigation of Complaints Against GP's.

The following notes focus on the complaints procedures that have been in force since the 1st April 1996. They are procedures that apply in respect of NHS treatment: they are *not* applicable to private patients. The procedures apply both to GPs *and* hospital doctors.

The Pre-1996 Background

While a complaint against a GP may be made directly to the GMC, many are made to the body which contracts with, and permits, a doctor to practice in a particular area - i.e. the Health Authority. The actual *investigation* of a complaint was, prior to the enactment of the *Health Authorities Act 1995*, made by a sub-committee known as the *Medical Services Committee*. The procedure was laid down in *SI 1992/664* – which, in essence, was another *disciplinary* procedure based on a GPs failure to comply with his obligations under his 'terms of service'. That the medical services committee had three doctors on its seven-member panel led to the criticisms that it:

- Was biased in favour of doctors;
- The procedures were 'opaque' in that hearings were held in private and records of proceedings were not made available to the public; and

- The focus was on disciplining doctors rather than on resolving complaints.

By contrast, complaints against *hospital doctors* were provided for in a ***Health Circular*** of 1988: **HC(88)37**. This required the location in a hospital of a designated officer who would be the recipient of formal complaints made by or on behalf of patients and who would be accountable for the investigation of those complaints *other than* those involving, *inter alia*, clinical judgments and criminal offences. That there was a separate procedure in respect of hospital doctors reflected the fact that the latter are employees of the health authority, whereas *GPs are independent contractors* – i.e., there is no contract between a GP and his NHS patient. [This was confirmed in the 1978 ***Pearson Report (The Royal Commission on Civil Liability and Compensation for Personal Injury)*** which stated in para.1313: ‘Under the NHS ... there is no contract between patient and doctor and a plaintiff must rely on an action in tort.’] Thus, the difference was between hospital doctors who provided a contract *of* service and GPs who contracted *for* services.

The circular, **HC(88)37**, also contained provisions relating to who could complain, how the complaint was to be made and the time limit within which the complaint should be made. Moreover, **HC(88)37** noted that ‘... unsatisfactory handling of a complaint may become the cause of a further complaint’. Yet this procedure - relating to non-clinical judgments - was less formal and complex than complaints relating to clinical judgment as laid down in **HC(81)5**. In relation to the latter, a (potentially) three-stage process came into being: stage one being the informal attempt at conciliation; if stage two was required it would be a more formal process involving the Regional Medical Officer. If stage three was reached, it would involve independent professional review by two independent consultants.

The procedures relating to non-clinical and clinical judgments were imposed via enactment of the ***Hospital Complaints Procedure Act 1985***. This Act came into force in July 1989, and the procedures were provided for in *ss.1* and *1A*, respectively. Thus, from July 1989, there was one system of complaints in respect of GPs and two different systems in relation to hospital doctors. This apparently unsatisfactory fragmentation of a complaints system led to a review and subsequent implementation of a ***unified***, but tiered system.

The ‘new’ system as from 1st April 1996

The *system* of complaints came into force on 1st April 1996 following the recommendations of the ***Wilson Report, Being Heard***, (1994). In essence, this comprises of up to three stages – with stages two and three coming into play only if there is no resolution of the complaint at the previous stage. The stages are those that relate to:

- (a) local resolution;
- (b) independent review; and, finally, review by
- (c) Health Service Commissioner.

(a) Local Resolution

GPs terms of service with the health authority require them to have a practice-based complaints procedure and to publicise it. The management of the procedure is for the practice to decide and the health authority might only get involved if the procedure fell below guidelines establishing national standards.

[Note how the following stages were (pre-1996) involved in pursuing a complaint against a GP – they indicated a breach of contract and, so, provided for *disciplinary* action]:

(1): The Complaint Must Have Related to the Terms of Service a GP was Contracted to Provide.

A legitimate complaint must have related to the terms of service a GP is contracted to provide. A GP is required to provide ‘all necessary and appropriate personal medical services of the type usually provided by general practitioners’ to NHS patients. The scope of the services was provided for in the *NHS (General Medical Services) Regulations 1992, SI 1992/635* and included the following {(SI 1992/635 has now been amended by *SI 1996/702*):

- A. giving advice, where appropriate, to a patient in connection with a patient’s general health, and in particular about the significance of diet, exercise, the use of tobacco, the consumption of alcohol and the misuse of drugs and solvents; and
- B. offering to patients consultations and, where appropriate, physical examinations for the purpose of identifying, or reducing the risk of, disease or injuries; [see para 12(2) schedule 2 to the 1992 medical regs.].
- C. offering to patients, where appropriate, vaccination or immunisation against measles, mumps, rubella, pertussis, polio myelitis, diphtheria and tetanus.
- D. arranging for the referral of patients, as appropriate, for the provision of any other services under the NHS;
- E. giving advice, as appropriate, to enable patients to avail themselves of services provided by a local social services authority.

(2) The Terms of a GPs Service Must Be Breached

That the terms of service must be breached was a requirement laid down in the *NHS (Service Committees and Tribunal) Regulations 1992, SI 1992/664*. The regulations included the provision of all necessary and appropriate services at the doctor’s practice premises; at the patient’s home; or some other agreed place but that ‘the doctor shall not be required to visit and treat the patient at any other place’. This, of course, was subject to the proviso contained in *Sched.1, para.4* of the *NHS (General Medical Services) Regulations 1992, SI 1992/635*, that a doctor may be required to give aid in an emergency to someone within his practice area provided he is available to provide such treatment and that: he is not engaged in some other duty at that time; he has not arranged for some other person to deputise for him; and the patient’s ‘usual’ doctor, who practises in the same practice area, is unavailable. These points appear to have been developed from the decision in *Barnes v. Crabtree* (1955).

If such emergency circumstances should prevail, then, with respect to any treatment administered, the doctor may plead necessity - and not in breach of his terms of service and so not accountable to the patient - if he should later be sued for trespass to the person provided, of course, he was not aware of any objection the patient would have raised to the treatment: *Re F* (1989). Furthermore, it is submitted, a doctor who attends a patient outside his surgery (or hospital) would have little difficulty in pleading necessity as a moral defence, given that the *International Code of Medical Ethics* provides that ‘a doctor *must always* bear in mind the obligation of preserving human life.’

Presumably, following *Malette v. Shulman* (1990), *Re T* (1992) and *Bland* (1993), a doctor-patient relationship might not come into existence, thus eliminating any possibility of accountability, if only one type of treatment was considered appropriate; the doctor was reliably made aware of the patient's anticipation of the possibility of the present situation arising and his / her continuing refusal to consent to such treatment; and the doctor respected the patient's autonomy by withholding administration of that treatment.

However, any uncertainty relating to the administration or withholding of treatment should be addressed by seeking a declaration of the patient's capacity. 1992, for example, was characterised by cases in which patients may have had the capacity to consent to treatment or to refuse treatment but whose refusal was held to be inapplicable to the specific circumstances of the case at the time the treatment / operative procedure was to be administered: *Re T* and *Re S*.

Irrespective of whether the administration of treatment is given in a hospital, in a GP's surgery, or at the roadside, etc., it would appear that the doctor-patient relationship comes into existence at the time the doctor assumes 'clinical responsibility' of the 'patient'. It is only from that point onwards that issues of accountability arise.

In a 1997 publication, however, *Mulcahy* and *Allsop* cited three problems with using the disciplinary procedures associated with *SI 1992/664* in resolving complaints, viz;

- The procedure could not offer a full range of remedies to the parties;
- The procedure encouraged a defensive response to complaints in which positions became entrenched rather than resolution possibilities explored; and
- The issues which could be considered by the Medical Services Committee were narrowly defined and did not permit airing of all the disputant's concerns.

Not surprisingly, then, one of the features of the 1996 reforms was to disengage the complaints procedures from the disciplinary procedures that related to GPs – and this was provided for in *SI 1996/703*. (So **N.B.**: whereas pursuit of a complaint still requires the breach of the terms of service a GP is contracted to provide, the complaints procedure is now distinct from the disciplinary procedures)

(3): Action in Respect of the Breach of Terms of Service.

The *1992/664 regulations*, alone, did not provide for the disqualification of a GP *as a principal*: enactment of the *NHS (Amendment) Act 1995* was necessary to permit the *NHS Tribunal* to disqualify the GP from practice *as a principal*- something the Health Authority as 'employer' - in the sense that the GP was contracted *for* services, i.e., he was an independent contractor not someone under a contract of service - was also unable to do under the terms of the contract. A sanction falling short of disqualification as a principal is frequently called for, however, and the less drastic ways in which a GP can be made accountable are as follows:

Firstly, the complainant, usually the GP's patient, must normally complain within 6 months of the event giving rise to the complaint. Until recently the complaint had to be in writing. However, oral complaints are now permitted following the enactment of provisions of the

1987 White Paper, *Promoting Better Health*. The complaint is then processed either *informally* or *formally*.

(a) The *informal* (or local resolution) procedure *may* involve the health authority aiming to bring about conciliation: under this, no sanctions are taken against the GP but the patient achieves his goal.

(b) Independent Review

More common, however, is that if the complainant is not satisfied with the outcome of the local resolution, then, within 28 days he may request the 'stage-two', or *formal* procedure of independent review. This may entail the oral presentation and defence of the case that is now subject to independent review. If this is the procedure adopted, then both parties 'may be assisted in the presentation of their case by another person, but a lawyer may not *conduct* the case on their behalf'. If a breach is found, potential sanctions include: limiting the number of the doctor's patients; withholding a sum of money from the doctor's remuneration; disqualification (as noted) under the *NHS (Amendment) Act 1995*; and, if the GP's conduct appears to amount to 'serious professional misconduct' or his performance is 'seriously deficient' as provided for in the *Medical Act 1983* (as amended), the matter can be referred to the GMC. Provision is made for an appeal to the secretary of state at the suit of either party against an adverse decision.

A complainant who is not satisfied with the conclusions of an independent review may seek to enlist the help of the Ombudsman or *Health service Commissioner*.

(c) The Health Service Commissioner

The office of *Health Service Commissioner* was created under *Part V* of the *NHS Act 1977*, *i.e.*, *ss106 - 120* (now repealed and replaced by provisions of the *Health Service Commissioners Act 1993*, as amended in 1996, and noted *infra*). The investigatory functions relating to a person who has sustained injustice or hardship in consequence of the failure in a service or the provision of a service or in consequence of maladministration were contained in *s.115*. *S.116* provided that *certain matters were beyond the jurisdiction of the HSC*. They included:

Action taken in connection with the ... *exercise of clinical judgment*; cases in which a patient has a remedy in a court of law *unless* it would be unreasonable to expect the patient to pursue this remedy; and GPs' dealings with their patients.

However, the main provisions of the 1977 Act have been repealed and re-enacted in the *Health Service Commissioners Act 1993*. This has been in force since 5 February 1994.

Furthermore, it is the *Health Service Commissioners (Amendment) Act 1996* that has brought GPs within the scope of persons 'subject to investigation by the Health Service Commissioner ... [because] they are persons ... undertaking to provide ... general medical services ... under the [*NHS*] Act 1977.' Of equal importance, clinical complaints can be entertained providing it is reasonable to expect that a where remedy is available in the courts it will not be pursued: *s.4(1)* of the 1993 Act as amended.

R v. Canterbury and Thanet district Health Authority (1994) still provides the authority for excluding a complainant from utilising the complaints procedure when he has indicated that he intends to pursue a remedy in the courts.

GP's and Private Practice.

Three points are to be noted if a GP operates a private practice. *Firstly*, there will be a contract between the GP and his patient and, in theory, the terms of the contract are for the GP and the patient to decide. *Secondly*, although private practice and NHS work are not mutually exclusive, if the GP also works within the NHS then he cannot concurrently provide private services for his NHS patients. 'He may have an NHS list and a private list but the two must not overlap' per *Margaret Brazier*, p357, 2/e. *Thirdly*, there is no counterpart in private practice to the grievance procedure through the health authority that is available to the NHS patient.

The Mental Health Act Commission

S. 121 of the *Mental Health Act 1983* provides that the MHAC is under a statutory duty to investigate complaints by detained patients. Unlike the HSC before the 1996 amendments, the MHAC has not, at any time, been precluded from hearing complaints of a clinical nature. On the other hand the MHAC has no power to subpoena witnesses nor to take evidence on oath. It is one of the bodies whose administrative function can be investigated by the HSC.

Further Recent Changes in the Rights and Obligations of Doctors.

Two recent noteworthy statutory enactments affecting the way a GP may conduct his practice are contained in, *first*: the *NHS (General Medical Services) Amendment Regulations 1997, SI 1997/730* which makes a doctor liable for ensuring "that the services provided by an organisation providing deputy doctors are adequate and appropriate and that its doctors are suitably qualified and trained and have not been either disqualified or suspended from practice by the NHS Tribunal. ... [and] if need be [the doctor will be required] to bring his arrangement with an organisation providing deputy doctors to an end."

(Extracts from the explanatory note to SI 1997/730).

Secondly, a GP may elect to become a salaried person, i.e., under the *NHS (Primary Care) Act 1997* if he is providing general medical services under a "pilot scheme" - likely to be a scheme for the provision of general medical services in, say, a deprived "inner city area." Such schemes must be approved by the Secretary of State and will not apply to those patients already catered for under *Part II* of the *NHS Act 1977*.

If the salaried GP is regarded as an employee of the Health Authority, accountability in the form of liability will, of course, be vicarious.

[Other Legislation:

See the provisions of the *Public Interest Disclosure Act 1998* - which have introduced a new *Part IVA* into the *Employment Rights Act 1996*. The 1998 Act, which was intended to give protection to whistleblowers, applies to GPs].

Tutorial Questions

1. Critically review the procedures not involving litigation by which an individual may pursue a complaint against a registered medical practitioner. Discuss any proposals for reform you believe are necessary in the interests of the parties and the ends of justice.

2. With reference to the pursuit of a complaint against an incompetent doctor, ‘the balance of power in the doctor-patient relationship in the mid-1990s has, at long last, reached a more equitable position’.

Discuss.

3. How, if at all, has the system of accountability of doctors to patients changed to the benefit of the latter in recent years?

4. “An aggrieved patient wishing to pursue a complaint against a doctor faces a procedural maze of considerable complexity; first, in the varied institutional structure of the NHS, covering general practice and community health as well as hospitals; second, in the distinction which has to be made between clinical and non-clinical complaints.”
(Quoted in: *Newdick, C. Who Should We Treat?* Oxford: Clarendon Press, 1995, p241).

To what extent, if at all, does this comment retain its validity in 2003?