The Ombudsmen and health

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In this paper, originally presented as part of an Honours seminar course on the Ombudsman, Julia Maskill focuses on the extent to which complaints about professional decisions in the area of health are within the ombudsman's jurisdiction to examine "matters of administration". Comparative references are made to the jurisdiction of the British Health Services Commissioner.

In deciding whether or not he is authorised to investigate complaints against Hospital Boards and the Department of Health the ombudsman must consider section 13(1) of the Ombudsmen Act 1975 which empowers him to investigate "any decision or recommendation made, or any act done or omitted . . . relating to a matter of administration . . . ". In the health area the ombudsman must decide how far this provision empowers him to pursue issues involving acts or decisions which result to a greater or lesser degree from the exercise of medical judgment. Complaints which relate to such clinical or surgical matters illustrate the jurisdictional problems which are peculiar to those fields of public "administration" in which professional or specialist decisions are involved. In addition, and in common with all the other areas within his purview, the ombudsman is also concerned to determine how far section 13(1) empowers him to investigate any industrial relations or "policy" issues.

I. EMPOWERING PROVISIONS

The office of ombudsman was created in New Zealand by the Parliamentary Commissioner (Ombudsman) Act 1962. Section 11(1) empowered the ombudsman to investigate acts and decisions relating to a matter of administration in the departments and organisations named in the schedule. The Department of Health was one of the departments so named.

The Parliamentary Commissioner (Ombudsman) Amendment Act 1968 extended the ombudsman's jurisdiction to two kinds of local organisations, namely Hospital Boards and Education Boards.[1] At the time the National Government was under pressure from the Labour Opposition to include all local bodies,[2] and this extension

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1 Named in Part III of the Schedule (inserted by the Parliamentary Commissioner (Ombudsman) Amendment Act 1968).

2 For example Hon. Mr. Spooner, Opposition M.P. for Wanganui, had introduced a Bill to amend the Act in this way earlier in the session.

was provided as the first "experimental" step towards that goal.[3] The new section 11(1A)[4] empowered the ombudsman to investigate any decision made by officers of these boards, without any limitation to matters of administration. The government was nevertheless concerned to exclude medical decisions from the ombudsman's jurisdiction. During the parliamentary debate on the introduction of the Bill, Hon. J. R. Hanan (Minister of Justice) made the point as follows:[5]

> [I]f the honourable gentleman was on the operating table and the doctor was making a decision about the operation and there were several different alternatives he could take, does the doctor have to bear in mind that the professional and technical decision he might make could be criticised later by the Ombudsman? This, I think, would be completely untenable.

So, the new section 11(5)(d)[6] specifically excluded

> Any decision of any medical practitioner or dentist, being an officer or employee of a Hospital Board, in respect of the medical, surgical or dental treatment of a particular patient.

The extent of the ombudsman's jurisdiction in the health area was thus first of all determined according to which authority employed the officer against whose decision the complaint was made. Potential anomalies abounded, for example:

(i) If the officer was employed by the Health Department then whether s/he was a surgeon or car park attendant his/her decisions were within the Ombudsman's jurisdiction insofar as they related "to a matter of administration",[7] even if they also related to the medical or dental treatment of a particular patient.

(ii) If the officer was a medical practitioner or dentist employed by a Hospital Board then all decisions "in respect of medical . . . treatment" (including administrative decisions in respect of such treatment) were outside jurisdiction, however, all decisions not relating to the treatment of a patient were within jurisdiction.

(iii) Decisions in respect of the medical treatment or patients made by nurses, physiotherapists, opticians or other employees of hospital boards other than medical practitioners or dentists were within jurisdiction.

Such anomalies were cleared up by the Ombudsman Act 1975. Thenceforward the ombudsman's jurisdiction in relation to officers and employees of the Health Department and Hospital Boards extended simply to decisions "relating to a matter of administration".[8] So:[9]

> Complete reliance is now to be placed upon the phrase 'relating to a matter of administration' as a fundamental pillar of the jurisdiction of the Ombudsman.

3 [T]he experience gained by this limited extension will show whether other local bodies could satisfactorily be included": Rt. Hon. J. R. Marshall, Prime Minister, N.Z. Parliamentary debates Vol. 359, 1968: 3991. It was considered appropriate to allow the Ombudsman, a parliamentary officer, to investigate these boards in particular because they were funded by money appropriated by Parliament.

4 As inserted by s. 2 Parliamentary Commissioner (Ombudsman) Amendment Act 1968.

5 N.Z. Parliamentary debates Vol. 356, 1968: 1312.

6 As inserted by s.2(5) Parliamentary Commissioner (Ombudsman) Amendment Act 1968.

7 The scope of this phrase is discussed in some detail below in relation to the current legislative provisions.

8 Section 13(1).

9 *1976 Annual Report* 7.

A. *Matters of Administration*

An example of an unequivocally "administrative" matter in the health field was provided by that part of Case no. A874[10] which related to a complaint that a medical superintendent had failed to reply to five letters sent by the complainant requesting information. The extent of the ombudsman's jurisdiction becomes less clear where issues relating to professional judgment, 'policy', or 'industrial relations' are raised by the complaint, or else where alternative remedies exist.

1. *Professional decisions in the health area*

It is generally agreed[11] that an element of professional decisionmaking will not automatically bar the ombudsman's investigation of complaints. For example, the procedural process which leads up to the final professional judgment usually may be considered. Like "policy"[12] decisions, professional decisions are not expressly excluded from the ombudsman's jurisdiction. Sir Guy Powles took the view that so long as the complaint relates to a matter of administration he has jurisdiction even though it may also relate to a matter of policy.[13] In the same way the office assumes jurisdiction to investigate complaints relating to professional decisions, so long as they also relate to administrative matters.[14]

In an address to the Wellington Clinical School[15] the Chief Ombudsman (Mr G. R. Laking) outlined the areas which he considered outside his jurisdiction:

> You will perhaps agree that as a matter of abstract analysis, professional judgment in the medical field is called for on three basic occasions and is directed to determine three rather different issues. First, there is the decision as to the present medical condition of a patient — the diagnosis. Secondly, a decision must be made as to what medical treatment is appropriate to improve the patient's present condition — the treatment and, one hopes, the cure. Thirdly, there is the decision as to what the patient's medical condition will be in the future if the treatment is maintained — the prognosis. Decisions of this kind seem to me to be fundamentally decisions of professional assessment, based upon years of study and experience, and not decisions of an administrative character and therefore not decisions which would fall within the jurisdiction of an Ombudsman.

The circumstances of each case will of course determine how far the ombudsman will go in his investigations. Unless the ombudsman is able to enlist expert advice

10 *1980 Annual Report* 86-87.

11 This view is supported even in Gillard J.'s judgment in *Glenister* v. *Dillon* [1976] V.R. 550, which overall presents a limited interpretation of the Victorian Ombudsman's jurisdiction to investigate "administrative actions". In Gillard J.'s words: "As (a) generalisation I cannot accept the argument that merely because the action was of a professional character, it could not be an administrative action . . ." (558). See also K. J. Keith "The Ombudsman and 'Wrong' Decisions" (1971) 4 N.Z.U.L.R. 361, 380; and the article "Judicial Control of the Ombudsmen?" by K. J. Keith in this issue.

12 The practice of contrasting decisions according to whether they relate to matters which are of a predominently "policy" or "administration" character is perhaps a confusing one. The two types of issue are bound to overlap to some extent, e.g. most matters of "administration" will usually involve some elements of "policy". For a detailed discussion see Gellhorn.

13 (1966) 9 *Canadian Public Administration* 133, 146 quoted by K. J. Keith "The Ombudsman's Jurisdiction . . ." *Official Record of Proceedings of the Conference of Australasian and Pacific Ombudsmen,* Wellington, 19-22 November 1974.

14 Interview of 19 May 1981 with Pamela Fellows, Investigating Officer, Wellington Ombudsman's Office.

15 15 March 1978.

to help him deal with complaints about decisions resulting directly from the exercise of a medical judgment, we may agree with the Hon. Mr. J. R. Hanan M.P., that the ombudsman's jurisdiction should not be so extensive as to allow him to:[16] "breathe down the neck of the surgeon while he is operating". The ombudsman's competence to judge the "rightness" or "wrongness" of specialist medical decisions is inevitably limited by his generalist role[17] and lack of technical expertise, and so it may be appropriate that he does not investigate decisions of an exclusively clinical character in the absence of expert opinion.

Problems inevitably arise in assessing whether or not an act or decision is clinical or administrative in character. In Case no. W10122[18] the Ombudsman declined to review a decision by a hospital medical superintendent to insist that a woman seeking an abortion should obtain her husband's written consent to the operation before the superintendent would decide whether or not the pregnancy should be terminated. Such consent was required neither by law nor by the ethics of the medical profession. The Ombudsman decided that:[19]

> [It] was . . . clear that the decision was a clinical decision and not a decision relating to a matter of administration. The medical superintendent stated that he felt that he would be assisted in reaching his decision if he were able to satisfy himself whether or not the complainant was personally and irrevocably committed to the termination of her pregnancy. The request that she seek her husband's consent was made to help him in deciding this question.

Accordingly, the Ombudsman decided that the complaint was beyond his jurisdiction and the investigation was discontinued. From his generalist position it would have been very difficult for the Ombudsman to attribute anything but a purely clinical character to the decision to require consent once the superintendent had stated his reasons for the decision in this manner.[20] The ombudsman has nevertheless not always refused to look at unequivocally clinical decisions. For example in Case no. 2329[21] the complainant alleged wrongful committal to a psychiatric hospital. In his report the Ombudsman says:[22]

> I reviewed the files and studied the proceedings leading to the committal, but could find nothing improper, and the clinical evidence clearly showed that the complainant was in urgent need of treatment for mental illness at the time.

So where the details of clinical decisions are made available to him the ombudsman may at times feel it appropriate to comment upon them.

16 N.Z. Parliamentary debates Vol. 355, 1968: 177.

17 ". . . [T]he Ombudsman (senses) that he, as a generalist, cannot really tackle the specialist on the merits of the decision, unless he can enlist an expert on his side": K. J. Keith, supra n.11, p.386.

18 *1977 Annual Report* 49-51.

19 Ibid. (G. R. Laking).

20 See also Case No. 1758, *1966 Annual Report* 22. There the complainant alleged unlawful detention in a psychiatric hospital. Having established that he was lawfully committed the Ombudsman declined to review the medical decision that the complainant had not recovered sufficiently to permit his release, since: "this was a clinical and professional question which I was not able to determine". (24). See also Case no. 4763, *1971 Annual Report* 43.

21 *1966 Annual Report* 26.

22 Idem.

The report made by the British Health Service Commissioner[23] into a complaint made against the Clwyd Health Authority[24] is worthy of some consideration. The complainant's 103 year old grandmother had fallen and been taken to the Accident Unit of the hospital for x-rays. These showed that no bones were broken, and so the Senior House Officer (S.H.O.) discharged her at 2 a.m. on a cold winter's night. She died of shock during the 12 mile ambulance journey back to the nursing home where she was resident. In his report the Commissioner said of the S.H.O.:[25]

> No doubt he took his decision to discharge her in the exercise of clinical judgment on which I cannot comment. Nevertheless, I can only consider a decision to discharge a lady of 103 at 2 a.m. on a cold November morning as inhuman.

The local Medical Practitioner's Committee responded very defensively to this statement, and called for the Commissioner's resignation. However, the Select Committee to which the Commissioner reports defended his comments on the basis that the decision to discharge was not based solely on clinical consideration and so was not outside his jurisdiction. They felt that against his clinical judgment about the patient's state of health the S.H.O. should have weighed other considerations about her situation, including[26]

> her very great age, the 12 mile ambulance journey she would have to undergo, the fact that it was the middle of a cold November night, and the fact that a bed was available in the hospital in which she could have stayed until the following morning.

It appears that the Select Committee was attempting to draw a distinction between clinical and 'common-sense' judgments, seemingly out of a concern to preserve the Commissioner's authority to investigate such complaints. It may well be significant that the consultant involved in this case had apparently told the Commissioner that in his judgment the S.H.O.'s decision was indefensible.

It is important to note that the British Health Service Commissioner will not be so eager to review medical decisions in all cases where some elements of common-sense may have played a part. For example, in relation to complaints about brain damage allegedly caused to children by vaccinations against whooping-cough in 1977, the Commissioner declined to investigate the actions of individual doctors who administered immunisations, "because this would be a matter within the clinical

23 The British Parliamentary Commissioner for Administration also holds the position of British Health Service Commissioner, which was created in 1973 by the National Health Service Reorganisation Act. The office is now held under the National Health Service Act 1977 (U.K.).

24 Case no. WW28/76/77, *Fifth Report of Select Committee on the Parliamentary Commissioner for Administration,* 1977-78.

25 Ibid. p. vii. Note that under the National Health Service Reorganisation Act 1973 (U.K.) the Commissioner's jurisdiction excluded the following matters specified in Schedule 3:
1. Action taken in connection with the diagnosis of illness or the care or treatment of a patient, being action which, in the opinion of the Commissioner in question, was taken solely in consequence of clinical judgment, whether formed by the person taking the action or by any other person.

26 Supra n.24, p.ix.

judgment of the doctors involved".[27] The complaint related to the doctors' failure to warn parents of the risks involved in immunisation. There is no apparent reason why the Commissioner was unable to assert jurisdiction on the grounds that elements of the decisions of individual doctors not to give such warnings were based on common-sense considerations. Perhaps the practical problems of investigating some 350 complaints could have influenced the Commissioner's decision.

It seems debatable whether or not the New Zealand Ombudsman would have investigated either of these two British cases. Cases W10122 and 2329 might indicate that he would not. On the other hand, the comments made by the Ombudsman in Case 16164[28] might show that a similar approach to that of the British Health Service Commissioner might be adopted. There the complainant applied to the Accident Compensation Commission (as it then was) for a hospital bed and shower to be provided at home for her husband who was a stroke victim, so that he could return from hospital on a trial basis. Her application was refused. The Ombudsman concluded:

> I accept that the decision of the Commission has been made on the basis of professional advice from the charge occupational therapist and the nursing staff. However it appears that insufficient consideration may have been given to (the wife's) personal circumstances.

The investigation was discontinued at an early stage when a hospital bed was in fact provided.

Some tentative conclusions may be drawn from these cases. It is submitted that they reveal that the main factor influencing both our ombudsman and the British Health Commissioner in their decisions whether to investigate medical matters is not so much an interpretation and application of the authorising enactment, as the degree of willingness they have to undertake the investigation.[29] This willingness will apparently be determined by the facts of the particular case, in particular as they influence the ombudsman's perception of his competence to investigate. Other factors include the extent of co-operation secured from the body being investigated, and the expert opinion available to provide specialist assistance.

2. *"Policy" decisions in the health areas*

Drawing the line between complaints relating to policy which the ombudsman may and may not investigate raises no unique problems in the health area, except to the extent that the policy is determined by professional considerations. The reported cases fall between two extremes, firstly where the ombudsman just accepts the policy applied in the particular case, and secondly where he challenges the rule or policy and proposes an amendment.[30]

27 Sir Idwal Pugh, quoted in *The Dominion*, Wellington, New Zealand, 8 February 1977. He instead investigated the alleged "maladministration" of the Health Department in not providing adequate warnings of the risks of immunisation.

28 Unreported. Filed at the Office of the Ombudsman, Wellington

29 ". . . [I]t is not a question in many cases of whether the Ombudsman has jurisdiction or not, but of what issues he will pursue, of how far he will pursue them, and of the way in which he pursues them": K. J. Keith, supra n.12, 24.

30 Supra n.14. See Ombudsmen Act 1975, s.22(3)(d).

An example of a case where the Ombudsman merely noted that the decision in question implemented policy is provided by Case no. 3742.[31] There the complaint was against the decision to increase the fee for sitting nurses' examinations, a decision which the Ombudsman decided: "had been properly done in accordance with a Governmental policy it was not my function to criticise".[32]

At the other extreme the ombudsman has sometimes proposed a particular policy rule as a result of an investigation. For example Cases no. 10 and 334[33] involved complaints about the Health Department's involvement in a local body referendum about fluoridation of water supplies. The Ombudsman decided that the department had acted contrary to constitutional principles and he recommended that in future no department should become involved in a contested local issue without government approval.

A further example of the ombudsman investigating policy in some depth is provided in the main part of the *1969 Annual Report* where he considered in detail the provision of the Mental Health Act 1911 which authorised the committal of people who are "socially defective". The legal definition of this class of person included an essential element of "anti-social" conduct. The Ombudsman decided that any judgment that a person was "socially defective" therefore involved elements beyond the purely clinical, and concluded that[34]

> basically the question of what in any community constituted anti-social conduct ought to be determined upon social grounds and not upon medical grounds, and that the proper organs of state to determine the former are the Courts and the Judiciary.

He made these and other views he had in relation to the proposed "psychopathic" class in the new Mental Health Bill known to the Minister.

Case 11066[35] is of particular interest as an example of a very wide ranging investigation and report by the Ombudsman. It involved complaints by the parents of a boy who was being detained in Lake Alice Psychiatric Hospital as to his committal and treatment there. As a result of his investigations the Ombudsman suggested amongst other things that the Department of Health undertake a review of the administration of electro-convulsive therapy in the light of his comments as to the merits of this form of treatment. Having considered expert psychiatric advice the Ombudsman "observed" as follows:

(i) that as a matter of policy the administration of unmodified ECT (i.e. without any anaesthetic or muscle relaxant) should be discontinued as a method of treatment for children and young persons detained in psychiatric hospitals;

(ii) that the use of ECT in the treatment of children and young persons in psychiatric hospitals should be discouraged in all but exceptional circumstances and where the principles of consent have been met fully; and finally

(iii) that consideration should be given to instituting legislative change to give effect to (i) and (ii).

31 *1969 Annual Report* 40-41.
32 Ibid.
33 *1964 Annual Report* 32-33.
34 *1969 Annual Report* 20.
35 Unreported. Filed at the Office of the Ombudsman, Wellington.

All of the recommendations referred to above, and many others made by the Ombudsman in Case 11066, involved questions of policy, and also professional expert considerations. There may be some difficulty in reconciling the extent of the investigation with the view of the ombudsman's jurisdiction as expressed by Mr G. R. Laking.[36]

It might be concluded that in the health area it is evident that section 13(1) is of no more conclusive assistance in deciding which policy decision will be considered to relate to matters of administration than in deciding which professional decisions the Ombudsman will investigate.[37] It is submitted that similar factors to those discussed in relation to professional decisions will play an important role in determining jurisdiction to investigate complaints relating to policy. This conclusion may be supported by the fact that the Ombudsman received considerable expert advice in Case 11066, a case in which he went much further in his recommendations than might have been expected.

3. *Industrial relations in the health area*

Many cases involving Hospital Board and Health Department employees raise issues which are covered by industrial awards and agreements which contain personal grievance provisions, the effect of which is to preclude investigation under the Ombudsmen Act 1975.

In some cases also the ombudsman may refer complainants to their representative body, as for example in Case no. 5897.[38] There two nurses complained of their status as "wage workers" rather than "temporary staff", and of their disentitlement to a night shift allowance. The Ombudsman concluded that[39]

> [these] matters covered major questions of staffing and wages policy with which the Public Service Association was best equipped to deal on behalf of the group concerned.

In other cases the ombudsman will in fact look at complaints which relate to personnel matters. For example in Case no. W14680[40] he investigated a complaint made by a psychiatric hospital employee that, as a result of the transfer of control of psychiatric hospitals from the Health Department to hospital boards in 1972, he had been disadvantaged in that he was unable to anticipate retiring leave. It is not clear why the ombudsman chose to investigate this complaint rather than refer the complaint to his union, but in any case he proved able to resolve the difficulty.

4. *The Availability of Alternative Remedies*

Section 17(1) provides:

> An Ombudsman may:—
> (a) Refuse to investigate a complaint that is within his jurisdiction . . . if it appears

36 Supra, see text accompanying n.15.
37 For other cases involving some degree of policy in the health area see: Case No. 29 *1963 Annual Report* 9. Case No. 2542 *1967 Annual Report* 36, Case No. 4571, *1970 Annual Report* 40.
38 *1972 Annual Report* 41.
39 Idem.
40 *1980 Annual Report* 28.

> to him that under the law or existing administrative practice there is an adequate remedy or right of appeal, other than the right to petition Parliament, to which it would have been reasonable for the complainant to resort.

Pursuant to this section the ombudsman often allows an authority against which a complaint is made to "put its own house in order" by recommending that the complainant seek a remedy directly from that authority. It is seen as an "existing administrative practice" to refer complaints concerning one employee to another employee of higher standing in the organisational hierarchy, or else to the governing body of the organisation. In cases where the complaint has arisen through a lack of communication or understanding, the provision of information from the authority may well serve to resolve the matter at an early stage.

In cases where there is an adequate remedy "under the law" the complainant will be advised how to pursue such remedy. So where complainants allege professional misconduct they may be referred to the relevant professional association so that disciplinary proceedings can be taken if appropriate.[41] Where personal injury is alleged to have resulted from the negligence of medical staff the complainant may also be recommended to seek compensation under the medical misadventure head of the Accident Compensation Act 1972.

Where the British Health Commissioner receives complaints involving allegations of professional negligence or malpractice which may found a legal action, he will nevertheless make his own investigations provided that the complainant signs an undertaking that whatever the outcome the complainant will not take legal proceedings. Although this undertaking is not legally binding the British Parliamentary Commissioner considers that[42]

> [the] essential confidence between the medical and nursing staff on the one hand and his investigators on the other would have been impossible to sustain if those questioned had considered there was a risk that what they said could be used in evidence in Court proceedings.

In cases where some action under the criminal law might be appropriate, for example where allegations of assault or sexual mistreatment are made by a hospital patient, the Ombudsman will ask the medical superintendent for a report into the matter and may also visit the complainant before any steps to notify the police are taken.

One area in which the availability of alternative avenues of complaint has led to some discussion about the extent of the ombudsman's jurisdiction is that of complaints made by patients in psychiatric hospitals. From 1964 to 1977 the ombudsman received 135 formal complaints from such people, involving for example committal proceedings, the treatment they receive, or the refusal to allow the release of committed patients.

41 For example Case No. 17208 (Unreported). Filed at the Office of the Ombudsman, Wellington.

42 These comments were made by Mr C. M Clothier Q C., (as he then was) the British Parliamentary Commissioner for Investigations at the 1981 Annual Conference of the Australasian and Pacific Ombudsmen held in 1981 in Wellington: [1981] N.Z.L.J. 431, 436.

The Mental Health Act 1969 allows two separate avenues of complaint for such matters. Under section 56 a district Official Visitor is to visit every psychiatric hospital at least once every three months, and direct representations can be made to him/her on those occasions. Alternatively, approaches might be made to a High Court Judge so that he may direct investigations to be made into any such matters affecting a person "detained or kept as mentally disordered in any hospital, house or other place" as the judge thinks fit.[43] Nevertheless the ombudsman will undertake investigations in cases where these other avenues are available. In the main part of his *1969 Annual Report* he pointed out that his office was particularly attractive to mental patients, who, he considered, were likely to regard official visitors as "part of the establishment", and High Court Judges as "too remote".[44] Although he would sometimes suggest that complaints should be redirected to the Official Visitor, the Ombudsman expressed concern that in some hospitals not sufficient information was available to patients about the availability of the Official Visitor. In such circumstances the Ombudsman would not necessarily redirect complaints. He expressed the view that he and the Official Visitor were empowered to make parallel investigations.

Under section 13(7) the Ombudsman may also decline to investigate a case where an appeal or review on the merits is available:

> Nothing in this Act shall authorise an Ombudsman to investigate:—
>
> (a) Any decision, recommendation, act or decision in respect of which there is, under the provisions of any Act or regulation, a right of appeal or objection, or a right to apply for a review, available to the complainant, on the merits of the case, to any Court, or to any tribunal constituted by or under any enactment, whether or not that right of appeal or objection or application has been exercised on the particular case.

However, under the proviso the Ombudsman is granted a discretionary power to investigate if he is satisfied that by reason of special circumstances it would be unreasonable for the complainant to have resort to such statutory appeal.

Altogether, the Ombudsman declined to investigate (or else discontinued his investigations) pursuant to one of the provisions of sections 13(7) and 17,[45] approximately 20 per cent of the formal complaints against the Department of Health and Hospital Boards recorded in the *Annual Reports* from 1962 to 1980.

43 Under s.74 Mental Health Act 1969.

44 *1969 Annual Report* 19. Committed patients in psychiatric hospitals may also apply to the Minister of Health for a Magisterial inquiry to be held into the patient's fitness to be released under s.73 Mental Health Act 1969.

45 As well as the ground that it appears "that under law or existing administrative practice there is an adequate remedy or right of appeal" (s.17(1)(a)); the grounds under s.17 include: that a complaint relates to a matter of which the complainant has had knowledge for more than 12 months before the complaint is received by the Ombudsman (s.17(2); or if in the Ombudsman's opinion the subject-matter of the complaint is trivial (s.17(2)(a)) or frivolous or vexatious or not made in good faith (s.17(2)(b)); or if the complainant does not have a sufficient personal interest in the subject matter of the complaint.

II. HOW EFFECTIVE IS THE OMBUDSMAN IN THE HEALTH AREA?

It seems that one of the factors likely to influence the ombudsman most in deciding whether or not to investigate a complaint is the degree of competence which he perceives his office to possess in repect of the particular circumstances of the case. In complaints in the health area he will inevitably at times be restricted by his lack of technical expertise to evaluate medical decisions. While the complainant may wish to retain another medical practitioner to provide him/her with a second opinion in the matter in order to assist the ombudsman in his investigations, the cost of this, especially where specialists are involved, may be prohibitive. In such cases it might be considered appropriate that the ombudsman seek professional opinion to assist in his investigations. It is clear that pursuant to section 21(4) no breach of the secrecy obligation imposed on the ombudsman would be involved if this course were adopted. Although there is no provision in the Act actively empowering such a course to be taken, it is apparent that this has not always been considered a handicap. So for example in Case 11066 the Ombudsman obtained expert psychiatric opinion about aspects of the case from the Professor of Psychological Medicine at Wellington Clinical School, the Director of the Psychiatric Unit at the Wellington Hospital, a Professor of Psychiatry at Auckland University School of Medicine, and the Professor and Chairman of the Department of Psychological Medicine at the University of Otago Medical School.

It is to be hoped that in all cases in which his effectiveness may thereby be enhanced the ombudsman will make full use of the expert opinions available to him.

The ombudsman might also perhaps follow the example of the Manitoba Ombudsman in recommending that in cases where there are special circumstances surrounding professional decisions an independent medical opinion should be sought.

As has already been noted, many complaints result from some misunderstanding or lack of communication, in such cases the ombudsman may ensure a resolution simply by ensuring that the complainant receives adequate information. Even if the substance of the complaint relates to a purely clinical decision, the ombudsman may assert his jurisdiction to investigate the authority's failure to respond to the complainant's inquiries. So, for example, in Case 16785 (unreported) the Ombudsman successfully argued that it was a "matter of administration" that the complainant had not received individual responses to all his queries, and ensured that the information was provided.

Coupled with his right of access to medical records and files held by health authorities[46] the informality of his office makes the ombudsman a most valuable avenue of complaint in the health area. Complainants will often be physically and psychologically dependent on the staff against whom they wish to complain, and their reluctance to do so may well be more easily overcome by the opportunity to complain to the ombudsman than to a more partisan body such as the Medical Superintendent or "official" body like a High Court Judge.

46 Section 19(1). See also D. J. Shelton's article in this issue.

By providing a conciliatory approach the ombudsman can be particularly effective in restoring a complainant's confidence in professional services in a way that an adversarial approach could never achieve.[47] This was illustrated by Case 6550,[48] where in the initial complaint the patient expressed dissatisfaction with her compulsory committal to a psychiatric hospital. The Ombudsman examined the Department of Health's reports and the medical files relating to the patient. Once he had explained the medical assessments of her condition made at various stages of her illness the complainant expressed complete satisfaction with the actions taken, and withdrew her complaint.

The last case mentioned provides an example also of how the ombudsman can fulfil the need for an impartial third person to examine medical records on behalf of the patient to whom the file relates. At present patients in hospitals have no statutory or Common Law right of access to their medical records,[49] a position supported by arguments that such access would prejudice all patients on the basis that medical staff would be inhibited from making completely frank comments in medical records. This policy was accepted by the Ombudsman in Case W12873.[50] It might be agreed, with Matheson, that the advantages in furthering patient education and in reducing a patient's anxiety about his or her health override these arguments. In the meantime, until patients are granted a general right of access to their medical records, there will be cases in which the ombudsman's access to medical records may help to put the patient's minds at rest.

Where a complaint relates directly to a decision refusing access to medical files the practice of the ombudsman is to recommend that the patient's solicitor or doctor be allowed access as his or her agent. However, this arrangement may well fall short of allaying the fears of those complainants who have developed such a distrust of the medical staff that they will only ever be satisfied by personally viewing their records.

III. CONCLUSION

Very few complaints were referred elsewhere by the ombudsman on the basis that they related to purely clinical decisions which were beyond his jurisdiction. It might therefore be argued that there is little or no need to extend the ombudsman's jurisdiction to include all clinical decisions. But the lack of a significant number of complaints relating to such matters is unlikely to be no more than a reflection of complete public satisfaction with medical services, or even of a public awareness of the limits to his jurisdiction which might prevent the ombudsman from investigating. To some extent the "divine authority"[51] with which the medical

47 John G. Regan "When Nursing Home Patients Complain: The Ombudsman or the Patient Advocate?" (1977) 65 Georgetown L.J. 691.

48 *1972 Annual Report* 47.

49 Ian Matheson *Freedom of Information: Patient Access to Medical Records* (LL.B(Hons) Legal Writing, Victoria University of Wellington, 1980).

50 *1979 Annual Report* 93. See also C418, Second Compendium of Casenotes of the Ombudsmen, March 1982, Wellington.

51 Ivan Illich *Disabling Professions* (Merrimack Publishing Corporation, Bridgeport, 1978).

professions have armed themselves has produced a situation where to complain about their services is akin to heresy and rarely countenanced by any but the entirely disaffected.

As the medical professions are making claims of exclusive expertise in ever widening spheres, where social and moral considerations are of at least equal importance with technical ones,[52] it is becoming increasingly important to reject any claims that the judgment of the professionally qualified in these areas is beyond scrutiny by independent non-medical experts. Dissatisfied patients must, moreover, be encouraged to make their feelings known.

The time might now be right to remove restrictions on the ombudsman's jurisdiction to investigate purely clinical decisions in order to satisfy the need for a lay observer of the whole public health service. It might also be useful to consider whether the present exclusion of the ombudsman from investigations into private hospitals and medical practices is tenable. Since these services are subsidised very substantially by the government it seems that the ombudsman might appropriately fulfil the role of watchdog on behalf of the public which contributes to the running of the service and may accordingly expect some degree of answerability.

52 For example: juvenile delinquency, abortion, poverty, emotional maladjustment .