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Called to account

Consultants who are cavalier about patients' complaints had better watch out; they could find themselves called to account before a parliamentary select committee. On 24 March Dr James Thirkettle, a consultant physician at Crawley Hospital in East Sussex, will appear before the Select Committee on the Parliamentary Commissioner for Administration, which shadows the ombudsman. Dr Thirkettle will be questioned on why a patient's family was not informed of his sudden and fatal deterioration in time to visit him while he was still conscious and why over the next six months he "fobbed off" written and telephoned requests for an explanation.

According to the ombudsman's report, Dr Thirkettle told him that a response would have led to "protracted correspondence" and that he did not have time to go through the clinical notes. But the invitation to appear before the committee is not one he will be able to decline. Select committees have the power to summon individuals to appear before them, and anyone who refuses will be in contempt of Parliament.

In December the committee summoned Mr G D Wood, a consultant dental surgeon at Arrowe Park Hospital, the Wirral, who on three occasions took more than four months to reply to patients' complaints. In two of the cases, when he eventually replied, he merely said: "I have no comment to make on the content of the letters sent by the respective authors." Mr Wood told the committee he fully accepted the ombudsman's criticism of him and recognised that he had failed to respond speedily to the complaints. He gave an undertaking that he would do everything in his power to ensure that nothing similar occurred in the future.

Parliamentary authorities believe the power to summon a consultant has been used only once before, some years ago. But committee members say it is likely to be exercised again in the future. The committee cannot impose any sanction on the consultant; its chief weapon is embarrassment. The cases it examines are chosen from the ombudsman's reports; its main role is to try to find out where things went wrong and to prevent a recurrence.

The ombudsman and the committee are constrained by terms of reference which allow them to investigate cases of alleged maladministration but not mistakes of clinical judgment. Administrative mistakes were made in both these cases. In one case relatives were not told of the serious deterioration in the patient's condition. In the other dental treatment was carried out on mentally handicapped children without proper parental consent. But had the consultants apologised or explained—or, at the very least replied—they would probably not have found themselves subjected to an embarrassing grilling before a parliamentary committee whose proceedings are open to the public and the press.

In both these cases district health authority administrators investigating the complaints cited difficulties in calling the consultant, an employee of the regional health authority, to account. When it comes into force later this year the Hospital Complaints Procedure Act 1985 will ensure that complaints are dealt with at a high level and will lay down a code of practice which should make the procedure for handling complaints more efficient. But for the consultant who thumbs his nose at the idea that he should be accountable to the consumers of his services the threat of a parliamentary appearance seems a useful sanction.

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Social skills training

One of the few consistent findings in patients with mental health problems is that they have poor social skills. We all need these skills to relate to each other and get through our lives. Deficiency in them is an important factor in patients with schizophrenia, mental handicap, depression, social anxiety, addictions, and psychosexual disorders as well as in those who have the particular problems of childhood, adolescence, and old age.[1] People experiencing a wide range of problems—such as loneliness, divorce, and disease—also tend to have poor social skills.[2,3] Poor social skills are important too in those who are not ill or under any particular strain—for instance, ineffective communication skills, which are not uncommon in doctors and nurses and affect the outcome of treatment.[4-6] It is against this background that social skills training has developed and been used widely for both helping patients and training professionals.[1]

The idea of social skills training is simple. Within the constraints of a person's biological endowment social skills are learnt—either by direct experience or vicariously through models. Good skills make people better able to cope, and bad skills lead to problems. As skills are learnt they can be taught to those that lack them. The first comprehensive theoretical model of social skills was put forward by Argyle and Kendon[7] and developed by Argyle and others.[8] The model draws on an analogy with serial motor skills and consists of three main sequential stages—perception, cognitive translation, and performance—and a feedback loop from the environment that completes the cycle. According to this model, all social behaviour is constantly monitored and adjusted.

The idea of social skills training is educational rather than medical: instead of a diagnosis being made and treatment prescribed deficiencies in knowledge and performance are assessed and training provided. Firstly, a skill is broken down into its verbal and non-verbal elements. Secondly, the skill is demonstrated by one or more models. Thirdly, the trainee practises the new skill in role play. Fourthly, the trainee is coached and given video feedback on his performance and reinforcement for improvements. Finally, the trainee practises the new skill at work or socially and keeps a record of the results.

The most broadbased social skills training includes modules on observation, listening, non-verbal communication, asking questions, self disclosure, conversation management, expressing feelings, use of social routines and linguistic devices, and more general themes such as self presentation.[8] More specifically programmes include assertion training,

communication skills for couples and families, parenting, and many others. Recent advances have added anxiety management training, cognitive therapy, and training in problem solving.

Many programmes—both for patients and for professionals—have now been evaluated.[9] The consensus is that short term gains are easy to obtain but maintaining the skills and generalising them to new circumstances are difficult. Researchers have now, however, developed pointers for improving the effectiveness of social skills training. One is to teach not only the skills themselves but also the competence to generate new skills. This includes training in how to improve perception of social cues and effective performances by others; how to select and implement alternative responses; and how to overcome emotional and cognitive blocks.

Social skills training is becoming increasingly available in the National Health Service and social services and is available to general practitioners mainly through departments of clinical psychology, community based hostels, and jointly organised community teams. Such services are currently being set up—for example, in Solihull as part of the joint National Demonstration Service in Rehabilitation. These services can accept not only patients with acute problems—such as social anxiety, depression, and addiction disorders—but also those with chronic problems, including schizophrenia and mental handicap.

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A poor start for the Health Education Authority

What is depressing about the members of the new Health Education Authority (p 710) is not only the connection with tobacco manufacturers and brewers (28 February, p 565) but also the kind of people they are—and the kind of people they are not.[1] Where are the public health experts, the nutritionists, the epidemiologists, the social scientists, the experts in health promotion, the statisticians, and the community physicians? What we have instead are representatives of marketeers, a "personality," a broadcaster, and a personnel manager leavened with an expert on infectious diseases, a professor of psychiatry, a community nurse, and a general practitioner. The balance is wrong: more front line troops are needed. The odd marketeer may be useful, but the exclusion of experts from evaluative disciplines is a mistake—as is the reported disbanding of the present council's advisory bodies such as the Joint Advisory Committee on Nutrition Education.[2]

Possibly Mr Norman Fowler may argue that he does not want any experts on health promotion or environmental disease on the Health Education Authority but that the authority will consult such experts on an ad hoc basis. We believe he is mistaken: surely it will be the HEA that decides broad issues of policy, and the more knowledgeable its members the better.

Our other cause for concern is the government's readiness to ignore or reject the opinions of its advisers and expert committees.[3,4] When medical and social scientists told the government that its campaigns on heroin and on AIDS had been less than wholly successful[5,6] it responded by quoting the results of unconvincing evaluations. For example, in the opinion of one academic the evaluation of the heroin campaign was designed so poorly that neither the claims of success nor the allegations of failure could be proved (or disproved).[7]

By now Mr Fowler should have got the message that campaigns must be evaluated, but will his new HEA commission the rigorous evaluations that are needed? Or will the experts he has assembled content themselves with superficial impressionistic assessments? The best market research is as disciplined as the best science—but both may come up with answers embarrassing to the establishment, as seems to be happening with leukaemia and nuclear power.[8-10] Somehow scientific authorities with established reputations in campaign evaluation need to be recruited to oversee future health promotion. Their absence from the HEA has eroded its independence even before it begins work—because such skill is essential to underpin independence.

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