both managerial and clinical staff have long experience of providing services for chronically mentally ill people.

Some critics also argue that there is a direct link between hospital closures and widespread homelessness and vagrancy, but this argument is not borne out by research. The Team for the Assessment of Psychiatric Services has shown, for example, that long stay and "new long stay" patients (those who have been in hospital between one and five years) generally do well when they are discharged into the community.[3] But there is a world of difference between these patients, discharged carefully to a community hostel, and those sent out at short notice after a few months in an acute psychiatric ward. This second group never gets the chance of continuing care because there are too many admissions and too few long stay beds or suitable community residential places. Their plight is an indirect result of the closure programme.

Since 1991 health authorities are meant to have ensured that mentally ill people who need continuing care are monitored on formal care programmes. This approach includes ensuring that patients are not discharged from hospital until adequate community care is available. But use of care programmes is patchy, not least because acute wards are under too much pressure to allow bed blocking.[4]

With so many problems impinging on the plans to close Britain's mental hospitals and, whether justified or not, a public perception that closures cause tragic failures of care, it seems extraordinary that the Department of Health cannot say how many mental hospitals are due to close. Such ignorance hardly inspires confidence. Nor is it in keeping with the call in the *Health of the Nation* for better information and understanding about the burden of mental illness.[5]

The aims of the new mental health task force, set up in January to monitor the mental health service modernisation programme (p 475), seem sensible, but if central data on the programme had been collected all along the team would not now have to go to the districts for information. At the very least, Mrs Bottomley should ensure that such data are collected regularly until there is clear evidence from research that the alternative to mental hospital care is working.

TRISH GROVES

Assistant Editor
BMJ

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Complaints by patients

A wide gap separates patients' and doctors' proposals for change

How complaints are dealt with strongly influences our assessment of a product or a service. A well handled complaint can enhance the supplier's reputation. The converse is equally true. Companies anxious to promote the quality of their products have found that advertising for complaints improves confidence. Doctors have been slow to appreciate that in a similar way their standing in the community could be raised if they encouraged complaints, investigated them rigorously, and made restitution when appropriate.

Medical complaints are increasing, but the response to them is still slow and convoluted—especially complaints against general practitioners. Complainants often end up disillusioned with the system of redress and angry with the whole medical profession; and the doctor against whom the complaint was made is often also traumatised by the experience. Patients who complain want information and explanation, and some also want compensation. A good system must be accessible, impartial, speedy, open, and effective.

Growing interest in the rights of consumers has spread to health care, and the dictates of the patient's charter have generated renewed interest in complaints systems in the NHS. Five papers are now in circulation, two from consumer groups,[1 2] one from managers,[3] and two from medical organisations.[4 5] All accept that the public is dissatisfied with the existing system, and all propose reforms. Some key elements are evident at this early stage.

The first perceived fault in the existing systems is the lack of common procedures for complaints against hospital staff and general practitioners, and for clinical and non-clinical problems. Three of the five papers recommend that all complaints should be dealt with in ways as similar as possible. Secondly, they recommend "inquisitorial" procedures, in which the complaint is investigated by designated people and the outcome is based on those facts which are established by the investigation. The ombudsman's office already conducts its inquiries in this way.

By contrast, most health service complaints at present are investigated by the "adversarial" system, which takes evidence from the two parties and comes to a decision—guilty or innocent. The paper from the Association of Community Health Councils and from Action for the Victims of Medical Accidents sees the investigation of complaints as just one important segment in the overall maintenance of standards. It recommends a complaints commission under the jurisdiction of an independent statutory health standards inspectorate. Such a body would have substantial lay membership.

The medical profession's proposals are much more cautious. The General Medical Council recognises the importance complainants place on rectification and that complaints systems should be able to rectify the circumstances that gave rise to the problem. Rectification is often more important than restitution. It recognises the need to take remedial action when poor general performance is alleged—but its inability to do so has, I believe, brought its regulatory function into disrepute.

The General Medical Services Committee and the General Medical Council seem unaware of the philosophical gulf that exists between the medical profession and user representatives. The papers from these two bodies are still talking about "self regulation." Non-medical advocates of reform have long since lost faith in that concept. They want an "independent" review by a body including a substantial proportion of non-medically qualified people.

The General Medical Council has tried to soothe doctors' fears of even limited lay participation by asserting that it would be restricted in clinical matters. Nevertheless, its paper agrees that "lay members are as able as doctors to recognise and respect the professional principles observed in safe-

guarding the confidentiality of patients." Most lay people see the profession's scepticism as an insult to their integrity.

The General Medical Services Committee's working party seems to have been unconcerned about how the public and politicians might view its proposals—otherwise it would not have proposed to increase professional control over a system already under challenge for partiality, lack of openness, and professional control. The public is unlikely to find its ideas acceptable. To suggest that most complaints are problems of communication, amenable to resolution by doctors themselves, will not be seen as an improvement. The extension of the informal conciliatory system will not satisfy the demand for an investigative system. It is in nobody's interest to increase the adversarial nature of the procedures, yet this is what the General Medical Services Committee acknowledges would result from its proposals.

Complaints should be seen as part of the system that assures quality and maintains standards. That requires an open, problem solving approach—and one that uses complaints to trigger reviews of standards. Agreement on philosophy would make agreement on procedures possible. These papers suggest that the profession has some distance to travel before recognising that an enlightened self interest would have it advertising for complaints and making sure that they were investigated independently. The public's expectations, raised by the citizen's charter, are unlikely to be satisfied with anything less.

FEDELMA WINKLER
Director of Service Planning and Development,
Barking and Havering Family Health Services Authority,
St George's Hospital,
Hornchurch,
Essex RM12 6SD

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Paradoxical pain

When the metabolites of morphine are in the wrong ratio

The recent case of a consultant convicted of attempted murder for administering a lethal injection of potassium chloride to a patient in intractable pain[1] has highlighted the issue of pain that, contrary to expectation, does not respond to opiates. What is this so called "paradoxical pain?"

There are essentially two pathophysiological varieties of pain. The commoner is that in which non-neural tissues are damaged and specific nerve endings (nociceptors) within them stimulated; it is therefore usually called nociceptive pain. Impulses generated in nociceptors follow classic "pain pathways" to consciousness. Many of the synapses in these pathways, as well as some peripheral nociceptor terminals, are sensitive to opioid drugs. The other category is neurogenic pain,[2] exemplified by post-herpetic neuralgia, trigeminal neuralgia, painful diabetic neuropathy, reflex sympathetic dystrophy, and central (thalamic) pain, in which there is no nociceptor stimulation. Impulses are generated as a result of neural dysfunction and do not follow classic pain pathways. Not surprisingly, such pains are not very susceptible to the action of conventional analgesics, including opiates.[3]

Most nociceptive (tissue damage) pains should be susceptible to opiates, in proportion to the drug's ability to bind to opiate receptors in central pain pathways. However, an increasing number of cases are being reported in which patients' pain does not respond as expected to the most powerful opiates. Most such cases are in patients with malignant disease, but some occur in such non-malignant conditions as rheumatic disease (as in the patient of the convicted consultant).[1] It is these cases of nociceptive pain not receptive to opioids which have become known as "paradoxical pain"[4] or "overwhelming pain syndrome."[5]

Morphine is metabolised in the liver to its 3- and 6-glucuronides, both of which bind to opiate receptors. While the 6-glucuronide is a much more potent analgesic than morphine itself,[6] the 3-glucuronide antagonises the analgesic activity of 6-glucuronide in experimental animals.[7] Thus patients' analgesic response to morphine appears to depend on their 3-glucuronide:6-glucuronide ratio, the 6-glucuronide being responsible for the analgesic effect.[8,9] This ratio has been reported in several series of patients with malignant disease taking continuing oral doses of slow release morphine and having satisfactory levels of analgesia: in one series of 40 patients the mean plasma ratio was 5:1[8] and in another of 151 patients it was 4·5:1[10]; in another 40 patients the ratio in the cerebrospinal fluid was 6:1.[8] Children appear to produce greater quantities of 6-glucuronide, so their ratios are lower.[11]

In some cases of paradoxical pain—that is, patients with chronic nociceptive pain which does not respond to morphine—the ratio has been found to be much higher,[12] meaning that lesser quantities of active 6-glucuronide are produced in proportion to the inactive, or even antagonistic, 3-glucuronide. There thus seems to be quantitative differences in the metabolic processes concerned. We do not yet know whether such differences are inherent or are induced by disease or even by the drugs themselves, or what part is played by age. Nor do we yet know what the normal range of ratios is when morphine is given to naive subjects.

Methadone does not follow the same metabolic pathways as morphine, so it has been suggested that it may be useful in morphine resistant nociceptive (paradoxical) pain.[4] Our recent clinical experience has found that it is effective in such cases.[12]

A distinction must be made between nociceptive pain not responding to morphine (paradoxical pain) and overmorphinisation. The latter, although a mainly psychic state (albeit drug induced), can be mistaken for non-responsiveness because of the patient's agitation and apparent suffering; it responds rapidly to reduction in opioid dosage.

DAVID BOWSHER
Director of Research

Pain Research Institute,
Walton Hospital,
Liverpool L9 1AE

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