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ARTICLE

The response from Scottish health boards to complaint investigations by the Scottish Public Services Ombudsman: A qualitative case-study

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Abstract
This article explores how complaint investigations undertaken by health ombudsman contribute to the improvement of the healthcare system. Using a qualitative case-study approach, semi-structured interviews were conducted with participants form the Scottish Public Services Ombudsman (SPSO) and three health boards within its jurisdiction. Health board participants were frustrated by complaints process used by the SPSO, in particular the lack of communication during an SPSO investigation especially when there were differences in clinical judgment. Using Braithwaite's typologies of motivational postures and Hertogh's models of administrative control it was found that a sense of capitulation was the primary determinant in ensuring health board compliance with SPSO recommendations and that the relationship between SPSO and health boards was predominantly coercive in nature. For the SPSO to be more effective in contributing to system improvement requires it to review its role and means of conducting complaint investigations.

Keywords: health ombudsman; complaints; motivational postures; administrative control; system improvement

1 Introduction

This paper is based upon primary research and considers how health boards within the SPSO jurisdiction respond to complaint investigations undertaken by the SPSO. This paper builds upon work published by Smith-Merry *et al.* (2017) which considered the motivational postures adopted by complaint managers within hospitals in Queensland and New South Wales towards their second-tier complaint organisations. Unlike that paper, this paper considers the motivational postures directed towards the SPSO, not only by complaint managers, but also by senior health board managers and frontline staff. This is important as it is these latter staff groups which have responsibility for making the changes that arise from upheld complaints. This introduction includes the role of health ombudsman in the health complaints system and their contribution to system improvement, the Scottish healthcare context and the response of healthcare clinicians to being subject to a complaint.

1.1 Health ombuds

In the United Kingdom, where healthcare is principally provided by the state and is a public service, when complainants are unhappy with the outcome of their complaint concerning publicly provided healthcare, they are able to take their complaint to their geographically based, second-tier healthcare complaint organisations (health ombuds) for consideration. Second-tier healthcare complaint organisations such as health ombuds were established as a result of public concern with the handling of complaints by healthcare organisations and professionals, limited alternatives for

securing redress and a desire from public and politicians for greater accountability from healthcare organisations and professionals (Beaupart *et al.*, 2014; Smith-Merry *et al.*, 2017; Gregory and Giddings, 2002). Healy and Walton (2016) argue that health ombuds demand particular attention as their primary responsibility is to resolve complaints and observe that healthcare organisations have been slow to learn from complaints.

Health ombuds are said to manage most complaints at the 'softer end of a regulatory pyramid' with a focus on the provision of advice, securing an apology and explanation, the publishing of reports and investigating complaints, with lesser emphasis on the imposition of sanctions (Healy and Walton 2016, p. 492). Carney *et al.* (2016) argue that the complaints considered by health ombuds differ significantly from complaints raised with other administrative complaint bodies as health complaints do not always lend themselves to a simple binary decision and complainants are often interested in the quality of healthcare and its improvement rather than simply having their complaint upheld.

Through their role as second-tier complaint handler, health ombuds are theoretically well-placed to contribute to system improvement through the identification of failings when investigating complaints about healthcare organisations, including the pattern of complaints that it receives, together with the use of other powers within their remit (Buck, Kirkham and Thompson, 2011; Stuhmcke, 2010). However, Carney *et al.* (2016) submit that if a health ombuds places too much emphasis on individual complaint resolution this may compromise their ability to secure system improvement.

Each of the UK public sector ombuds has, as a strategic objective, an ambition to contribute to the improvement of services over which they have oversight (NIPSO, 2020; PHSO, 2018; PSOW, 2019; SPSO, 2020). A former PHSO ombuds claims that this is the 'ombudsman dividend' where the activities of an ombuds go beyond that of individual grievance handling to include activities which contribute to system improvement (Abraham, 2012, p. 94; see also Behrens, 2015; Neave, 2014; O'Reilly, 2015; Tyndall *et al.*; 2018). This argument that ombuds are able to contribute to system improvement is also made by academics (Seneviratne, 2002; Kirkham, 2005; Kirkham, 2012; Stuhmcke, 2010a; Healy and Walton, 2016). This dual role of individual complaint handling and system improvement has been questioned (Gill, 2018). Carney *et al.* (2017, p. 82) argue that trying to balance the activities of both individual complaint resolution and system improvement can be problematic 'both conceptually and in the overall governance system'. This may help explain Gill's (2011, p. 181) claim that the evidence demonstrates a 'mixed picture of the influence that the ombudsman may have in this area'.

For public sector ombuds, recommendations arising from their investigation of complaints are typically non-binding. Steyvers, Reynaert and Passemeiers (2009) argue that, despite lacking the power to make binding recommendations, it should not be assumed that public sector ombuds lack influence as their influence results from the moral authority that arises from the quality of their investigations and the nature of their relationships with the public and bodies in jurisdiction. This means that 'the office can have influence without power' (Steyvers, Reynaert and Passemeiers, 2009, p. 18; see also Buck, Kirkham and Thompson, 2011).

1.2 The Scottish healthcare context

Within Scotland, the responsibility for public healthcare is devolved to the Scottish government. The delivery of publicly provided healthcare in Scotland is via the Scottish NHS which comprises fourteen geographically-based health boards and seven specialist health boards. The fourteen geographically-based health boards are unitary bodies with responsibility for the provision of all public healthcare services within their geographical area. This includes acute hospital care, independent providers in primary care, community services and mental health services. By size, they vary from one of the smallest healthcare organisations in Europe to the single biggest healthcare

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organisation in Europe. The result of their size and responsibilities makes health boards very complex organisations.

The SPSO is the second-tier complaints handler in Scotland whose aim is to 'contribute actively and positively to Scotland's development and delivery of first-class public services: putting people and learning at the heart of what we do by being innovative and world-leading in our approach to complaints, reviews and standards' (SPSO, 2019, p. 2). The SPSO seeks to deliver this aim through its core functions of individual complaint handling and acting as the Complaints Standards Authority. In addition to these core functions, the SPSO undertakes a range of activities that may be considered as helping to contribute to system improvement and include the provision of training, submissions, an annual conference, the provision of guidance, newsletters and guidance on good complaint handling. It does not have the power to conduct own-motion or systemic investigations. The SPSO, in common with the other UK public service ombuds, is able to consider complaints about clinical practice.

In considering complaints, the SPSO utilises a two-stage process. In the first stage, there is an assessment of the complaint which considers both whether it meets the statutory tests applicable but also whether there are good reasons not to investigate the complaint, such as the health authority having taken all reasonable steps to deal with the complaint already, and which meant that there was limited public benefit to be gained from a reinvestigation (SPSO, 2022a). The second stage of the process is an investigation which may result in the complaint being rejected, upheld in total or upheld in part. Where a complaint is partially or totally upheld the SPSO will typically make recommendations to address any identified failing (SPSO, 2022a).

In 2020–21, the SPSO investigated 284 complaints, of which 73 percent were about the healthcare sector. Sixty-three percent of complaints were upheld and 511 recommendations were made (SPSO, 2022). The SPSO (2022a, p. 60) reports that a total of 91 percent of recommendations were either completed within the target timescale set by the SPSO or within three months after that target date. This 91 percent achievement is comparable with the 90 percent figure achieved by all public services. Only 49 percent of recommendations were completed within the initial target date set by the SPSO which is slightly better than the 46 percent average secured by all public services. There are no published figures on non-compliance with SPSO recommendations.

1.3 Response from healthcare clinicians to being subject to a complaint

Clinicians, not uncommonly, react negatively when they are the subject of a complaint (Zengin *et al.*, 2014), with Siyambalapitiya *et al.* (2007, p. 108) stating that clinicians can experience a 'sense of indignation towards the patients, frustration, doubts about their competence and fear of litigation'. Cunningham (2004) suggests that many clinicians who are the subject of a complaint demonstrate both short- and long-term negative psychological responses which appear to negatively impact their clinical practice. Defensive behaviours were likely to be exacerbated by a focus on errors (Gray and Williams, 2011).

The adverse psychological consequences on clinicians can be compounded if the complaints process is problematic. Nash, Tennant and Walton (2004) contend that doctors desire the complaints process to be transparent and run by competent staff. Bourne *et al.* (2016) found that clinicians thought that an unclear duration of an investigation, poor communication between clinician and complaint investigator, the perceived uncertainty around the complaints process were all particularly stressful.

Using a qualitative case-study approach, this research explores how the SPSO attempts to contribute to system improvement in healthcare through complaint investigations and, secondly, examines how health boards within its jurisdiction respond to these complaint investigations. The structure of the paper is as follows. Section 2 briefly considers existing ombuds research and introduces the conceptual models of motivational postures (Braithwaite 2014) and models of administrative control (Hertogh 2001), Section 3 details the methodology while Section 4

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reports the research findings. Section 5 discusses these findings while the final Section, 6, details the main conclusions that arise from the findings and discussion.

2 Literature review

2.1 Ombudsman research

There is limited empirical research into the impact of ombuds (Hertogh, 2013; Siemaitycki *et al.*, 2015; Stuhmcke, 2012; Gill, 2011). Lim (2015) suggests that ombuds research can be divided into two categories: firstly, research on measures of ombuds 'effectiveness' such as complaint numbers, duration of investigation, funding or compliance with recommendations (see Danet, 1978; Ayeni, 1999; Bizjak, 1999; Fowlie, 2008; Passemiers, Reynaert and Steyvers, 2009), while the second strand of ombuds research focuses upon the impact of ombudsman (see Stuhmcke, 2006; Hertogh, 2001; Gill, 2012; Siemaitycki *et al.*, 2015).

2.2 Motivational postures

When authorities take action to secure compliance with their demands, individuals and organisations under their jurisdiction can display a variety of responses, called motivational postures, which 'are outward displays of approval or deference' (Braithwaite, 2014, p. 195). Originally identified in the context of regulation (Braithwaite, 2014) the concept of motivational postures has been tested in a number of scenarios between bodies in jurisdiction and their oversight body, including the compliance of farmers with environmental laws, taxation, the regulation of care homes, policing, child protection and, even, in war-making and peace-building in Indonesia and the resettlement of refugees from South Sudan (Braithwaite, 2014). Smith-Merry *et al.* (2017) successfully tested this approach with hospital health complaints. Braithwaite (2014) suggests that these motivational postures provide an important insight into an organisation's attitude towards its controller and its willingness to accept the controller's rules and processes (Braithwaite, 2014, p. 915). Underpinning the concept of motivational postures is the idea that individuals and bodies can independently determine the distance that they place between themselves and bodies in authority. On some occasions individuals and bodies can be open and receptive while on other occasions they can be closed off and distant (Braithwaite, 2014).

Five motivational postures have been identified and include: (1) commitment, which exists when a body recognises and respects the authority of its oversight body and accepts that its objectives should be supported; (2) capitulation, which is where bodies comply with their oversight bodies requirements without necessarily understanding or agreeing with them and reflects submission to the oversight body; (3) disengagement, where bodies are unconcerned about their relationship with their oversight body and takes minimal notice of what the oversight body says or does; (4) gameplaying, where bodies attempt to get their own way while appearing to comply with their oversight body, and (5) resistance, where bodies demonstrate antagonism towards its oversight body, often not because of its existence *per se* but because of the way that the oversight body is using its authority (Braithwaite, 2014). In most bodies, different motivational postures coexist and bodies can switch motivational postures dependent upon the actions of its oversight body (Braithwaite, 2014).

The postures of commitment and capitulation are motivational postures that are said to demonstrate alignment between the body and its oversight body while the motivational postures of disengagement, game-playing and resistance are held to demonstrate a lack of alignment (Braithwaite, 2014). Oversight bodies are able to work with bodies demonstrating the motivational postures of commitment, capitulation and even resistance, as all three recognise the authority of the oversight body. Demonstration of the motivational postures of game-playing or

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disengagement is more difficult for oversight bodies, as this indicates that the bodies question the authority and existence of their oversight body (Braithwaite, 2014).

Smith-Merry *et al.* (2017) applied this model to the views of hospital complaint managers towards their health ombuds from a sample of hospitals in New South Wales and Queensland. Smith-Merry *et al.* (2017) identified the existence of three sets of motivational postures exhibited by complaint managers, those of commitment, disengagement and resistance. They found that the complaint managers as a group, displayed commitment to their health ombuds' recommendations viewing the recommendations as helpful in improving services. Other complaint managers indicated disengagement with their health ombuds by suggesting that many complaints should be referred back to the hospital for action, while, finally, the researchers also identified potential resistance to the health ombuds when complaint managers believing the ombuds' recommendations to be unreasonable, considered the risks to their organisation of not implementing the recommendations.

In the UK, health ombuds are unable to enforce compliance with their recommendations. Therefore, how bodies in jurisdiction view their ombuds will influence the degree of voluntary compliance that will arise from the ombuds' recommendations (Smith-Merry *et al.*, 2017).

2.3 Models of administrative control

For an ombuds to contribute to system improvement, bodies need to take the outputs from their ombuds and make changes to their polices and processes which are then sustained. Hertogh (2001) argues that the ability of ombuds to secure sustained change within bodies in jurisdiction is determined by the ombuds' model of administrative control. Hertogh (2001) identifies two 'ideal' models of administrative control: coercive control, where oversight bodies can force bodies in jurisdiction to comply with their decision, and, co-operative control, where an oversight body secures an outcome with a body in jurisdiction through consultation. Hertogh (2001) found that the Netherland courts are archetypical bodies which use coercive control while the Netherlands National Ombudsman (NNO) predominantly uses a co-operative model of control to secure compliance (Hertogh, 2001). In this co-operative model Hertogh (2001) found that during the case, staff from the NNO would discuss the case with the agency involved, including, when a complaint was upheld, the production of recommendations. This co-operative approach was widely welcomed by staff in the agency as it allowed the agency to be satisfied that the recommendations were deliverable, an approach described as the 'many roads to Rome' approach (Hertogh, 2001, p. 57).

Hertogh (2001) describes a conceptual model which imagines the administrative decision-making process as having three consecutive phases although the second and third phases are near simultaneous. These phases are the information phase where the body asks itself what is the decision of the ombuds, the transformation phase, where the body asks itself what are the implications arising from the decision, and the processing phase, where the body asks itself how should it react to the decision.

Hertogh (2001) then proposes that for each of these three phases there is a potential barrier to change. During the information phase, if the decision or recommendations are unclear then this will act as a barrier. For the transformation phase, where the body assesses the implications to it of the decision, the greater the change from extant policies and procedures together with the degree of organisational commitment to these existing policies and procedures the less likely will the change be made, referred to by Hertogh as 'policy tension', and, for the final, processing, phase of the model, any defensive reactions that arise within, the body will influence the depth and sustainability of any change. Hertogh (2001, p. 59) concludes that degree of sustained change that arises from the decision and recommendation of an administrative body will be governed by 'the degree to which their decisions result in (some of) these barriers'.

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For the purposes of this article, the concepts of motivational postures and models of administrative control were combined to form a conceptual framework to assist exploration of how bodies in jurisdiction respond to the recommendations of their ombuds. Bodies in jurisdiction may respond to their ombuds' recommendations by demonstrating one of the five motivational postures described earlier. However, these motivational postures could be generated by another mechanism, in this case those of the dominant model of administrative control utilised by the ombuds. Whether an ombuds adopts a coercive or co-operative approach towards bodies in jurisdiction will influence the response adopted by that body.

3 Methodology

The research aimed to explore how health ombuds make a contribution to the healthcare system as a result of the complaint investigations that they undertake, together with the way that they work with bodies in jurisdiction.

For this research a critical realist research paradigm has been adopted. With critical realism, parts of the universe are called entities and it is their interaction which causes the events that humans observe. Entities can be material, such as trees or people, or immaterial, such as with legislation or social groupings so entities can be real in different ways (O'Mahoney and Vincent, 2014). Entities have causal powers that are unique to it (O'Mahoney and Vincent, 2014). For example, criminal courts have the power to imprison people or, as in this paper, the SPSO has the power to investigate bodies in jurisdiction. Change occurs when the causal power of one entity interacts with other entities. For a causal power to effect change there has to be a *mechanism* through which that power is expressed. In this research, the mechanism under investigation is the existence of, and conformity with, the investigation reports produced by the SPSO. Ackroyd and Karlsson (2014, p. 23) argue that there are only a limited number of research designs which are appropriate for research based on a critical realist paradigm and that case studies are the most appropriate research design as they allow for the study of a mechanism or entity in whole or in part within its specific context.

The selection of cases is critical to good case-study research. A commonly held view is that the case-study under investigation should maximise what can be learned (Stake, 1995; Merriam, 1988; Sarantakos, 2005). Sarantakos (2005, p. 213) advises that 'The minimum parameters to be considered ... are whether the case or cases are suitable, accessible, researchable and methodologically adequate and whether the study is ethically permissible'. With qualitative case-study research, non-probabilistic or purposive sampling will be the method of choice (Merriam, 1988; Stake, 1995). One form of purposive sampling is criterion-based sampling (Goetz and LeCompte, 1984) where a researcher adopts specific criteria to help select the case.

In this research, purposive sampling based upon particular criteria was utilised to help identify the potential case to be the focus of the study. For health ombuds, it had to consider that it had a role in contributing to system improvement and that there was a sufficient number of healthcare complaints considered by the office to enable the research team to collect sufficient data which is important for ombuds offices that have oversight over a wide range of public services. Once potential ombuds were identified, they were contacted in order to gain their agreement to participate. For Scottish health boards the research team excluded health boards with very low numbers of health complaints considered by the SPSO as this may signify low levels of exposure to the SPSO. The research team then contacted potential health boards until three health boards had agreed to participate.

A critical realist approach to participant selection has been described by Smith and Elger (2014). They suggest that two categories of participants can be identified: practitioners, often senior managers, who may be expert on why policies and procedures were formulated, and, subjects, typically more junior staff, who have a better understanding of the impact of the policy and

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procedures. For that reason, in this research, participating organisations were asked to provide a range of participants. Seven participants agreed to participate from the SPSO and came from across the SPSO, both functionally and hierarchically. Five interviews took place as, three participants requested to be interviewed jointly. Interviews took place in November 2017.

For the Scottish health boards a total of twenty-two participants were interviewed. In all three health boards, participants represented staff from front line staff to board level, as well as complaints and corporate staff. The one staff group that was underrepresented in the interviews was medical staff. A total of twenty interviews were held with health board participants. In two interviews two participants were present at the request of participants. With the agreement of participants, the interviews were recorded, professionally transcribed and uploaded to NVIVO to assist with data coding and analysis. The average duration for interviews with SPSO participants was fifty-eight minutes, while the average interview length for health board interviews was forty-eight minutes. Table 1 below provides details on the profile of the participants from the Scottish health boards:

Table 1. Profile of participants from Scottish health boards

Staff category	Number of participants	Gender profile (F/M)
Director level	7	6F/1M
Nursing staff[1]	8	8F
Patient affairs/complaints staff	6	6F
Non-clinical operations manager	1	1F

This research used a combination of qualitative interviews and the analysis of documents on the SPSO website relating to its service model and approach to casework. Qualitative interviews can be used to determine 'what is in and on someone's mind' (Merriam, 1988, p. 71). Semi-structured interviews were used as this allows for a more conversational approach to interviewing while ensuring that all topics are covered.

Earlier in this paper a combined conceptual framework linking motivational postures and models of administrative control was proposed following a critical review of the literature. This conceptual framework helped the researchers to identify areas to include in the interview topic guides. For example, topics for SPSO participants included their understanding of administrative justice and health complaints within that construct, how they prioritised their differing statutory functions, their approach to undertaking casework, including their interaction with health boards, whether they believed that the SPSO had a system improvement function and, if so, their approach to securing their contribution to system improvement, and had they identified difficulties in using health complaints to drive system improvement. Topics for health board participants included their understanding of the administrative justice and their ombudsman's role within it, the roles and actual activities undertaken by their ombudsman, their views of the SPSO, how their health board responded to SPSO decisions and recommendations together with their opinion of their organisation's response, their view of the SPSO's approach to casework, the SPSO's procedural and interactional fairness towards health boards, the opportunities and challenges involved in making change arising from SPSO recommendations together with examples of changes secured, and an analysis of a sample of five upheld SPSO investigations into their own health board seeking their awareness of the case and what changed as a result of the investigation.

Thematic analysis was used to capture 'a rich thematic description of the entire data set' and is appropriate when 'investigating an under-researched area' (Braun and Clarke, 2006, p. 83). Braun

[1]Note that all of the eight nurses had operational management responsibilities either at ward level or at a more senior level.

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and Clarke (2006, p. 79) define thematic analysis as 'a method for identifying, analysing, and reporting patterns (themes) within data' and state that thematic analysis 'offers an accessible and theoretically-flexible approach to analysing qualitative data'. The following general approaches to data analysis approaches, described by Braun and Clarke (2006), were adopted: a theoretical rather than inductive approach was used as we wished to explore the research participants' perspectives and how these might resonate with aspects of the conceptual framework that arose from the literature review. In practice, the data was read in its entirety, identifying initial themes and views with initial tagging. There then followed a second descriptive stage to review and sort the data and tags arising from this initial review followed by an increasingly explanatory third and fourth level analysis which led to further refining and identification of the themes and their linkage to the conceptual framework. (Ritchie and Lewis, 2008). When conducting this analysis two elements were of importance. Firstly, the identification of recurrent themes voiced by health board participants and secondly a look for alternative views that may contradict themes previously expressed. There was also consideration as to whether additional, previously unidentified, motivational postures were expressed by participants. Themes were analysed at a semantic level attempting to link the identified patterns with previous literature and conceptual framework. An essentialist approach was used which assumes that 'language reflects and enables us to articulate meaning and experience' (Braun and Clarke, 2006, p. 85). To reduce the risk of potential bias during the research, multiple sources of data were used to aid corroboration and thick description used in the results section (see Savin-Baden and Howell Major, 2013). Reflexivity was undertaken during the research including the development of a positionality statement at the outset of the research, the identification of preconceptions about health ombuds and their roles, keeping a journal through the research noting reflections, ideas and issues (see Savin-Baden and Howell Major, 2013).

As male participants represented only a small proportion of all participants, in order to maintain confidentiality, all participants were given computer-generated random female names. The low proportion of male participants in the research reflects the gender make-up of the organisations under study.

Ethics approval for this research was obtained from both Queen Margaret University and a Scottish health board.

4 Research findings

The research findings are discussed under four headings. First, there is a brief description from SPSO participants on its intended relationship with health boards; second, there is consideration of the nature of the relationship that does exist between the SPSO and health boards; third, there is consideration of, both, the approach to recommendation-making used by the SPSO and the response from health boards and, fourth, consideration of the motivational postures that are adopted by health board participants as a consequence of the first two sets of findings.

4.1 SPSO view on its relationship with health boards

SPSO participants stated that a key objective for the SPSO is for it to contribute to the improvement of the healthcare system because 'the more improvement work you do the less pressure you have on the complaint, the individual complaint handling side of the business' (Chloe) and that 'you would hope that the things that come to you are genuinely the things that are complex and intractable and genuinely need an independent view' (Chloe).

It was noted earlier that the SPSO ultimately achieves high levels of compliance with its recommendations but one concern for the SPSO was that staff 'were making the same recommendation to the same body about the same thing and that didn't seem to be being particularly effective' (Ellie). Accordingly, the SPSO attempted to introduce a more collaborative approach

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to recommendations. 'Before, we kind of sat there, at our desks, and tried to think what has gone wrong and what can fix it' (Ellie). In the new approach the onus was put back on the organisation to 'take ownership of it [the identified failing] and fix it, and tell us how you fixed it' (Ellie).

The rationale for this new approach was recognition that the SPSO 'may not always be best placed to make a recommendation that is appropriate because we might not know fully the extent of the organisation's structures and resources' (Mary). SPSO staff were clear this this new approach was not a 'negotiation' (Chloe) but 'recognition that if what we really want is improvement then that has to be through dialogue, you know effective dialogue but without compromising our independence, our impartiality, and our transparency' (Chloe).

4.2 The relationship between SPSO and health boards

With the appointment, at the time of the interviews, of a relatively new ombuds, the SPSO was working at developing an increasingly co-operative relationship with health boards but this was not the expressed experience of the majority of health board participants who appeared frustrated by the lack of communication between them and the SPSO.

It was reported by health board participants that, while informed of an SPSO investigation, they were concerned that they were unlikely to have any involvement with the SPSO during the investigation, 'it feels like it goes into the ether' (Eleanor). Nearly all participants expressed dissatisfaction about the level of communication. Typical responses included, 'they're not coming out to us and talking to us and interacting with us' (Jessica), and, '. . . that's what I see as missing because they're there and we're here and only the twain shall meet in writing' (Donna). The lack of communication between SPSO and health boards could leave the health board finding it difficult to respond appropriately to the SPSO:

> 'It's as if there is this barrier, and it's like, why can't we pick up the phone and say "Can I just say what is it you're looking for? . . . " These people are just doing a job the same as us, so why can't we pick up the phone and question them?' (Emma).

Many participants held negative opinions on the approach used by the SPSO. 'I think their view would be [that] it [the SPSO] is collaborative but from a services point of view I would say it's pretty remote' (Fiona), 'collaboration involves discussion and explanation and negotiation. I don't get a sense that happens a lot with the ombudsman' (Yvonne) and 'they tell us . . . it's not a communication, it's not collaborative' (Jackie).

The difficulties in communication between health boards and the SPSO were exacerbated when health board staff had a difference of views with the SPSO. Many participants stated that they could not challenge the ombudsman: 'I get the sense they're [the SPSO are] quite directive and not really open to a challenge'. One participant described an especially difficult case, 'We challenged once and the Ombudsman came back and chastised us for challenging it . . . It felt quite punitive' (Rhoda).

Health board participants suggested that the SPSO did not take into sufficient account the view from health boards that legitimate differences in clinical judgment could exist, 'There's always the potential that they [the SPSO's clinical adviser] may be an expert in their field but there are lots of experts in the field [that] may have a different view' (Fiona), and 'Sometimes there's no right and wrong answer. It's about clinical opinion at that point in time' (Emma).

Health board participants suggested that too much onus was placed on the advice from the SPSO's clinical adviser even when the SPSO was presented with alternative opinion supporting the health board's position: for example, 'The bits we have queried have all been around clinical opinion and their expert's view. And even when we've gone back with guidelines . . . we didn't get anywhere' (Isobel).

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One example of the frustration felt by health board participants were provided by Donna who described a meeting with the ombuds. The health board argued that the SPSO had reached an incorrect decision as its clinical adviser was unaware of the clinical pathway of care for the medical problem central to the complaint. As a result, a meeting was held between board representatives and the ombuds:

> 'While the ombudsman is always very willing to come and talk to us about things, they talk at us. And it's not a genuine dialogue . . . it was a very interesting initial conversation about the needs to have dialogue and then the dialogue, but I didn't feel there was any real intention to take our points of view on board' (Donna).

As a result of the lack of communication between health board clinicians and the SPSO's clinical advisors, negative responses from clinicians can arise: 'So, there are occasions where they [the SPSO] proceed to print things that our clinicians don't agree with. Which gives us a challenge back from the board then, how do we deliver the action plan for improvement?' (Meg).

When a complaint is upheld, the SPSO will send a decision letter or, for more significant complaints, a full investigation report together with the resulting recommendations. These letters and reports are replete with the language of judgment: complaints are either upheld or not upheld while the language used within the reports and letters is of failings, significant failings, unreasonably failed, inadequate, and serious failure in care (SPSO, 2020b). Should a clinician receive such a letter or report, this language is likely to prompt negative reactions and defensive behaviours.

The result of this apparent lack of communication between the SPSO and health boards was the development of negative views about the SPSO, 'I think they're more dictatorial' (Jackie), 'it actually feels quite aggressive . . . it feels really persecutory at times' (Rhoda) and, 'very much a kind of stick approach as opposed to engagement, working collaboratively' (Fiona).

4.3 Recommendations

This subsection begins by considering the SPSO's approach to recommendation-making which had recently been revised at the time of the interviews and is followed by the views from health board participants on SPSO recommendations.

The SPSO seeks to secure improvement in the healthcare system through the recommendations that it makes following an upheld complaint:

> 'If you are upholding a complaint, it is because something went wrong, it is because you didn't do what you were meant to, something didn't go the way it should have, therefore you have upheld the complaint. There must be learning from that.' (Mary).

Typically, the health board is asked to provide an apology to the complainant and to provide the SPSO with an action plan to address the identified failing(s). Each recommendation made by the SPSO will identify the desired outcome that the body is required to achieve. The prescribed outcomes tend to be that of established best practice – as identified within policies and guidance produced by the Board concerned or national standards and guidelines (see reports in SPSO, 2020b):

> '. . . what we look at is really what should have happened in line with national guidance or something. So, if we are writing, making a recommendation, in a lot of cases what we are just telling the organisation is under the guidance you should be doing this, therefore take it away, look at it, see what the problem is, and make sure that in future you do act in line with the guidance' (Susan).

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This description suggests that the new approach is not intended to be prescriptive but one participant from the SPSO stated that the recommendation 'will set out what improvement we [the SPSO] will expect to take place, what evidence we want to confirm that that has taken place, and the implementation date' (Susan). A review of the summaries of investigation report suggests that, in practice, and in keeping with Susan's comment, a more prescriptive approach is utilised. Each investigation report summary contains recommendations arising from the complaint and each recommendation contains detailed requirements that must be delivered with frequent reference to clinical guidelines and policies (SPSO, 2020b). As a consequence, health boards do not have an entirely free hand in developing their response:

> 'Although they [health boards] have the opportunity to identify and evidence how they will achieve the desired outcome, the ombudsman, the SPSO, still retains the authority to say, well that's not quite good enough ... we have not abdicated responsibility in terms of recommendations' (Mary).

The new approach was termed 'outcome-focused', so rather than being prescriptive in terms of what this is what you must do, the recommendation will identify what the ideal outcome should be for a particular complainant' (Mary). It was suggested that the new approach was appreciated by Scottish health boards, 'the feedback, anecdotally at least, but the verbal feedback that we get is that the new approach to recommendations is welcomed' (Mary).

All three health boards had clear processes in place to disseminate the ombudsman's report to those involved and to provide an appropriate response. The health board will identify a small working group to be involved in drawing up the action plan in response to the ombudsman's report and recommendations, its execution and subsequent reporting on delivery. Senior management will sign off the action plan which is then implemented.

Unsurprisingly, there was acceptance from participants that it was simpler to make process changes rather than policy changes, 'for us to change a policy ... there is a process that we need to go through, one that involves partnership and engagement and all of that' (Fiona), and there are 'recommendations that have a system-wide, organisation-wide, maybe national policy impact' (Phoebe). However, participants were of the view that the changes were mainly small-scale in nature: 'I haven't seen the big, wider organisational changes' (Fiona), 'I would say most of them are manageable. None of them ... have been reflective of organisational change across the whole of the board' (Sally) and, 'For our system, most of it has been small-scale things' (Donna).

While some health board participants suggested that many SPSO recommendations were exercises in box-ticking, 'You can sometimes feel a lot of their recommendations are about ticking boxes' (Eleanor) and, 'I think from an operational perspective, it's a bit of a tick box exercise' (Vicky), two broad findings emerged in relation to SPSO recommendations: first, the clarity of the recommendations and the nature of the evidence required to demonstrate compliance, and, second, the achievability of the recommendations.

Some participants described recommendations from the SPSO in positive terms, such as 'generally sensible' (Fiona), or 'I would say on the whole they're probably quite measured and realistic' (Vicky), but many participants were critical of the clarity of specific recommendations. Indeed, six different participants independently used the term 'woolly' to describe the recommendations that had been made by the SPSO. Other comments included: 'I don't even understand that. I don't know what ... it is not clear what they're looking for' (Emma), 'sometimes you have to read it a few times to figure out what it is that they're getting at' (Trish) and,

> 'You'd love to see them in the boardroom to say "What do you mean by that? Explain what you actually want us to do", because again in black and white, I can read that and think "I don't know how I can deliver that ...?"' (Darcie),

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There was also disquiet voiced by a small number of participants about the lack of clarity about the evidence required from health boards to demonstrate compliance with the recommendation: 'And sometimes what'll happen is, you'll go back to the Ombudsman with what you've done. And sometimes they'll [the SPSO] come back and say, "Well, that's not what I'm looking for. I'm looking for this"' (Emma) and, 'Staff at different levels within the organisation get themselves worked up because what do they mean by evidence' (Tess).

Health board participants raised concerns about the deliverability of some recommendations. These concerns ranged from, alleged failures by the SPSO, first, to understand the degree of the work that would be necessary to implement the recommendation, which was memorably described as 'industries around the SPSO' (Darcie), and, 'You can write one sentence [in an action plan], but that sentence actually could be months and months and months of work' (Darcie); second, the deliverability of the recommendations through the failure of the SPSO to understand fully the complexity of the modern healthcare system,

> 'It wasn't clear how we would actually make the change because we already have our regional multidisciplinary team for … patients and, therefore, that was already happening. And that's the bit where I think that lack of general understanding about how the system works these days.' (Donna) and,

> 'But sometimes they do come back and they come out with wild stuff about "See everybody within 12 weeks and make sure that somebody doesn't have to travel from A down to B for a scan." And you think "Okay. Right. Move on".' (Isobel)

and third, the importance of local context, 'a health service is a health service is a health service. It is to a certain degree but local context is important' (Meg), and, 'part of the challenge we've got is … they'll give us local recommendations and we'll go away and work things up, but sometimes there are bits that they come back with, that you think, "This is completely unrealistic".' (Isobel).

4.4 Motivational postures adopted by health board participants

It was discussed earlier in this paper, how the concept of motivational postures can be used to assess the attitudes and beliefs of individuals or bodies to an external oversight body (Braithwaite, 2014). In this research, there were two dominant motivational postures that were identified, those of capitulation and commitment.

The first dominant motivational posture described by health board participants was the motivational posture of capitulation. Here, participants used language such as seeing the SPSO as a threat (Vicky), of staff being in fear (Vicky and Darcie), being instructed to accept the SPSO findings and recommendations by their managers (Darcie), and taking action through a fear of negative consequences if they did not do so, all the while lacking true commitment (Yvonne).

It was noted earlier that the SPSO does not have the power to force compliance with its recommendations. However, it can submit a report on a health board's refusal to comply with its recommendation(s) to the Scottish Parliament and this would inevitably lead to adverse reports in the press and a risk to the careers of health board staff. Van Ackers *et al.* (2015, pp. 15–16) report that among the reasons why public sector organisations have difficulty securing change is that they are risk averse, fearing public criticism and that politicians in charge wish stories of success not failure to be published within the press and, thus, may create career risks to individuals. And, as was made clear by participants from health boards, adverse press coverage is a reputational risk to the organisation. It is a fear of these negative consequences that act as an incentive to comply with the SPSO's recommendations.

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Health board participants did express a fear of negative consequences if they were not seen to comply with the SPSO, the most feared of which did relate to risks to the health board's reputation: 'We have to deliver on the recommendations. And, if we don't, they [the SPSO] don't close the case, and they write to our Chief Executive, and that comes back to reputational issues' (Jackie), 'We probably risk assess it [the SPSO report]. What's going to have the biggest impact for us, because you don't want to end up on the front page of the Daily Record'[2] (Jill) and, 'I guess the thing is, there's a pretty clear message around these ... there's that whole bit around reputational risk' (Tess). This fear led to some noteworthy depictions of the SPSO: 'the minute you hear the ombudsman, you think "Ugh" (Isobel). 'Everyone says, "the Ombudsman". It's like the grim reaper' (Darcie), 'It's like Big Brother watching you a wee bit' (Trish) and 'It's keeping the wolf away from the door' (Eleanor).

There were also many views that were indicative of the motivational posture of commitment, such as the imperative to take the ombudsman seriously and consider its findings and recommendations seriously (Trish), recognition of the importance of the SPSO's independent investigation which supports its findings and recommendations (Fiona and Justine). Jessica noted that despite the fact that an upheld complaint, could upset staff, it was nonetheless important for the health board as the health board was then in a position to learn from it, an opinion echoed by Trish, who described the feelings engendered by an upheld report as 'sore' but, if used properly, could still be a source of learning Several participants recognised the importance of the ombudsman institution, as an external reviewer (Phoebe) and in driving improvement (Tess). This view was, perhaps, best described by Jackie, who said that the primary objective for health boards upon receipt of an SPSO report should be 'to make the patient, the complainant, whoever it may be, feel better and feel that we've properly listened to the recommendations and are acting upon them'.

In addition, a sense of disengagement was also voiced by health board participants but, typically, in relation to the behaviours and attitudes of other clinicians who had previously been involved in SPSO complaint investigations but were not involved in the interviews. It is, therefore, suggested that disengagement may be more widespread within health boards than may be thought: 'There are some [clinicians] who are probably, like, "the SPSO, who? I don't really care what they [say] you know?"' (Vicky). 'I suppose it depends what the recommendation or what it is they've upheld as to what we need to change or potentially change' (Jessica), 'It will vary, I suppose, on what the recommendations are' (Emma) and, 'then other things we think, "Really?". It's almost making recommendations for the sake of it rather than genuinely understanding what happens in the system' (Donna).

Perhaps motivated by the motivational postures of capitulation and disengagement, defensive behaviours from clinicians was also viewed as a potential problem, 'we can all be quite defensive when we're responding to complaints' (Eleanor), 'I have witnessed other folk ... perhaps, getting quite defensive and feeling that some of the recommendations or commentary is personal' (Deirdre) and, 'I'm quite saddened sometimes to get the reaction from, particularly, clinical staff who feel very aggrieved' (Vicky).

5 Discussion

Hertogh (2001), in his research on the NNO, detailed a three-phase conceptual model to describe the decision-making process adopted by bodies in jurisdiction when they receive adverse ombudsman reports, and also identified that for each of these three phases there was a corresponding potential barrier to change. The greater the cumulative size of these barriers the less likely that sustained change will occur. Hertogh (2001) suggests that the discussions between the NNO and bodies in jurisdiction assisted the NNO overcome potential barriers to change. In this research the finding appears to be different.

[2]The Daily Record is the largest circulation daily newspaper in Scotland.

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This research indicates that these barriers were potentially very significant between the SPSO and health boards. In this research, many health board participants did not always find recommendations from the SPSO to be clear, with over a quarter of participants, describing SPSO recommendations as 'woolly' or 'unclear'. In addition, some health board participants expressed disquiet about the lack of clarity from the SPSO about what the SPSO required in the form of evidence that demonstrated their compliance with the recommendation. A lack of clarity from the SPSO about what they wish to see happen makes it more difficult for health boards to deliver the required changes.

The likelihood that the recommendations made by an ombudsman will be implemented appears to be strongly influenced by the policy tension that exists between the recommendation(s) made and the existing organisational policies and procedures together with the degree of organisational commitment to those policies and procedures. In this research, it was found that on many occasions, health boards did not fully accept, or had concerns about the clinical advice received by the SPSO. When this occurs it is likely that the findings of any complaint that is upheld yet based on this disputed advice is unlikely to be fully accepted by health board clinicians. This reality was recognised when Meg posed the question how does a health board deliver an action plan when there is no acceptance of the findings. This is exacerbated when recommendations are either unclear or appear not to reflect the local context in which that health service operates. As health board participants claimed that, on occasions, SPSO recommendations were unrealistic and not rooted in their everyday reality, combined with a view that the SPSO did not take into sufficient account either the local and national context for the delivery of healthcare, it is clear that significant policy tensions will arise.

The third element of Hertogh's triad is that of defensive behaviours from staff within bodies in response to the findings of their oversight body. To health board participants there are problems with the complaints process used by the SPSO. At the beginning of an investigation, it appears that the SPSO does not advise health boards of the likely duration of the investigation and its published performance standard is to complete 85 percent of investigations in twelve months (SPSO, 2020a). During an investigation there is usually little communication between the SPSO and health boards, leading to uncertainty of what is happening during the investigation and there is frustration at not being able to discuss the clinical aspects of the case. This is known to increase the adverse psychological consequences suffered by clinicians who are the subject of a complaint (Nash, Tennant and Walton, 2004; Bourne *et al.*, 2016). The risk of defensive behaviours is further increased with the language used by the SPSO in its investigation reports with its focus on 'unreasonableness' and 'failings' (see p. 22). In this respect, the findings of Siyambalapitiya *et al.* (2007), that a focus on alleged incompetence increases a sense of frustration among clinicians who are the subject of a complaint, and those of Gray and William's (2011) finding that a focus on error increase the chances of defensive behaviours from clinicians will together increase the risk that clinicians will respond negatively to SPSO investigations. Taking all these issues together, they are likely to increase the negative psychological impact of the investigation upon the clinicians and lead to increased defensive behaviours. Indeed, several health board participants reported, that the result of these features is defensive behaviour on the part of many clinicians.

The triad of potential barriers detected by Hertogh (2001) is, therefore, demonstrated. There may be a lack of clarity about the intent of the SPSO's recommendations, linked to a significant policy tension between what is proposed by the SPSO and existing health board policies and procedures, and clinicians may exhibit defensive behaviours. In isolation, any of these obstacles could negatively impact the implementation of SPSO recommendations, but it is not impossible that all three will coexist for any particular SPSO report. If it is the fear of negative consequences arising from non-compliance that motivates action, it would be unrealistic to expect an enthusiastic response from health board staff.

These issues are, in part, created and, in part, exacerbated by the nature of the relationship that exists between the SPSO and health boards. For the SPSO to be successful, there is a need for SPSO

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caseworkers and, in complaints involving the assessment of clinical decision-making, for clinical advisers to situate themselves as best they can in the shoes of the clinician at the time the clinician made their decisions or undertook their actions. But as was noted earlier, there is typically very little, if any, communication between the SPSO and health board staff during an investigation particularly around clinical advice. Health board participants suggested that the SPSO believes that it works co-operatively with health boards but that was not the apparent lived experience of the participants from health boards who expressed frustration at the lack of communication and interaction. This was particularly the case when there were differences in clinical judgment between the health board and the SPSO's clinical adviser. Here participants described an apparently dismissive attitude from the SPSO.

Smith-Merry *et al.* (2017) reported that hospital complaint managers welcomed a collaborative approach between ombudsman and their hospital as they suggested that this would enable the production of better, more realistic, recommendations. Hertogh (2001) found that staff from the NNO also, generally, adopted a co-operative approach, with regular communication with bodies in jurisdiction about the investigation and recommendations. Similarly, in this research, health board participants made clear that, they too, would welcome the opportunity to have stronger interactions with the SPSO during an investigation, including the opportunity to discuss the clinical advice and proposed recommendations. The participants suggested that enhanced interaction between SPSO and health boards would lead to a greater acceptance of both the ombudsman findings and to implementation of recommendations.

The poor relationship that generally exists between the SPSO and health boards will exert a significant influence upon the motivational postures that are exhibited by health board personnel. Smith-Merry *et al.* (2017) found that complaint managers demonstrated the motivational postures of commitment, resistance and disengagement. In this research, a slightly different trio of motivational postures were exhibited, those of capitulation, commitment and disengagement. However, as was suggested by previous research on motivational postures (Braithwaite, 2014; Smith-Merry *et al.*, 2017), the motivational postures demonstrated in this research are not absolute, either for health boards or for individuals within health boards. The dominant motivational posture demonstrated by individuals may change dependent upon the outcome of the complaint investigation and associated recommendations. The motivational posture adopted by a health board or clinician can be specific to the immediate situation, and/or, individual, where, when faced with the same circumstances, different individuals adopt differing motivational postures.

In this research, it was found that individuals within health boards review the SPSO's complaint investigation report and its associated recommendation(s) before making a decision on how much they accept. If the findings and recommendations are accepted then there will be increased commitment to the implementation of the recommendations. Where participants within health boards fail to be convinced by the SPSO's report and recommendations then it is more likely that a motivational posture of capitulation will be adopted together with lesser commitment to the full implementation of the recommendations.

The good news for the SPSO is that both of the motivational postures of capitulation and commitment are recognised as demonstrating alignment between oversight body and bodies in jurisdiction, where bodies in jurisdiction are open to co-operating with its oversight body (Braithwaite, 2014). This provides the opportunity to the SPSO to recover its relationship with health boards. Should the motivational posture of disengagement be widespread that would represent a more significant problem for the SPSO, as this indicates that its existence and authority is questioned. To overcome this challenge would require the SPSO to self-critically review its underpinning rationale, the rules and processes that are intended to be a reflection of that rationale and consider how they can employ these rules and processes in a way deemed respectful to those over which they have oversight (Braithwaite, 2014).

The problem for the SPSO is that, while Steyvers, Reynaert and Passemeiers (2009) and Buck, Kirkham and Thompson (2011) suggest that an ombudsman's ability to influence change arises

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from its moral authority derived from the delivery of high-quality investigations, in this study, this is not what health board participants generally felt to be the case. Here it was the fear of negative consequences that apparently encouraged compliance. Where this occurs, organisations may introduce changes for 'symbolic' rather than for 'instrumental' purposes, that is, without making significant operational changes in an attempt to maintain their legitimacy with their oversight body while making as little change as they can (Heimer, 1999). This may help explain the SPSO's opinion that, historically, it would receive similar complaints about the same health board. To overcome this requires the ombudsman to introduce 'procedural reforms such as dealing with people more fairly, respectfully and openly' (Braithwaite, 2014, p. 917).

There are some limitations with this research, three of which are important. First, while there were a number of front-line nursing staff included within the sample of health board participants, there was only one medical participant in the sample. Second, it is unknown to the research team whether any of the health board participants had been the *subject* of an SPSO complaint or their experience of SPSO complaints arose from their *involvement* in responding to an investigation or subsequent action plan. Given the uncertainty regarding the degree of disengagement that may exist within clinical staff it would be of interest to clarify the degree that this or other motivational postures that exist within this important staff grouping. Third, it would be of interest to understand to what degree the motivational postures that were expressed in this research are dependent upon being the subject of an SPSO investigation.

Much has been made in this paper of the nature of the relationship that exists between the SPSO and health boards but this is based principally on the perceptions of health board participants. And, as stated earlier in this paper, at the time of the interviews a new ombudsman had relatively recently assumed post within the SPSO, and a small number of health board participants stated that they had begun to notice a change in attitude from the SPSO in its ways of working with health boards. It would be of interest to hear the views of the SPSO on this issue.

6 Conclusion

The nature of the relative roles and power relationships that exist between the SPSO and health boards indicates that the SPSO is the dominant player in the establishment of the relationship that exists. While many health board participants recognised the role and expertise of the SPSO leading to a positive view of the SPSO's investigations for many others there is a sense of fear and dread towards the SPSO with compliance to its recommendations generated by a fear of negative consequences rather than a sense of commitment. This is important as the implementation of recommendations from upheld complaints is the SPSO's primary route for contributing to system improvement. However, as was seen in the current research, the approach to complaint investigation utilised by the SPSO is desk-based and paper-driven with apparently little, if any, communication with health boards or the clinicians involved in the complaint. This apparent lack of communication between the SPSO and health boards is an interesting contrast to the more co-operative approach adopted by the NNO which led to an apparent greater acceptance of the ombudsman findings and recommendations (Hertogh 2001). This co-operative approach involving a discussion of the case would be welcomed by Scottish health board staff which is similar to the findings with hospital complaint managers in Queensland and New South Wales.

However, the SPSO's apparently non-co-operative approach feeds into the development of, and expectations around, the SPSO's recommendations following an upheld complaint. The SPSO's new approach to recommendations was intended to provide the health board with freedom to develop its 'own road to Rome' (Hertogh, 2001, p. 57) but appears to be more prescriptive in practice as recommendations state what should happen, by when, and what evidence is expected from the SPSO to demonstrate compliance from the health board with the recommendation.

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The consequence of the SPSO's approach to complaint investigation and production of recommendations means that while one of the two dominant motivational postures demonstrated by health board participants was that of commitment, the second, dominant, motivational posture was that of capitulation. Both of these motivational postures demonstrate alignment between oversight body and bodies in jurisdiction, and that bodies in jurisdiction will comply with the findings of their oversight organisation. The lesser voiced motivational posture of disengagement is more problematic for the SPSO. If this motivational posture is more widespread within clinicians, then the SPSO can have serious concerns about its legitimacy with these health personnel. To overcome this would need the SPSO to undertake a fundamental review of its purpose, processes and way of working with bodies in jurisdiction and the people within them. Otherwise, compliance with its findings will be due to a sense of capitulation due to the fear of negative consequences and reputational risk and not due to the moral authority that arises from the quality of its investigations (Steyvers, Reynaert and Passemeiers, 2009) leading to changes that would be more symbolic in nature (Heimer, 1999). This may explain the concern among SPSO participants that its case reviewers kept on receiving complaints of a similar nature.

There is the opportunity for the SPSO to address this problem by modelling its investigative processes upon best practice within the field of justice theory. This would involve the SPSO basing investigations upon best practice in the areas of distributive justice, procedural justice and interactional justice. Making these modified approaches would improve the relationship between the SPSO and health boards and, should create an enhanced degree of commitment from health boards and clinicians towards the SPSO.

One such method could mean the SPSO using an approach similar to that used by the NHS when investigating significant untoward events (for an example of this approach see Woloshynowych *et al.*, 2005). Doing this may not only be welcomed by health board and clinicians but also by complainants. It was noted earlier that complainants were more interested in improving the quality of services and that reaching an upheld/ not upheld decision can be less satisfactory for complainants. This approach would also take into account the complex nature of healthcare. It is recognised that such investigations can be resource intensive and it could be that the SPSO, like the NHS, triages complaints on the basis of their impact, (potential or realised) to determine which complaints receive a full approach while other complaints receive a modified approach but which, nonetheless, meets best practice in the field of justice theory.

Conflicts of Interest. Dr. Gavin McBurnie: retired GP, retired director in the Scottish NHS and retired director at the Parliamentary and Health Service Ombudsman in England.

Dr. Jane Williams and Dr. Margaret Smith declare none.

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