On the whole NHS Boards operate in a satisfactory way. However, there is one complaint that can be made against them: they commonly attempt to cover up mistakes made by their employees. This practice should be contrasted with that of the aircraft industry where care is taken to investigate each accident involving an aircraft so that lessons can be learned and similar accidents avoided in future. This approach has had the result that, in relation to the number of flights, aircraft accidents are rare.

By contrast, medical mistakes which harm patients are common. In fact, an article in the BMJ of 3 May 2016 suggested that medical error was the third leading cause of death in the US. Whether or not that is true in the US or elsewhere is not relevant, because it is known that some deaths are, beyond reasonable doubt, due to medical mistakes. One such death occurred in a care home near Aberdeen in 2002 when Mrs D died only eighteen days after entering that home. Unfortunately the Crown Counsel instructed Aberdeen's Procurator Fiscal that there should be no Fatal Accident Inquiry and hence no lessons were learned from Mrs D's unexpected death; one that could have been learned was that care must be taken not to prescribe a nephrotoxic drug to an elderly person with known renal impairment.

No health board could be held responsible for the decision of the Crown Counsel that no Fatal Accident Inquiry be held into the unexpected death of Mrs D. However, a health board did attempt to cover up failures on the part of hospital staff to provide an acceptable standard of care to the late Mrs A. The initial failure consisted of a misdiagnosis of the reason for her collapse when shopping, a collapse that had led to her being taken to the Accident and Emergency Department of the hospital in question. (A misdiagnosis is a common type of medical error.) A more serious complaint against those responsible for the care of Mrs A is that they ignored the BMA consent guidance: they used force to treat Mrs A against her will. The force used when she was held down and injected with drugs was such that she was badly bruised. She was also so traumatised that she later required psychotherapy.

Thanks to the good offices of the Feedback Advisor of the Board in question, Mrs A and I met those hospital staff who had been responsible for her care. The consultant primarily responsible insisted that it was the doctor's duty to act in what he believed to be the best interests of the patient: there was a refusal on his part to acknowledge that patients have a right to refuse treatment.

In view of that refusal, I wrote to the Chief Executive of the Board on behalf of Mrs A. In his reply, the Chief Executive refuted the allegation that Mrs A had been forcibly injected!
However, he suggested that if Mrs A would like to pursue her complaint further, then she could contact the Scottish Public Services Ombudsman.

I wrote to the Ombudsman on behalf of Mrs A. In his report, the Ombudsman upheld her complaint and required the Board to issue an apology to Mrs A for the failings identified in the report. The Ombudsman concluded his report by stating that "For the sake of patients and health practitioners, lessons from this disturbing incident must be learned not only across the Board concerned but across the NHS in Scotland".

As well as sending me a copy of the report the Ombudsman also sent one to the Scottish Ministers. Regrettably, the Scottish Ministers did not appear to take any immediate action. They could at least have publicised the need for there to be informed consent prior to the commencement of any medical treatment. Another, and more important action, would have been to amend Scottish mental health and incapacity legislation to ensure that it complies with the UN Convention on the Rights of Persons with Disabilities. The fact that they have now, more than seven years later, agreed to amend Scottish incapacity legislation in this regard is to be welcomed though it is to be regretted that they have not yet agreed to amend Scottish mental health legislation also.