Child abuse

Sir,

I am gathering information in preparation for writing a chapter on 'Child abuse and the GP'.

I would be most interested to hear from general practitioners with an interest in this subject and particularly for comments on child sexual abuse cases that they may have come across.

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Good practice allowance

Sir,

With his full authority as Chairman of Council, John Hasler has used a *Journal* editorial (September *Journal*, p.394) to attack the numerous members (possibly a majority; as yet, no one knows) who are either uneasy about the proposal for a good practice allowance or completely opposed. 'To reject a quality incentive equation', he writes, 'is to reject the new resources that modern general practice now needs and our patients deserve'. Apparently TINA (There Is No Alternative) is extending her rule even to the College.

Of course, there are other ways of getting resources; we spent a year discussing them on the General Purposes Committee. Unfortunately, the document which finally emerged was not, as promised, a discussion paper (a balanced and documented review of the various options available), but a single take-it-or-leave-it statement of one option favoured by some officers of Council and some members of GPC. No doubt it was the nearest we could get to genuine consensus, and certainly none of us felt sufficiently opposed to isolate ourselves as non-signatories; but why had we to be manoeuvred into a position in which we had to make such a choice? The consequence now is that just one out of many options is being made into a test of loyalty for the whole membership, as it was first on GPC and then on Council.

Unfortunately, it is a present fact of life that there is no true consensus, either within the College or among general practitioners as a whole, on how to move forward, or even on the need to move at all; many general practitioners are fairly happy with things as they are, and believe any change is likely to be for the worse. If there is a crisis in primary care, it is perceived more by patients than by doctors. But even among those general practitioners who recognize that substantial new resources are essential for continued advance, there can be no lasting agreement on how to get them, for one simple reason; a majority even of the most thoughtful and well-informed established general practitioners still wants, and believes it can get, more public funding without more public accountability. The consequence of this unrealism will be a succession of devices (of which the good practice allowance in its present ill-defined form is the first) designed to give the appearance of public accountability, while actually reserving all effective rights to criticism and control to ourselves. This was tolerated in the past only because so much of medical care was illusory that little of our work could have survived any serious audit, because it was cheap, and because we did nearly all of it ourselves, from our own parlours or lock-up shops. In these days of team practice from modern premises, total autonomy is no longer tolerable, either to the political right, which grudges every penny spent on anything unprofitable, or to the political left, which wants open medicine with responsibilities increasingly shared, both between the different members of the team, and between care-givers and the people they serve. Yet concessions in either direction immediately isolate the leaders of the College from its members, as we saw in the deputizing dispute.

Is it really necessary for the College to have a consensus policy on these matters anyway? The National Health Service was not designed by the profession, indeed it was initially bitterly opposed by most general practitioners. The great strength of the College in its early years was that, in contrast to the British Medical Association, it accepted the reality and necessity of the profound social change the NHS represented, and did its best to make it a success. There are now few general practitioners who want even a partial return to private practice, and most are prepared to work for a more effective, more equal public service. Through the College, they can give skilled and useful advice to any government willing to listen, but though we hope government decisions will be realistic, and take into account our experience (and that of other primary health workers) in actually delivering service within a wide variety of constraints, in the end it is they and not us who must formulate policy.

Rather than prepare any one monolithic policy for structural reform, imposing this on a far-from-monolithic membership to give an appearance of consensus, the best way to help both ourselves and our patients would be to set out and document all the main options available, taking into account our own experience, but having some regard also to experience in comparable societies abroad, so that government decisions can be realistic and well informed.

This more modest realism has so far been absent from the College officers' responses to the green paper. Good practice allowance beauty contests doubtless appeal to the present government's faith in a society of winners and losers, but with only 18 months at most of further office, there will be no reform before the next general election. The green paper is in fact a pre-election policy statement, comparable with those now published by the Labour, Liberal and Social Democratic parties, any or all of which may compose the next government. These parties, at least nominally committed to tackling the widening splits in society discussed in the Black report and further highlighted by the 1981 occupational mortality statistics, are unlikely to see the good practice allowance as a serious weapon for social change, when 85% of general practitioners have still not fully availed themselves of the staff resources allowed by the 1966 package.

Over the next five years, primary care is either going to leap forward to a new stage of intelligent social planning with local democratic control, or retreat to an openly two-tier service for the two nations we shall have become. Never has there been a greater need for intelligent, imaginative, and realistic leadership. Good leaders know when and how to conduct a necessary retreat, just as good doctors know how to admit a mistake. At present, we are being marched straight into a bog.

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Sir,

The *Quality in Practice* bulletin (special edition of September 1986, no. 28) states that: 'South East Thames thought that the good practice allowance was an excellent idea ... '. This is an extremely misleading statement from what is meant to be an academic body. When and where was the meeting to discuss this issue, who was notified, who attended, and what was the result of the vote? I have not been able to find any College member who can answer these questions or indeed was even invited.

A true reflection of what South East Thames thinks of the good practice allowance can be obtained from the Kent local medical committee survey of 781 general practitioners in which the majority (3:1), which included members of the College, rejected this proposal.

The section is this bulletin on the good practice allowance reads like the work of a politician who has selected and produced only the evidence to back his own views. Hopefully you will print the correction in the next edition along the following lines: 'South East Thames thought that the good practice allowance was a bad idea'.

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