

Patient care — crunch time

The NHS carried me into the world, slapped my backside and gave me breath, kept me warm and fed, vaccinated me, supplied the occasional antibiotic, filled my teeth (mercury and gold), X-rayed me and reassured me, trained me for my lifelong profession, brought my son into the world and saved his life, sorted out my wife's pain, embraced my father and father-in-law as they both slipped comfortably to the grave, and now turns its attention back to me as my family history looms in view. Thank you.

Only doctors born in the early 1920s will now remember practising in Britain before the inception of the NHS in 1948.

My professional career in primary care has enjoyed a halcyon time, largely able to consider patient care in an atmosphere unclouded by constraints of cost and the patient's ability to pay.

True, the occasional momentary dryness of mouth when I stand, goserelin poised, reminds me that all this of course has to be paid for somewhere, but this is not a conflicting consideration at the immediate coal face of patient care.

Our regulatory authorities underpin these privileges, guiding us to make patient care our first concern — and never to abuse the trust that our patients place in us.

So, all is well ...

Meanwhile, in other spheres a very chill wind has recently blown through our financial world. As we try to understand and react appropriately to this new threat we struggle with the need to apportion blame — on the banking sector and its pursuit of bonus culture at the expense of fiscal prudence, on the apparent rewarding of failure, and on ineffective regulatory bodies. The love of money fuelling unethical behaviour? Never to trust again?

The Quality and Outcomes Framework (QOF) was introduced to British general practice in 2004 rewarding us for implementing good practice and paying us a bonus dependent on achievement.

In the beginning QOF was embraced by the majority of practices across the

country — the criteria were achievable and financial rewards were significant. There was ethical comfort to be taken from a countrywide raising of the standard of patient care in many clinical areas.

However, subsequent years have become concerning with year on year tinkering. New QOF domains have been introduced and criteria tightened, no doubt with the aim of improving patient care, but with the accompanying effect of making targets, and their linked financial bonus, more difficult to achieve.

Further, year on year, new GPs are inducted into this bonus culture and will know nothing else. Will I, as my life comes to a close, be able to exercise choice and place my trust in a practitioner who remembers patient care before QOF?

As chronic illness overtakes me, and were I to have the opportunity, what would be in my Charter for Patient Care?

PATIENT CARE

1. The clinical care given to me will enable me to trust the giver's altruism and enable me to rest safe in the knowledge that it is based on clinical need rather than the pursuit of a financial bonus. While I respect and understand the intelligence underpinning QOF, I would hope that it is always applied with wisdom, and with regard to my humanity.
2. I expect the care that I may receive to be given patiently. After my coronary I would expect to be allowed to introduce my raft of therapeutics gradually, building up a knowledge of their effects and side effects. Should I fail to meet my targets in cholesterol and HbA1c I do not want to be regarded as 'sub-prime'. The care will also be based upon longstanding continuity, with the same physician if possible. The safety net of care will remain patiently in place from year to year, until I need it when I fall.
3. I will not be inclined to diminish the care I give as a patient. I am buoyed up daily

in practice by a shared understanding from my patients. They understand when we come to the ethical dilemma, the uncertainty of the diagnosis or the prescribing of time, or more bluntly, when therapeutic options have been exhausted. This understanding cares for me as the physician, and is based on mutual respect and trust.

4. My cares as a patient will be acknowledged and addressed.

I will know that my physician will have no conflict of interest in acting as my advocate. Money will not get in the way. I will be able to continue trusting.

I expect QOF has achieved an improvement in patient care, and no doubt outcomes, across a range of chronic disease illness nationwide. I suppose the main focus of my concern is where we go from here. I would urge caution in tipping the delicate balance too far in favour of a bonus culture. I hope our regulators will share this view in theory and action, but above all, I hope the prime directive imbued in future generations of doctors will be the ethos of altruistic patient care, untarnished by a toxic bonus culture.

We can always learn much about professional medical practice from the worlds around us — whether the currency under consideration is fiscal, or the harder to quantify world of caring. Let us pay heed then to the experiences of our colleagues in the financial sector and their experience of the primal human response when trust is lost.

In this climate, can we afford not to?

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'Just a furious, helpless roar'

'Shame on this country! Shame on England!' Thus novelist Hilary Mantel concludes a reflection on the case of Baby Peter, the focus of a national furore over child protection services in Haringey, in the light of her personal experiences as a trainee social worker in Stockport more than 30 years ago.¹ Mantel echoes what she describes as 'just a furious, helpless roar' that issued from the mouth of a woman, 'young, blonde, bawling', captured in a television news report of one of the protests demanding punitive measures against the social workers and doctors who were blamed for failing to prevent this child being tortured and killed.

Mantel describes herself as the sort of 'more thoughtful person' who 'doesn't usually agree with the things the spontaneous shout in the street', and still less with 'the vengeful vox pop outside courtrooms'. But in this case the literary snob feels drawn towards the common mob and patrician condescension gives way to endorsement of the anti-professional prejudices fomented by the tabloid press. 'Maybe it's time to stop being sentimental about the family', she concludes, implicitly endorsing the consensus that it is time for a more intrusive and coercive official policy towards the families of the inner city poor.

In the same week that Mantel's cry of national shame was heard in London, the report of the Ryan commission into the physical and sexual abuse of children in institutions² run by religious orders in Ireland provoked strikingly similar responses from both public and private figures who expressed their shame at being Irish and at being Catholic.³ In both Britain and Ireland the intensity of moral outrage over child abuse reflects the bad faith of societies that in the past denied the reality of abuse and are now inclined to see it everywhere.

Although the findings of the Ryan commission were widely received as shocking revelations, in substance the report contained little that was not already widely known. The conditions in the residential 'industrial schools' for the children of the poor had been exposed by a long line of whistleblowers going back to the 1940s.⁴ Yet the system continued, protected by the power of the state and the church and public denial. The Irish journalist John Waters notes the 'ritualistic

expressions of shock, horror, disapproval' that recur in response to periodic revelations about institutional abuse.⁵ The intensity of ostentatious outrage 'becomes an almost precise replication of the earlier denial'. As he recognises, 'it is not that the scales have been lifted from the eyes of society, but that, as a result of the easing, by the passing of time, of collective guilt and powerlessness, a new generation feels able to ventilate and excoriate the sins of its predecessors.' Waters warns against a 'dangerous condescension to the past', and of the complacent contrast between contemporary enlightenment and the barbarous dark ages of mid-20th century Ireland. He detects in modern Ireland's 'unlimited appetite for past obscenities' a worrying indifference to evils in our midst today.

Detailed accounts of the abuse in the industrial schools now provide a sort of pornography for Ireland's chattering classes in a way similar to the Baby P case in Britain. A voyeuristic preoccupation with clerical abuse coexists with a pusillanimous reluctance to take any action to limit clerical influence in education and social welfare.

In Britain, Mantel's self-indulgent outburst is linked to an endorsement of the sort of authoritarian child protection policies that will result in more children being taken into institutional care. History, in Britain as well as in Ireland, suggests that this is unlikely to guarantee their welfare (and it will not stop some parents from killing their children).

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