John Holden considers a pre-eminent issue for Christians

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THE VULNERABLE: their quality of care

key points

Care for the vulnerable dominates medicine, both clinically and ethically, and Jesus endorsed Old Testament obligations.

In contemporary Britain, vulnerability extends beyond poverty and it is a lack of strong relationships with reliable people which makes many especially vulnerable, particularly when they have to turn to the NHS for help.

The author makes practical suggestions for serving the vulnerable in personal and spiritual ways, and concludes that care for the vulnerable is a God-ordained task, in work and beyond work.

I have worked for 25 years as an NHS GP in the north west of England. Care for the vulnerable is the main purpose of my job, and the direct or indirect professional concern for most of us each day. Aspects of vulnerability are also the main ethical issues we encounter most often in our work.

The Old Testament Law and Prophets had a great concern for the poor. For example: 'Do not take advantage of a hired man who is poor and needy'.[1] Isaiah urges God's people to practise true fasting, such as setting the oppressed free and 'not to turn away from your own flesh and blood'.[2]

Ezekiel has this interesting comment: 'Now this was the sin of your sister Sodom. She and her daughters were arrogant, overfed and unconcerned: they did not help the poor and needy.'[3] Micah 6:8 tells us: 'He has showed you, O man, what is good. And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God.'

This teaching was wholeheartedly endorsed by Jesus, who characterised his mission as being to preach good news to the poor.[4] And the care of needy widows was an early church priority,[5] led by those especially 'full of the Spirit and wisdom'. Biblical teaching implies, and instructs us, that our care for others is the expected way of thanking God for our salvation.

The vulnerable: who are they?

Christians have always been concerned for the poor and victims of injustice. In Britain today a simple lack of money seldom causes hunger or ill-health, so viewing poverty merely in material terms misses the point. *Vulnerability* is a far better word to use. Although people who are materially poor are vulnerable; most of the vulnerable people I meet are not materially poor.

For many, it is a lack of strong relationships with reliable people rather than material poverty which makes them especially vulnerable. This is often clearest when illness removes independence and patients have to turn to the NHS for help. Indeed vulnerability and powerlessness sum up the state of the sick people most dependent upon us.

The vulnerable: what should our attitude be?

Jesus' expression of thanks to his disciples at the end of his life, 'You are those who have stood by me in my trials' strikes me forcefully.[6] So often our greatest need is for people to stand by us, especially when the pain will not go, the vomiting will not stop, the depression will not lift, and fear is still gnawing. I particularly find this quote, from a retired doctor about the care of his terminally ill wife, a helpful summary: 'The essential concept is that the doctor (or at least the practice) will stay firmly with the patient and relative at their time of need and not desert them'.[7]

For most *Triple Helix* readers the vulnerable are right here with us each day in our surgeries, clinics and wards. The issue is 'how can we care for these people as well as possible'? Unfortunately we cannot assume NHS care of patients is universally good, since a series of scandals has shown the opposite. NHS care, as known to me, ranges from excellent through mediocre to dangerous, and I have reported care that I and others consider dangerous, as the General Medical Council's *Good Medical Practice* requires us to do.

The vulnerable: how can we best serve them practically?

We would give Jesus excellent care if he were our actual patient, so the question is 'how can we deliver excellent care to the vulnerable people we serve?' Often this will be through the best achievable technical care, which evidence based medicine has helped us to understand better.

In general practice the Quality and Outcomes Framework, 'QOF', has delivered unprecedented high levels of chronic disease management.[8] Indeed this quantum leap forward has been directly observable, a rare phenomenon when advances are usually slow and piecemeal. In hospital too, the two week cancer targets and 18-week referral to treatment goals have, at least from the outside, transformed performance.

But we will also want to give excellent non-technical care too, which may be less obvious but is an equal challenge. Since starting a new practice in 2004 we have sought to create systems that serve vulnerable patients in particular. We started by trying to be very efficient, stripping out unnecessary tasks whenever possible so that the pace of work never becomes frenetic, which inevitably damages staff and patients if sustained for long. Here are some examples.

- **Access**. Impersonal telephone systems can be hard for the vulnerable to navigate. Many NHS phone numbers are not answered directly, and people who are unfamiliar with appointment systems become confused and just give up, later entering 'did not attend' statistics. A local mental health service requires patients to complete a questionnaire before even giving them an appointment, a gross example of discrimination against those most in need of the service.
- **Personal care**. It is heart-warming to observe staff knowing patients and their needs personally and individually. This is a true mark of quality and one that is easily taken for granted. The combination of friendliness and taking people seriously is enormously therapeutic in itself.

  When we started our practice I was prayed for in church. A few days later the impersonal patient-call system was not working! Ever since we have called patients from the waiting area individually and by name, something that is appreciated enormously more than the effort it requires.

  My experience of well over 100,000 consultations leads me to suspect most people are hardly ever taken seriously. The case then for 15 minute, rather than 10 minute, appointments in general practice is almost unanswerable and increasing numbers of practices are now offering this. Once achieved it quickly becomes a necessity.

  Vulnerable patients, such as those with a psychosis, need people whom they can know and trust and who know their values. Indeed the rapport that can develop with many psychotic patients has been a particular source of professional satisfaction for me.
- **Planned care**. For the most vulnerable, screening and monitoring of chronic disease needs to be largely opportunistic. Skill is needed to meet patients' wishes while ensuring safe and effective delivery of the good therapeutics which can significantly improve their symptoms. In my view many QOF targets *are* worthwhile just as long as they are not seen as an end in themselves.
- **Spiritual care**. Christians should not be dazzled by a reductionist, solely biophysical model of health. While we are not nihilistic we also see that death is natural and usually not a failure. Indeed people become tired at the end of their lives and it requires considerable experience and wisdom to realise someone is terminally ill, the final state of vulnerability.

Values and preferences

Vulnerable people are less able to articulate their values and preferences but are certainly not, in my experience, averse to risk. Indeed they may be particularly sceptical of screening and other aspects of my agenda, and sometimes able to reject sharply what is offered. I recall one elderly man with advanced COPD telling me, with humour, 'The difference between you and me is this Doc: you want me to go on and on, and I don't!'

Values are a central part of spiritual care, and these may clash sharply with our own. It is tough to 'stand by' people whom we can see destroying themselves by substance misuse.

Conclusion

Vulnerability affects us all. We start life as vulnerable children, and usually end our lives in vulnerable old age, once again dependent on others for our welfare. Abortion and euthanasia are important not least because they affect the vulnerable unborn, vulnerable parents, vulnerable terminally ill people, and vulnerable families.

But care for the vulnerable is seldom one-way. We are told that God has chosen the poor in the eyes of the world to be rich in faith.[9] Their care for other vulnerable people warms and challenges my heart, I trust making me less self-satisfied than I otherwise would have been. And of course care for the vulnerable extends beyond our work, and almost all of us will have vulnerable relatives, friends, neighbours to care for in complementary ways. Care for the vulnerable is a God-ordained task, in work and beyond work.

Yet this is not a detailed argument about why vulnerability should be pre-eminent. It is merely an invitation to consider it, and if it resonates with your understanding of what Jesus' invitation to follow him means, then be encouraged in all you do for the vulnerable, and ask how we can all do this better.

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references

1 Deuteronomy 24:14
2 Isaiah 58:7
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4 Luke 4:18
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6 Luke 22:28
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8 Doran T *et al*. Pay-for-Performance Programs in Family Practices in the United Kingdom. *NEJM* 2006;355:375-384
9 James 2:5