Just stick to the facts:

remember Goodhart's law

BALANCING PROACTIVE AND REACTIVE CARE

Doctor Bell fell down the well
And broke his collar bone
Doctors should attend the sick
And leave the well alone.

Accusations that GPs are responsible for increased accident and emergency (A&E) attendances and slow cancer referrals prompted me to look back to an article that I co-wrote in 1995 outlining the lack of evidence for policies that affect daily practice.[1] In 2008 Iona Heath[2] described similar issues, stimulating comparisons with Goodhart's law, *'when a measure becomes a target it fails to be a good measure'*.

The 1990 contract was imposed using free market principles. Academics with a dream of sustained perfect health colluded with government free-market ideology. Health became a commodity. Your GP would satisfy your greed for health.

Science then and now, prophesied an undeliverable outcome. The greatest determinants of health are genetics, poverty, inequality, and education, controlled by governments not GPs.

Struggling to balance reactive care with target-driven proactive care we warned of dangers to come. We described *'moving away from listening and responding to talking and telling'*.[1] Seeing all patients the same day, inappropriate consultations were an education opportunity. In others, the opportunity to instantly address a long-standing but hidden problem was seized. After 1990, unsolicited judgement on smoking and lifestyle invaded the patient agenda prompting guilt about illness and risking further concealment. Computer-prompted inquiries now compete with complex cases and careful, patient, and thorough practitioners have poor timekeeping electronically audited and their style criticised.

General practice is part of the 'social capital' of a rural community; A&E attendances can result in a 30-mile round trip. When well-funded and expensive outreach services found 2 hours travel to see one patient unjustifiable we filled the gap while struggling with a contract that stretched our resources with useless or even harmful tasks.

> *"... just because science doesn't know everything doesn't mean you can fill in the gaps with whatever fairy tale most appeals to you."*

HOW WE LIVE, OR WHEN WE DIE?

Our article quoted Bacon (1561–1626) who said *'we cannot command nature except by obeying her'*.[3] We persist in trying to order nature around, without acknowledging how science demonstrates a lack of evidence for well-man checks and a reduced effectiveness of unsolicited advice. A 'utopian' vision of computers removing the drudgery from doctoring is demonstrably a delusion. Failure of algorithms to reliably detect cancer underlines the absurdity of such a simplistic approach.[4] What we did not predict was how the system's GP servants rather than its creators would be blamed.

Has this effort really made health better? Few population-based interventions improve all-cause mortality. Proponents expediently ignore the inconvenience of attending, and the emotional and physical risks of a positive screening test; over-diagnosis and treatments cause harm.[5] In 1988, breast screening was promoted as a woman's responsibility not a choice. Not until 2013 did invitation to participate include the negative effects of overdiagnosis. Targets based on surrogate outcomes and relative not absolute risks are at best futile and at worst harmful.[6] Doctors like targets because they are rewarded financially, or they prefer control, pursuing a more comfortable and controlled passage through a more simplistic consultation. Increasingly large practices field anonymous teams achieving targets but with inevitable depersonalisation. Measurable outcomes prevail, often regardless of true benefit.

The rapport between pharmaceutical companies and government was bad enough: Tesco and Virgin, among others, are now mentioned as providers, hardly altruistic partners. Skrabanek clearly described the way in which this relationship between private industry and politicians influenced public opinion with wide-ranging and perverse effects on health.[7] GPs and the pharmaceutical industry are paid to achieve target-driven surrogate markers such as HbA1c and cholesterol, ignoring death as an endpoint[8] and using relative not absolute risk.

A federated large practice College policy ignored evidence that small practices could be as good,[9] offered better continuity,[10] are preferred by patients,[11] and may reduce A&E attendances. Academics supported politicians who ignored these facts, and imposed policy. Using a whole nation in an uncontrolled experiment is unethical and expensive. Returning to the motto *Cum Scientia Caritas* (scientific knowledge applied with compassion), would be a good start. Dara Ó Briain says:

'Science knows it doesn't know everything; otherwise, it'd stop. But just because science doesn't know everything doesn't mean you can fill in the gaps with whatever fairy tale most appeals to you.'[12]

APPLY SCIENCE AND SAVE MONEY

Simply crying out for more resources without scientifically reviewing what we currently do is unlikely to be effective and to be delivered in difficult financial times. Science could drive a process that will save money, reduce pointless daily drudgery, and improve morale and public opinion. Morale, now at the lowest level for decades[13] was falling in 1995; what has been done about it?

The Royal College of General Practitioners (RCGP) is the largest college by a considerable margin with 48 000 members. Engaging with members is a challenging and unenviable task on a scale not faced by other colleges. It is not surprising that looking sideways to other specialist colleges who inevitably consider a selected population, and upwards to politicians who crave easily-measured performance targets to headline, is chosen over engagement with members. For the

"Our primary goal should be enabling access to the benefits of good treatments and comforting those who cannot be helped, not worrying the well with no proven benefit."

College, supporting bigger practices makes life easier, but is reducing diversity best for our patients who choose personal care? Could it be the cause of the problem? Instead of ignoring or trying to change us, our representative structures and communication should first change. Small practices struggle through a mass of irrelevant and time-consuming paperwork, using processes and structures that have been designed for larger units. We should have a mature and productive debate about how to include all our members. Flexibility is required; my nearest faculty involves a 4-hour round trip; it is an irrelevance. There is no way that I can engage with my College. Yet in 1995, in our RCGP Occasional Paper,[1] we evaluated the science, predicting what is now happening, and were not listened to.

PATIENT ADVOCATE OR POLITICAL SYCOPHANT?

The relationship between the College and politicians is unsightly and with hindsight probably self-serving. A comfortable relationship is not mandatory. Another national IT development has recently faltered on the basis of confidentiality and informed consent. These issues were raised in 2008.[14,15] Rather than accept these concerns as one side of a reasoned argument, they were dismissed as inaccurate[16] or an abuse of editorial freedom.[17] These projects cost millions of pounds with no discernible outcome. The failure to see both sides of the debate was indefensible, and these sums could have been spent on front-line services.

Our dialogue should include a clear analysis of the evidence from both sides, a proper use of science, and challenge government policy where appropriate. It is immoral to demand more resources when so much is squandered on useless targets and failed capital projects. It is wrong not to enumerate the negative consequences of policy: depersonalisation of care, poorer access to hard-pressed GPs, and the resource and clinical consequences of creating ill-health by screening.

Politicians blame us for this change in focus. Our primary goal should be enabling access to the benefits of good treatments and comforting those who cannot be helped, not worrying the well with no proven benefit. GPs are best employed as patient advocates, using a combination of science and professional judgement on individual cases. It is time we advocated helping patients using science not belief, and encouraged individual beneficence to overcome impersonal algorithms. We should oppose governments promoting populations as recipients of valueless advice or interventions, freeing up our current resource while negotiating for the new assets we need. To realise these aims we too have to change.

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