Trust, performance management and the new GP contract

'Without trust, we cannot stand.[1]*'*

SINCE long before the National Health Service (NHS) was created, medical practice has been based on a relationship of trust between medical practitioners and their patients. Patients have assumed that doctors are their guardians and, in the case of general practitioners (GPs), the agents who guide them to their best advantage through primary care and the hospital systems.

However, this doctor–patient relationship is not the only one that affects public trust in the doctor. For the first 40 years of the NHS, the government trusted the profession to deliver high quality care to the NHS. As Klein has noted,[2] during this period the government focused on funding and expenditure control (maybe too successfully in retrospect) and the profession was assumed to be focusing on the delivery of high quality care. This division of labour was undermined by the combination of a rise in scepticism about the evidence base for medicine, epitomised by Cochrane,[3] and increased political questioning of 'value for money', personified by Thatcher in the 1980s. Mounting distrust between the medical profession and their funders, public and private, was the result.

The impact of the paediatric cardiac surgery enquiry in Bristol, the striking off of gynaecologists Neale and Ledward and the uncovering of the Shipman serial killings appear to have damaged doctor–patient trust less than doctor–funder relationships. The deterioration in the latter is giving rise to a plethora of policies designed to manage the performance of both GPs and consultants, with funders, the NHS or private insurers like BUPA, making large investments in clinical governance, performance management and consumer protection.[4,5]

The effect of acting as 'double agents',[6] on behalf of their patients to obtain the best care available, and on behalf of their funders to secure value for money, creates conflicting demands on doctors. Trained in the Hippocratic tradition of providing what is of benefit (clinically effective) to the patient, doctors are ever more constrained by the purchasers' requirement to be demonstrably cost-effective, ensuring resources produce maximum improvements in population health.[7]

Evidence-based medicine, delivering clinically effective care to patients, is being replaced by a new form of 'EBM' — economics-based medicine, propagated by organisations such as the National Institute of Clinical Excellence (NICE) and monitored by the Commission for Health Audit and Improvement (CHAI).

Such 'guidance' is also being reinforced by changes in the GP contract. Heightened emphasis on performance in primary care is demonstrated by the ten quality indicators, which will have a growing influence on GP practices. The 1990 contract and the introduction of fee-for-service payments for influenza vaccination in 2000, demonstrate how quickly GPs respond to financial inducement. While this incentivisation is a worthy approach, it has its limitations. As the economist Oliver Williamson emphasises, 'all complex contracts are unavoidably incomplete', and they contain inevitable 'gaps, errors and omissions'.[8]

Predictably, incompleteness affects behaviour. While the new GP contract will lead to quality performance changes benefiting the patient, whatever is not incentivised may well be marginalized. Thus, cost-effective interventions may exist, for instance in the areas of pain control, incontinence management, and the care of drug users, but there are no financial incentives for the provision of such services.

Furthermore, what is incentivised may be institutionalised. As the evidence base evolves, it may be necessary to alter the terms of the contract, both contract categories and the content of these categories. Managing the financial and service delivery consequences of such changes will challenge contract negotiators.

The incompleteness of contracts means that trust remains in a position central to the efficient, equitable and humane delivery of primary care. The Oxford English Dictionary defines trust as 'a firm belief in the honesty, justice and strength' of an individual or organisation. The major attribute of trust as a determinant of market exchange in the NHS or elsewhere, is that it is potentially more cost-effective than the alternative, which is explicit, detailed and incomplete contracting that constrains discretion and is expensive to design and implement. Trust saves the patient the cost of appraising alternative service producers in the market, and it saves the healthcare funder the cost of policing practitioners.

Adam Smith, the 18th century founding father of economics, is often depicted as a liberal guru who held the view that economic progress could only be achieved by the exploitation of self-interest (or self-love) and greed in competitive markets. But Smith also emphasised the importance of duty and the legal or moral obligation of traders:

> *'Those general rules of conduct when they are fixed in our mind by habitual reflection, are of great use in correcting the misrepresentations of self-love concerning what is fit and proper to be done in our particular situation ... The regard of those general rules of conduct is what is properly called a sense of duty, a principle of greatest consequence in human life, and the only principle by which the bulk of mankind are capable of directing their actions.*[9]*'*

Most doctor–patient transactions in medicine continue to be based on trust. However, funders, and in particular central government, do not appear to share the patients' optimism about clinical performance. The challenge for medical practitioners is to invest in trust between themselves, their patients

and the funders, in order to moderate the growth of well-intentioned, cumbersome, costly and often potentially inefficient performance management. How can this be done?

Although there are general practices with good information systems, all too few are linked regionally and nationally to facilitate comparative performance management by practitioners. Hospital Episode Statistics (HES), which are growing in accuracy, enumerate GP referrals and hospital inpatient processes: these are necessary but not sufficient inputs into management in general practice.

Information about patient events has to be transformed into continuing management of longer-term episodes of patient care. The GP is fundamental to this task as the patient's agent. Further changes in incentives, including the resurrection of budget holding, will also be vital. As shown recently, fund holding had demonstrable benefits in reducing GP referrals to hospitals.[10]

To re-establish and maintain trust in GPs and the whole system of NHS primary care, greater transparency is needed in 'honesty, justice, duty and strength', with acknowledgement of deficiencies in patient care and clear, incentivised policies for remedying them. Without this, performance management will be imposed by funders, and will substantially inflate the transaction costs of primary care. These physicians must heal themselves by investing in improved transparency and accountability with both patients and purchasers. Both the profession and its regulators need to recognise and value the role of trust for them and those in their care. Its further erosion will be to the detriment of the profession and its patients.

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Alcohol and primary care — will an emphasis upon harm reduction engage general practitioners?

ALCOHOL misuse is a major public health concern that has a huge impact on the economy of the United Kingdom, costing the National Health Service up to £3 billion per year.[1] Twenty per cent of patients presenting to primary care are likely to be excessive drinkers, meaning that the average whole-time equivalent general practitioner (GP) is likely to see 364 excessive drinkers a year.[1] Many of these consultations are for the health complications of alcohol overuse, principally gastrointestinal problems, psychiatric problems, or accidents.[1] Recently, the Department of Health completed its consultation on its imminent (at the time of writing) National Alcohol Harm Reduction Strategy. The consultation document made reference to doctors providing 'brief interventions' to those identified as being at risk from alcohol misuse. Certainly, the strategy is the most significant alcohol-related document produced by the government since the Health of the Nation strategy, which aimed to reduce by a third the proportion of the adult population drinking above 'sensible' limits by 2005. General practice is ideally suited to help achieve these targets.[2] However, these targets are not being met, and many GPs are less than comfortable with such expectations.[3] Therefore, if the National Alcohol Harm Reduction Strategy is to have any chance of being effective, both the barriers

and expertise within primary care need to be acknowledged and addressed.

Barriers to effective provision in primary care

GPs have cited a lack of basic training, lack of clear direction and management strategies, lack of support, lack of experience, time constraints, cost, and pessimism at the outcome as their main impeding factors.[2,4] This is despite most GPs having positive attitudes towards prevention and health promotion.[4] If GPs' involvement in this area is to increase, then realistic outcomes relevant to primary care need to be devised, underpinned by training appropriate to the primary care setting. Until recently, GPs have been under-represented at alcohol training programmes.[5] In 2002, the Royal College of General Practitioners sought to address this lack of training by initiating a certificate course in the management of drug dependence, in which training in alcohol misuse interventions was integral to the course. The course provides protected time and resources for GPs wishing to extend their skills to an intermediate level or to the level of a GP with a special interest.

Regarding GPs' pessimism, we contend that general practice will benefit from embracing harm reduction outcomes, as well as focusing upon abstinence.

Management of problematic alcohol use in the primary care setting

In the primary care setting, identification of alcohol dependent patients is best achieved through simple questioning. This is more effective than laboratory tests in identifying alcohol dependence.[6] Arguably, the AUDIT-C questionnaire, by combining reliability and validity with brevity, is the most appropriate screening tool for primary care.[6] However, many GPs question whether alcohol screening in the context of the primary care consultation is time- and cost-effective, and it remains contentious[7,8]; one reason, for example, is that many young drinkers grow out of hazardous drinking, and whole population screening is therefore inappropriate. It would seem more appropriate, therefore, to target screening at practice sub-populations. Such targeting could form part of new patient, 'well woman' and 'well man' clinics. This would consolidate screening and health promotion activity and place it within the remit of the practice nurse. Additionally, it would ease the burden upon GPs, who could then target screening at those with physical problems suggestive of alcohol overuse; for example, persistent dyspepsia, depression, or signs of liver dysfunction.

Following identification, there are various treatment options, depending upon the severity of problematic alcohol use. Brief intervention counselling from their GP is likely to help those who are able to reduce their alcohol intake in a controlled manner. A meta-analysis found that excessive drinkers who received brief intervention therapies were twice as likely to moderate their drinking compared to excessive drinkers who did not receive any intervention.[9] It is still uncommon for GPs to carry out brief intervention, despite the evidence base for its efficacy and the fact that it is well received by patients.[10]

For patients with a more severe alcohol dependence problem, detoxification is the most appropriate option. Traditionally, alcohol detoxification has taken place in an inpatient setting. However, in recent years there has been a shift to detoxifying patients at home. Home detoxification in primary care, supplemented by counselling, support, and drugs to prevent relapse where appropriate, is clinically safe and cost-effective for most problem drinkers.[11] The Department of Health has described the following as necessary criteria prior to home detoxification: no history of fits or delirium tremens, no risk of suicide, the presence of social support, no significant polydrug misuse, and no dependence on benzodiazepines. We would add to this: no evidence of jaundice or severe liver failure that has an associated risk of alcohol-related hepatic encephalopathy.[12]

Detoxification needs to be followed by interventions to prevent relapse. Alcohol deterrents have been used for many years.[13] Acamprosate is a recent addition to the relapse prevention therapies, and it has been shown to have positive effects on reducing drinking frequency, with some evidence of enhancing abstinence.[13] Although not licensed, naltrexone has been used to prevent relapse. In a study setting it did not delay return to drinking or to heavy drinking; however, compared to a placebo, it reduced the amount that was drunk in the last month of the study and reduced cravings for alcohol.[14]

Disulfiram (Antabuse) reduces the number of drinking days and the mean weekly consumption of alcohol.[15] Therefore, by implication, GPs who have received training and are competent in the primary care management of alcohol dependence could have success with disulfiram as an intervention to reduce harm, rather than solely as a treatment to achieve lifelong abstinence. The National Treatment Agency for Substance Use has recently produced outcomes that are applicable to alcohol dependence. These include: reduced use, improvement in physical and psychological health, fewer working days missed, and improved family relationships.[16] These important outcomes can help minimise GPs' sense of pessimism and failure when a patient relapses and does not meet a 'cessation of use' outcome. However, owing to its mode of action in causing an unpleasant alcohol–disulfiram reaction if alcohol is consumed while taking the drug, the British National Formulary suggests that disulfiram should only be used 'as an adjunct in the treatment of alcohol dependence under specialist supervision'. This places a responsibility upon both primary care and specialist services (including those provided by GPs with a special interest) to work collaboratively in shared care arrangements. We would recommend that specialist services establish self-referral 'drop-in' relapse prevention clinics where rapid access can be granted to a patient wishing to start disulfiram. Once the drug has been safely initiated, it could be continued in primary care under a shared care arrangement. For those GPs with a special interest who have the skills to initiate this treatment in primary care, they would be aided by improved tests to exclude the presence of alcohol prior to commencing disulfiram treatment. These tests include alcometers and spot urine tests, which have a high degree of sensitivity and specificity. Additionally, the patient could

be encouraged to take the medication as part of 'directly observed therapy', with the help of a friend or relative, to achieve optimal compliance.

Such models of primary care provision show considerable progression from the 1950s, when disulfiram was prescribed in secondary care settings as an aversion conditioning therapy. In such a setting, the patient was forced to drink alcohol after taking the drug.[17] By experiencing an alcohol–Antabuse reaction, the therapeutic hope was that the patient would be loath to consume alcohol again. However, there is now an understanding that fostering a patient's motivation, rather than coercion, leads to greater therapeutic gain.[18]

In summary, the pessimism and sense of failure experienced by GPs when their alcohol dependent patients fail to achieve lifelong abstinence are significant demotivating factors. We welcome a renewed emphasis upon harm reduction outcomes that are achievable in primary care. Much of modern primary care involves secondary and tertiary prevention of common chronic illnesses that have a pattern of relapse and remission. Adopting this model for alcohol dependence within both harm reduction and abstinence frameworks, according to clinical need, will, we hope, increase the motivation of GPs to work with this patient group.

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