

Letters

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Mangin on QOF

I am no great lover of the Quality and Outcomes Framework (QOF) introduced to general practice for payment from the NHS. However I believe that the thrust of Mangin and Toop's editorial¹ in the June 2007 issue is wrong. I can see how the QOF may appear to some to lead British GPs to coerce patients into accepting care that they do not want, but I do not believe that this is inevitable.

I dispute 'the message that QOF priorities are the most important aspects of care.' What happened with the introduction of QOF is that the delivery of chronic care clinics by nurses has been accelerated, probably because it is perceived as a cheaper option. Unfortunately, nurses are good at following protocols and less good at asking difficult questions of the evidence behind them. This is the trend that I believe leads to uninformed treatment, but it is not due to QOF — it was already happening as the preferred method of delivering chronic disease management in primary care. The effect is that I am less likely to manage life-shortening chronic conditions such as atherosclerosis. Paradoxically, QOF has in some ways reduced the importance of these conditions.

Looking at my working week as a part-time GP, less than 6% of my face-to-face time is spent with the main purpose of delivering care for QOF-related conditions, mainly epilepsy and COPD.

The introduction of QOF has provided software that reminds me when the patient in front of me has important medical conditions which may benefit from being addressed. I can do this after the problems my patient brings to the consultation. We can have an informed discussion together considering the QOF reminders, my clinical knowledge of the evidence, and the patient's viewpoint. Informed dissent is the

opposite of treatment and is built into the contract. Without informed dissent the QOF would have the intention of coercion. What the contract actually does is to reward informed discussion. This counteracts the chronic care delivery in nurse-led clinics.

The QOF merely provides a framework for doctors to manage disease. It is the doctor's own professional values and interpretation of the evidence which determines how that framework is shared with patients and the joint decisions applied.

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Reading Mangin and Toop's¹ editorial one would get the impression that the QOF only means doom and gloom. No positive effect is mentioned and the 'unwanted influence of the state' seems near. They suggest a professional education system with the aim to improve the quality of care.

This seems a very one-sided view. Is everything regarding QOF so bad? Reading June's *BJGP* provides a more balanced impression. At least two articles provide a positive effect of QOF: Steel *et al.*,² show the substantial quality improvement for incentivised conditions. Tahrani *et al.*,³ saw significant improvement in diabetes quality indicators recording. Obviously these studies have their limitations, yet at the very least these effects should not go unmentioned.

However, Mangin and Toop¹ do not seem to look at these studies. Nor do they offer suggestions about how QOF could be improved, for example by more input from the Royal College of General Practitioners' (RCGP) regarding the evidence base of the

indicators and which conditions should be covered. Instead, Mangin and Toop advocate an alternative: a professional education system, which uses evidence and feedback, guidance, and options for GPs and patients to interpret themselves. This sounds like an appealing option yet what will their system bring? Grol provides a good overview regarding which interventions lead to improved medical care.⁴ This research indicates that a focus on education alone is seldom effective and, as such, Mangin and Toop's suggestion may not deliver. Combined and multi-faceted interventions are recommended and a combination of QOF with an educational system would have more chance of success. For example, one could add a system like Quality Team Development which would help to grasp the intangible aspects of care.⁵

Abandoning QOF completely, however, and going back to just education systems does not seem the way forward.

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Mangin and Toop¹ provide an interesting overview of QOF, reflecting the many useful

papers on aspects of QOF in the June issue of *BJGP*. Their criticisms of QOF make sense from a deontological (duty based) ethical perspective. It is far from clear that medicine is a deontological enterprise any longer.

There is a strong utilitarian perspective on QOF that sees the greatest good of the greatest number of patients as being a worthwhile objective. If this good can be measured then so much the better. (The *felicitific calculus* is achieved.) Outcome measures would be ideal but intermediate process measures will do well enough. 'Scientific' measurements have apparently been made, and managers have 'accurate' spreadsheets and reports. Politicians can show that their targets have been met and that their 'investment' has 'performed' well. Individual GPs can play along with this game and reap the profits from it. So too can pharmaceutical companies, as under-treated illnesses and risk factors are systematically discovered and treated. It can all be justified as there is no shortage of under-treated disease and the rule of halves is so obviously a challenge that needs to be tackled.

General practice to this view is 'Applied Public Health', and the quirkiness of individual doctor-patient interactions is all very well, but ultimately stopping patients from smoking, and getting their cholesterol, blood pressure, and glucose levels normal is more important than the messy details of patient's lives. The patient becomes a means to a public-health goal, not an autonomous individual with their own specific goals. The doctor loses autonomy, and has to document deviance from guidance, rather than being trusted to do what is right in a given situation. Tallis describes this as 'sessional functionaries robotically following guidelines.'

This utilitarian imperative is in alignment with public health and political imperatives but is directly at odds with a model of medicine based on individual doctors and patients reaching shared understanding of life, events, times, and illness.² The ideals of patient-centred care, good consultation skills, respect for patient autonomy, the patient as an end in themselves, the doctor as a responsible agent, are all lost to this utilitarian mission. Much of the best general practice work of the last 30 years is

rendered impotent under the new contract.^{3,4}

The new contract is a reflection of the democratic deficit and the loss of trust in British medicine. Instead of trusting professionals to do their jobs properly we have now lost toleration for error, and instead we are subjected to the external tyrannies of measurement and regulation.

Goodhart's Law is in full flow. In time the measures used for QOF will cease to measure anything. However, for now the utilitarians are in the ascendant, and as a GP I will use my QOF score to get through appraisals and revalidation, and to earn some money. It is quite clear that I will get next to no credit or recognition for doing real general practice well.

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The editorial by Mangin and Toop,¹ describes how the QOF has made British GPs into government data collectors and agents of pharmaceutical companies. QOF does not measure our clinical skills or kindness: there are no points for recognising rare diseases at an early stage or in giving sympathy. In medicine, despite all our cleverest scientific advances, all we can do is to influence the process, not the eventual outcome of life, which has an inevitable 100% mortality. A significant part of our role must be to help our patients live their lives to the full. Instead we have made many obsessed with numbers, which they have come to regard as the keys to happiness and eternal life, not realising that what we measure are merely fluctuating bio-statistics. To retain the enormous confidence invested in us by our patients, it is imperative that we keep our critical and clinical skills, honed by our professional training, and use them to the benefit of our patients to provide the best advice and

medical care we can in the interest of their individual wellbeing. This surely is the real value of general practice and the art of being a healer.

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Confidentiality on ward rounds

I have a little anecdote relating to 'Confidentiality in the Waiting Room' by Scott, *et al.*¹ I myself call patients into my consulting room using first and last names. The person who responds is not always who I called, so I often ask them to confirm their address or DOB once they are in. While this is not very confidential, I am not aware of any specific complaints from the patients as yet, and I know of no better way to get them in at the right time, apart from 'Next please', and then having to ask them who they are.

However, I remember a ward round in a certain hospital once, where the usual entourage started the round at bed one: consultant, junior doctors (two), myself the student, ward sister and two nurses. The patients were all lying tidily in or on their beds in regimented readiness. One of the patients in the first bay was unable to walk, due to having a 'drip', and therefore having been tied down, but by the time we got to the fourth bed in the second bay, the 'entourage' had been augmented by the first six mobile patients. As we left the bay and moved towards the double doors that separated the men from the female end of the ward, all six dutifully returned to their own beds, and the two male nurses went to attend to the bedridden patient.

The same happened in the female ward, except that the only males present were the medical staff, of course.

I suppose it was not terribly good for confidentiality, but it did mean that the other patients on the ward knew exactly what was wrong with their neighbours, (due to various nationalities of the staff, the