Letters

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QOF

In the June editorial 'The Quality and Outcomes Framework (QOF): what have you done to yourselves?',[1] the authors don't — in my opinion — seem to be reflecting professionalism or general practice as I see it being practised in the UK. They seem to ignore the history of the NHS and where these reforms fit in.

First the history — QOF is the son of banding. Government 'interference' with health in the UK started, in my memory in the early 1980s, with the introduction of the 'blacklist'. The government, quite radically, stopped GPs prescribing certain medication — including the idea of stopping doctors prescribing diazepam by its trade name! Uproar ensued — the doctor–patient relationship was threatened. Then came the 1990 contract, which was profoundly shocking. Major changes were the introduction of health clinics (the kick-start of increasing practice nurse involvement in primary care) but more shocking still was the introduction of targets for smears and immunisations. It seemed so unprofessional, yet targets undoubtedly worked, and within a few years much higher coverage was attained. However, when left to doctors' professionalism, rates had been low. Money is a driver for change — and the self-employed status for GPs is key to this. 'Banding' was a system of collecting data on smoking, weight and blood pressure, introduced to replace clinics a few years later, partly because a significant number of GPs were manipulating the clinic system to increase their earnings significantly. So QOF is not a new idea but a development over the last 15 years — a period representing 25% of the entire NHS history.

While the authors criticise QOF targets, they do not identify one that has no basis in evidence, or one that is wrong to be attempting. If QOF is evidence based and focuses on basic standards of practice (which in the main it does), then two things follow: that the profession should generally succeed in achieving high points, and that the profession should accept it. It is worth remembering that most of what is involved in QOF is delegated to nurses and practice staff — what happens in the consulting room is very little different to what has happened over the past 20 years (at least in mine!).

Professionalism in is described in pink and fluffy terms in the quote from Downie used in the editorial.[2] Professions usually came into existence to protect their members, not the people they serve. Professionals are people who have special knowledge that they often try to prevent others obtaining. Our professional bodies (such as the BMA and RCGP) spend much time and energy in promoting the status (and pay) of doctors. The RCGP has remained doctor centred rather than developing a lead role in primary care in its totality.

I suspect that the qualities described by Downie (interest in education, self-development, integrity, and beneficence) are not organisational or group based, but rather individual attributes — attributes maybe more associated with class and culture than an organisation. The Harold Shipman case is probably best seen as a tip-of-an-iceberg phenomenon. The failure of the GMC in its professional self-regulation role further underlines the need for external regulation. Doctors are none other than ordinary human beings with all the weaknesses that go with that.

Finally, health is a social construct. Difficult to see when faced with a collapsed patient but totally clear when faced with mental illness. I believe that the correct body to have a major say in what health is, what the priorities should be, and how tax payers' money should be spent, is the democratically-elected government, not a group of doctors. We may not like it, or agree totally with the direction, but it is surely inherently unsafe to allow doctors to decide!

We need to drop the humbug and live in the real world!

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REFERENCE

1. Mangin D, Toop L. The Quality and Outcomes Framework: what have you done to yourselves? *Br J Gen Pract* 2007; **57(539):** 435–437.
2. Downie R. Professions and professionalism. *J Philos Educ* 1990; **24(2):** 147–159.

Corrections

In the letter 'Developing primary care treatment of depression'. *Br J Gen Pract* 2007; **57(539):** 501–502, the author's name was misspelt, it is in fact Mark Agius. In the paper 'A case-control study of presentations in general practice before diagnosis of coeliac disease' *Br J Gen Pract* 2007; **57(541):** 636–642, there is an error in the conclusion of the Abstract. The first line should have been deleted as it is repeated at the end of the paragraph. It should read: 'GPs should consider testing for coeliac disease when patients present often, especially when diarrhoea and/or who are discovered to be anaemic. Further research is required to clarify the role of depression and/or anxiety in the diagnosis of coeliac disease'.

The corrected versions are available at: http://www.rcgp.org.uk/bjgp