can also do harm.

However, it is the statement that 'Not to have incentivised GPs to identify a group of people who were more at risk clinically ... would have been negligent' that is truly outrageous. Here there are QOF points for applying a universal method that also has substantial error rates, with the possibility again that this will lead to over and under identification. Dr Cohen here has subscribed to the suggestion both damaging and now proved to be erroneous, that GPs will only take action that is financially rewarded. If the lie were correct, then what is the implication for all those other patients with long-term disabling conditions, also at higher risk of depression? Or is he suggesting that this QOF provision should be extended to all patients? In which case it would become, effectively, a screening programme for which, again as Toop points out, there is no convincing evidence.²

The QOF approach began as a limited set of targets to encourage more universal application of a number of measures that were backed by sound evidence and generally accepted as both achievable and beneficial. It has gradually expanded to incorporate more dubious measures that command less acceptance, and looks more and more like a set of hoops to make recalcitrant GPs work harder with little extra gain for patients. Meanwhile, the clamour from numerous lobby groups for inclusion of their pet measures in the QOF continues to grow. Not only de-professionalising, but very depressing and sadly, all too predictable.

David Jewell,

20 Duchess Road, Bristol, BS8 2LA.

E-mail: david.jewell66@gmail.com

REFERENCES

1. Cohen A. The QOF, NICE and depression. *Br J Gen Pract* 2011; **61(590)**: 549.
2. Toop L. The QOF, NICE and depression: a clumsy mechanism that undermines clinical judgement. *Br J Gen Pract* 2011; **61(588)**: 432–433.

DOI: 10.3399/bjgp11X612990

Primary care electronic health records: who is in control?

As a late adopter of electronic health

records, apart from repeat prescribing, I was reluctant to leave my efficient paper practice notes that I controlled and wrote my patient's narrative. It is now routine to record such contacts on the computer record but my eyes rarely lift from the keyboard. At the same time part of my mind is involved with the software set-tasks, often government driven, that need to be slavishly tackled in order to gain essential payment. I warned my past colleagues that this was the electronic hamster wheel of the medical primary care workload and they have nearly all retired early. I am still at the primary care coalface but this is due in part in trying to wrest some personal control of this electronic record in order to aid my patient care.

Here I refer to the recommendation to use clinical indications on all repeat prescriptions, which is an excellent use of the repeat prescription electronic process, described in detail on my website.¹ The latest draft of the GMC guidelines on good prescribing recommends that all doctors should consider including such a process in their prescribing.² Smoking recording is another area that has needed revisiting and my smoking pack year calculator³ provides a smoking exposure dose on those 'ever smokers' so that smoking is searchable and potentially predictive. In addition I have developed some paediatric drug dosage calculators to aid my busy everyday work. These self-created additions have given me the much needed personal 'locus of control' of the electronic health record, but will scream in the face of industry standard setting and may make it impossible to transfer my detailed data reliably from GP system to system. Still I cherish my patient's records in our small practice and a recent letter from a young consultant vascular surgeon unprompted said it all ... 'The computerised notes summary in your surgery is extremely impressive'.

Nigel Masters,

GP, Highfield Surgery, Highfield Way, Hazlemere, Buckinghamshire, HP15 7UW.

E-mail: nigel.masters@nhs.net

REFERENCES

1. Masters N. Learn about clinical indications. [www.http://clinicalindications.com/about/](http://clinicalindications.com/about/) (accessed 8 Nov 2011).
2. General Medical Council. *Good practice in prescribing and managing medicines and devices consultation document on prescribing for doctors June 2010*. London: GMC, 2010.
3. Masters N, Tutt C. Smoking pack years. <http://www.smokingpackyears.com> (accessed 8 Nov 2011).

DOI: 10.3399/bjgp11X613007

Electronic health records: research into design and implementation

I was surprised that the only systematic review referenced in the editorial on electronic records in your October issue¹ was 10 years old and based on studies of record systems that are long obsolete.² The editorial failed to mention a 2009 systematic review by my own team, that summarised 24 previous systematic reviews on electronic records (including Mitchell and Sullivan's) and that offered a new synthesis of primary literature from the organisation and management literature, including but not limited to actor-network theory approaches.³ The editorial also failed to mention the 2011 'review of reviews' of e-health applications by Ashly Black and colleagues, that summarised 108 previous systematic reviews on electronic records and other information and communication technologies in health care.⁴ While this editorial made some good points and referenced some of the important recent studies and commentaries in this area, it was 'freely submitted, not externally peer reviewed' and illustrates the dangers of such a policy.

Trisha Greenhalgh,

Professor of Primary Health Care and Director, Centre for Primary Care and Public Health, Blizard Institute, Barts and The London School of Medicine and Dentistry, 58 Turner Street, London, E1 2AB. E-mail: p.greenhalgh@qmul.ac.uk

REFERENCES

1. Beasley JW, Holden RJ, Sullivan F. Electronic health records: research into design and implementation. *Br J Gen Pract* 2011; **61(591)**: 604–605.
2. Mitchell E, Sullivan F. A descriptive feast but an evaluative famine: systematic review of published articles on primary care computing during 1980–1997. *BMJ* 2001; **322(7281)**: 279–282.
3. Greenhalgh T, Potts H, Wong G, *et al*. Tensions and paradoxes in electronic patient record research: a systematic literature review using the meta-narrative method. *Milbank Q* 2009; **87(4)**: 729–788.
4. Black AD, Car J, Pagliari C, *et al*. The impact of eHealth on the quality and safety of health care: a systematic overview. *PLoS Med* 2011; **8(1)**: e1000387.