

Performance management:

can patients' autonomy be protected?

INTRODUCTION

Performance management is one of the government's ways of trying to exert control over the NHS.¹ Accordingly, the Quality and Outcomes Framework (QOF) and referral management were introduced into general practice in 2004 and 2006. GPs have expressed doubts about them and my concerns, as a patient activist, overlap with theirs. I am especially concerned by threats to patients' autonomy. Autonomy — doctors' as well as patients', yours as well as mine — means being free to act without coercion in making decisions according with our own moral values, our interests and our responsibilities to ourselves, to those dependent on us, and to our communities.² Autonomy in making personal decisions within the law is a basic value in Western society; and respect for the autonomy of individual patients is a professional obligation in medicine.³ In accepting the QOF and referral management, GPs relinquished some of their clinical autonomy. In that relinquishing, GPs potentially sacrificed their patients' autonomy: patients' freedom to choose particular courses of action depends largely on their doctor's freedom to offer them unbiased information together with independent advice about what the doctor thinks would be best for them. When GPs accept constraints, patients are constrained. While it can be ethical for one person to give up some of his or her own autonomy, it can be unethical to limit someone else's. Can GPs do anything to protect their patients' autonomy?

THE QUALITY AND OUTCOMES FRAMEWORK

The QOF is intended to bring GP practices up to certain uniform standards of treatment and care by enabling GPs to earn extra money by reaching targets for undertaking specific actions and for giving specific clinical advice to defined populations of patients.⁴ But QOF has three serious defects.

First, using money as an incentive for carrying out specific actions is dubious. Money is so cogent a motivator that it can blunt independent thought and criticism. This is dangerous in a discipline like medicine, based on science and its uncertainties. If GPs are dissatisfied with QOF or feel that their criticisms would be futile or could damage their careers, they

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may adopt a passive approach to it.⁵ As one GP said to me, 'I just get on with the job'. However, given the variability in the quality of general practice, and the difficulties of the Royal College of General Practitioners in inspiring and guiding all GPs, some of whom are not its members, to practice to acceptable standards, incentives of some sort may be necessary. But incentives should avoid provoking the charge 'GPs only do good things for money', sometimes heard from patients.

Second, targets present problems of meaning and metaphor. To earn extra monies, GPs must score successes in securing patients' consent to specific courses of action. To hit the targets, GPs must aim their bows at individual patients. Patients may feel that being a target for their doctor's financial gain is incompatible with the delicacy and intimacy of good clinical relationships. In addition, limiting information about options for treatment will breach the standards in *Good Medical Practice*.⁶

Finally, the ethical step of ensuring that all patients will know about QOF, if and when it becomes relevant to them, has not been taken. During their consultation, the GP is not obliged to tell the patient of any rewards that the practice will receive if the patient is given certain specific advice. That prevents the patient from being aware that their doctor's advice is not necessarily based solely on his or her judgement of the patient's clinical needs and personal preferences. This silence breaches the ethical value of lucidity, patients' right to know all the relevant details of the situation

in which they find themselves.⁷ (Lucidity is American; transparency the less precise UK equivalent). Without that information, patients cannot take into account factors that could affect their decision to accept or reject their doctors' advice. Lack of lucidity undermines shared decision making based on mutual openness and trustfulness. It can vitiate the validity of the patient's consent to a proposed course of action. It can threaten the patient's autonomy so severely that it can constitute coercion.⁸

QOF is not secret and some patients know about it. But they may think that probing would seem a slur on their doctor's professionalism. GPs may believe that they can act without thought for QOF's financial rewards; and this will often be true. But the Department of Health would not waste money on QOF if it did not think it worked. Indeed, GPs' behaviour has changed.¹

To respect patients' autonomy, GPs should tell patients when their clinical actions and advice carries financial reward. Patients' responses would vary:

- they might be reassured that their GP was complying with national standards;
- seek further information from, for example, the internet;
- ask to be referred to a specialist; for example, a cardiologist if statins or medication for controlling hypertension were the subject; or
- simply reject the advice as too biased or as self-serving.

Being open with patients would entail explanation and take time. But it would

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also foster patients' trust in their GP as well as helping both doctor and patient make decisions more autonomously and in a more genuine partnership with each other.

REFERRAL MANAGEMENT

Referral management is also not secret. It is intended to ensure that GPs make appropriate and cost-effective use of limited resources. Like QOF, it has complex ethical and practical implications. In their consultation, the GP and the patient are each free to propose or decline a referral. If they agree to refer, the GP's referral letter to a hospital specialist or other healthcare practitioner goes to a referral management centre where it is forwarded, redirected, or barred.⁹ If the referral is barred, it is by persons unknown to the patient, with no clinical responsibility for him or her. Most, but not all, GPs accept some form of referral management: those who do, relinquish some of their own autonomy and override that of their patients.

The immediate step to be taken with regard to referral management, as with the QOF, is to tell the patient whenever it might affect him or her. If the referral is barred, the patient may protest to the referral centre. If that fails, only expensive, impractical, or inequitable recourses remain. (Pay for a private consultation with a specialist? Change their GP practice? Move to a foreign country where patients can refer themselves to specialists?) So patients can

feel helpless. Under such circumstances, general practice as a safety net for patients can fray.

CONCLUSION

In accepting the QOF and referral management, GPs cooperated well with managers, but at a cost to patients' autonomy. Moreover, in acting against their own ethical values, GPs gave up some of their professional independence from their employers, although that independence is ultimately what makes doctors valuable to society.¹⁰ So what can be done? Could GPs free themselves from the need to augment their incomes through the QOF by becoming salaried like other doctors? Or should they re-negotiate the GP contract? Either way, giving doctors financial incentives to take specific courses of action within their clinical relationships with individual patients should be precluded. Performance management needs to be re-thought and refined, paying careful attention to the interests and values of doctors and of patients and of managers,¹¹ to make it humane and ethical.

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