Editorials

Secrecy and coercion in the QOF:

a scandal averted?

The Quality and Outcomes Framework (QOF) has ended in Scotland and is viewed with disapproval by some GPs in the rest of the UK.[1] This is a good time to look at how it works: does it conform to medical ethics and, in particular, does it ensure that patients' autonomy will be respected, since that is a fundamental principle in medical ethics?[2] We can answer this question by reading the reports of inquiries into two high-profile 'hospital scandals' published shortly before the QOF was introduced into general practice in 2004. Official public inquiries found that the Bristol Royal Infirmary had sought parents' consent to cardiac surgery on their child, without telling them that their surgeons' outcomes were worse than in other hospitals.[3] Doctors had also not told parents that, if they consented to a postmortem, their child's organs might be retained for research, teaching, or audit, rather than being replaced in the child's body. Alder Hey Hospital in Liverpool had also kept this practice secret.[4] The inquiries' reports concluded that parents or patients must be given all the information they need to reach their decisions on consent. Put another way, consent obtained without offering all relevant information is consent obtained coercively, denying patients autonomy.[5] Thus the 'scandals' showed what patients' autonomy meant in practice and why secrecy was unethical. The parents' distress, the public's disquiet, and the doctors' dismay and regret were so manifest that it seemed that such breaches of medical ethics could never occur again. Yet for the QOF, they have.

THE GENESIS OF THE QOF

The QOF is a managerial scheme, not a professional one. Managerialism's doctrines and practices had become influential in the 1980s and 1990s, affecting all public services.[6] The QOF was promoted by government ministers and advisors, civil servants, and top managers: people who believed in economic and population measures, and in using money to motivate doctors to carry out officially prescribed actions.[7] This was alien to doctors' sense of vocation and to their concern for individual patients. So scope for unrecognised conflicts of interests, values, and ethical principles was inherent. The 2003 contract between the Department of Health and GPs that introduced the QOF was negotiated between the British Medical Association (trades union) and the NHS Confederation (managerial organisation) acting on behalf of the government. The Royal College of General Practitioners (professional standards) as a charity took no part in these negotiations. Nor did it consult its patient liaison group whose role was to keep the College aware of patients' perceptions and values (J Dale, personal communication, 2006).

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When the QOF was implemented, it slotted into GPs' customary practice. GPs had been in part paid for work done as items of service. Paying them to take specific courses of clinical action — pay for performance — seemed to many GPs merely an extension of that system, especially as they considered its clinical standards high and consistent with professional values.[8] So presumably GPs saw no need to tell patients about the QOF's financial incentives. But they overlooked the lessons from the scandals, that patients must be given information relevant to their decisions about consent. Sparing patients distress (beneficence); making decisions on their behalf (paternalism); concealing some wider objective, for example collecting organs for study or improving practitioners' competence; protecting reputations or institutions; securing personal gain; or simply saving time and trouble, are invalid as reasons for withholding relevant information. Little could be more relevant than financial incentives.

SECRECY

Information about the QOF is in the public domain, posted on the internet.[9] But patients and the public are not alerted to this resource and so cannot search for this crucial information. GPs' surgeries seldom (if ever) provide leaflets about it. Over the last few years, I've asked many friends, strangers, and fellow patients in hospital clinics if they have heard of the QOF. Few have. All were surprised or dismayed when I then outlined the financial angle. In our conversations, some patients told me about their experiences of the QOF, once they realised that some of their care had probably been affected by it.

Within the GP–patient consultation, reticence had ruled for these patients. 'It was never mentioned' said one patient who knew about from other sources. Most other patients are probably unaware of the QOF and its financial implications. If then they consented to a rewarded clinical action, that consent was obtained coercively, without respect for their autonomy. In addition, when patients were called to the surgery, they could fear that their GP knew something ominous about their health that they did not. (I talked with one patient just after she had received such a letter; she was upset by it.) When they were offered tests or screening, they could suppose that was due to their GPs' professional concern. So secrecy can deceive patients about something as fundamental to medical practice as the doctor–patient relationship.

Among the patients I talked with, those who knew about the QOF, but not which clinical actions it rewarded, felt anguish, anxiety, and distrust. Was their doctor's advice dictated by clinical acumen or by money? Patients who knew which clinical actions were rewarded were in a better but still uncomfortable position. When offered unrewarded advice, they could trust their doctor's motives; but unease could remain. If they knew that rewarded

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advice applied to populations of patients and did not necessarily fit their own clinical circumstances, they could reject it. Or they could reject rewarded advice as an act of resistance to the QOF itself and its introduction of financial incentives into GPs' clinical relationships with their patients. Refusing to have blood pressures taken; spurning repeated invitations to come to the surgery for biochemical tests; asking to see a hospital consultant before agreeing to treatment, were examples of resistance from three knowledgeable patients. Such were the difficulties for patients that the QOF can inflict.

OTHER CONSEQUENCES OF SECRECY

Meeting the requirements of the QOF can lead GPs to act in ways that the public would regard as cynical or overbearing. Research found that some GPs put exact monetary values on patients. They saw them as 'walking bags of money' and calculated the sums to be gained if Mrs Smith and Mr Jones were called in to undergo tests and treatments, just as if they were money-earning commodities.[10] Research in another practice found that patients who did not attend the surgery for tests were chased by letters, telephone calls, and home visits until they complied: '... so there's no escape' said the GP.[11]

The warnings in 2007 from two New Zealand GPs that the QOF would harm general practice's standing in society have probably only escaped becoming true because of the scheme's largely secret life.[12]

COULD SECRECY AND COERCION HAVE BEEN AVOIDED?

Yes, if the RCGP had taken note of the lessons from the 'hospital scandals' during the negotiations over the QOF at its inception. Yes, even after that. After Bristol and Alder Hey, pathologists wrote new national guidelines for carrying out postmortems and new information for relatives.[13] Cardiothoracic surgeons drew up information for patients about the mortality rates of individual surgeons.[14] Once research showed that patients were at risk of coercion from the QOF, the RCGP could have followed those specialties' suit. It could have published and distributed guidance for GPs and information for patients about the QOF, its objectives for public health and its financial incentives. It has not yet done that; but it should. For GPs' sakes as well as for their patients' sakes, the College should either reject the QOF or ensure that all patients know about it and can take it into account in their clinical relationships with their GPs.

CONCLUSION

Secrecy with its risks of coercion, whether inadvertent or intended, can have no place in a profession that respects patients' autonomy and values their trust. Can GPs now take courageous steps to ensure that the QOF's serious ethical flaws are not carried into any new schemes that aim to improve the quality of general practice?

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