Who do doctors work for?

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The GP contract was created in 2003, with the intention to reward practices for achieving 'quality'. This was defined by the QOF, the 'Quality and Outcomes Framework', which was distilled down into many tasks, some of which were being done already, and some of which weren't. We were to be paid for having registers of patients with heart disease, to ensure that we had performed cervical smears on large proportions of women, and clinics for people with chronic pulmonary obstructive disease, for example. It changes annually, and every year practices have their April deadline targets to meet – or be financially penalized.

The contract may have originated with good intentions and with the best of evidence, but it has transmuted into a monster. Within a few years of the start of it, Patricia Hewitt, the then health secretary, noting the large increase in GP earnings, said: 'Now it is quite true that neither the government or BMA anticipated how much GPs would do in response to performance-related pay.'[1] Worse has been the lack of evidence for many of the targets. The 2006/07 contract rewarded practices for a standardized assessment of depression, as well as case-finding in people with diabetes and ischaemic heart disease.[2] Two symptom scores were evaluated in 2007 and concluded that 'it is unlikely that case-finding instruments, by themselves, will improve the quality and outcome of primary care for depression'.[3] In 2010 it was clear that the patient health questionnaire (PHQ), which the contract demanded, should be used at diagnosis and performed again at follow up, and that 'in diagnosing depressive disorder, a formal diagnostic process following PHQ-9 remains imperative'.[4] Indeed, a meta-analysis in 2011 concluded that 'clinicians should not rely on the two-questions approach alone', which is used to begin the screening for depression process in chronic disease management.[5]

From my side of the desk, the diagnosis, management and safe treatment of depression in ten minutes is a challenge. I have to establish a relationship with my patient, who may be upset and vulnerable. I have to take an adequate history, and to ensure that my diagnosis is correct; review past problems, relate choices and the risks and benefits of each; ensure it is possible to access these. I may need to share this with a carer or relative; I need to ensure the person is safe, has access to advice in emergencies, and will be able to return to see me.

The GP contract effectively seeks to push the government agenda past my patient. I am not treated as a professional who has the best interests of my patient at heart, but as a potential renegade who must adhere to contract criteria to show 'quality'. We have evidence that it is not just me who finds the contract interruptions to the patient's story distruptive and inhibiting. A qualitative study in 2011 found that it had required 'practitioners to work hard to minimize negative impacts on their work'.[6] As a starting point, this is hardly good for patients or practitioners. A conflict is created. Rather than concentrating on the priorties for the patient – listening, understanding, sharing options and ensuring safety – I am pushed into a tick box working arrangement which will not help me improve my diagnosis or outcomes for the patient.

This is not the only area of the GP contract found wanting when it comes to evidence – the 2009 QOF Framework, for example, instructed doctors to achieve the target of 7% HbA1c despite the ACCORD study showing an increased mortality where this was achieved; this has now been dropped.[7] Numerous organizations have

campaigned for their issue to be included in the QOF – from alcohol misuse[8] to benign prostatic enlargement[9] to osteoporosis.[10] The QOF is seen as a way to drive an agenda from within the health service. We must be careful.

GPs have a duty toward the holistic care of their patient; there is nothing new in this. What has changed is the number of external drivers into the space of the consultation. Overwhelming the patient's story is the panopoly of competing interests for my attention. From the contract point of view, it matters little if my diagnosis is correct or if I have empathy, or if I remember to explain the benefits of cognitive therapy well. It matters most that I have distilled my patient down to a sheet of A4 paper and a numerical answer to how many days he or she has felt hopeless.

Is this such an advance? Before I even meet my patient, my needs for the contract are being put before his or hers. We screen for cardiovascular risk routinely; we have the blood pressure cuff, the speculum for the smear, the smoking tickbox ready to be completed almost before the patient has sat down. Part of my job is summarizing old notes, and when I reach for the Lloyd George envelopes, and the one line summary of illness, I have envy. Then, the patient stated what was wrong; the doctor had then a duty to act. The distractions were few, the priority was obvious.

All change. We do not even know that financial incentives improve quality of primary healthcare.[11] The contract may mean that politicians think they know more about what general practioners are doing, but much of that probably doesn't matter much. We have lost far more; the ability of the patient to direct the consultation to what matters most to them. The GP contract erodes professionalizm and has to stop; we need to reclaim medical vocation and put it to the use of our patients.

References

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