

NO HOLDS BARRED Margaret McCartney

Statins: we lack tools to help patients decide

The National Institute for Health and Care Excellence (NICE) earlier this year approved atorvastatin for people in England and Wales who have a 10% risk of a cardiovascular event within 10 years; it had previously been a 20% risk.¹ GPs are advised to treat such people—which includes everyone older than 85—and to continually review everyone else in case they pass the 10% threshold.

This decision on funding statins is based primarily on cost effectiveness to the NHS.² The press release from NICE mentioned the potential benefit to the population (namely, it “could help prevent up to 28 000 heart attacks and 16 000 strokes each year”³) but not the absolute benefit to the individual.

But life is more complicated than that: people make choices for multiple reasons. Many patients stop taking statins after starting them⁴; others, faced with the choice of taking a drug



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with a small chance of benefit, would rather not do so; and some people will want to take them no matter how low their risk may already be.

We lack the tools to predict accurately individual risk at such low thresholds—leading to overtreatment and, to a lesser extent, non-identification of risk.⁵ The general practice cake is finite; cutting a bigger slice for healthy people at lower risk means a smaller slice for people who have symptoms and are unwell. The chance of a longer life is offered to people who are willing to take tablets consistently, but we know that these compliant patients are already more likely to live longer, even when taking a placebo.^{6 7} This policy, which benefits people who are already the healthiest, has the potential to widen health inequalities.

Who is keeping an overview of where NICE is taking us? The conflicts of interest among the members on its

drafting panels are buried in minutes rather than in the guidance itself, and we still lack public access to most of the trial data that NICE uses.⁸ But we are told to press ahead regardless when, most bewildering of all, we don't have a decent shared decision aid—designed and tested for the five million more people advised to take statins—about the benefits and harms of statinisation and the management of cardiovascular risk.

“Should I take statins?” is a question asked of GPs every day. We urgently need better tools to allow guidance to guide, rather than dictate new targets. Our lack of resources to deal with such a common question simply isn't acceptable.

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Competing interests and references are in the version on thebmj.com.

Provenance and peer review: Commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2014;349:g5688

BMJ BLOG OF THE WEEK David Oliver

The media narrative on quality in healthcare—helpful or harmful?

I was recently part of a panel speaking on the media representation of quality in healthcare.

As we head towards the 2015 general election, we have learnt that “the NHS” is the biggest concern mentioned by voters, so prepare for more reportage, much of it driven by political parties and ideologues with an axe to grind.

As fellow panellists pointed out, newspapers are an industry in serious decline. There are notable exceptions, but by and large, there is big pressure in a contracting industry to publish whatever sells and generates online hits. Inevitably and understandably, this skews the content and style of reporting away from emphases that those working in or leading health services might prefer to see.

Those members of our panel who came from a journalism background

cautioned against snobbery towards mass circulation outlets, such as the *Daily Mail*, firstly because of its reach and influence, and also because the readers are ordinary voters and service users—so it's not too “patient centred” to disparage them.

The issue of the Liverpool Care Pathway was a prime example of how media coverage can cause real problems in frontline service, and harm care and public confidence. At least once a year, a similar piece of scandal and scaremongering means that frontline staff have to spend a lot of contact time with patients and families combating misinformation.

There are also many aspects of quality that the media don't tend to cover. Social care itself receives far less attention than the NHS, and local government cuts have been under-reported. These are all things to get

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legitimately steamed up about, but they get little air time.

There is also remarkably little on delivering constructive solutions or on celebrating service models that can deliver them. There is plenty of good news from people leading innovative services around the country, but it seems that, with the odd exception, solutions don't sell.

Finally, as someone who is part of the clinical leadership community, I am struck by the mismatch between some of the zeitgeisty groupthink in those echelons and the priorities in the news media. Everyone is talking about “prevention,” “integration,”

“care closer to home” with “new models outside hospital,” “supported self care,” and “person held records.” All this magic thinking comes from a small empowered group of largely middle class, educated service users. I am not saying any of these priorities are wrong, but it's like a small policy elite is trying to dictate to the wider public what its priorities ought to be.

Out there in the press and the opinion polls, the public still use and want the reassuring old fashioned terms of “doctor” and “patient.” They still have confidence in buildings (their local hospital or GP surgery) and basically want the care from those organisations to be caring, responsive, and accessible. The media haven't caught up with the zeitgeist and neither have the public. But who's to say they are wrong?

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David Oliver is the president of the British Geriatrics Society

GPs should be rewarded for patient experience

The NHS's Quality and Outcomes Framework no longer offers points for patient experience. But these are a good incentive to encourage general practitioners to offer person centred care, says **Geva Greenfield**

Person centred medicine is seen as crucial to high quality healthcare in the NHS and abroad.¹ The UK government envisions that patients should be "at the heart of everything we do" and that for patients there should be "no decision about me, without me."² The NHS constitution says that NHS users should receive a patient centred approach to their care, respecting their needs, values, and preferences.

A person centred doctor is sympathetic and interested in patients' worries and expectations, knows the patient and his or her emotional needs, discusses the problem and treatment, is definite about the problem and when or if it will resolve, and is interested in its effect on the patient's life.³ This kind of doctor starts from the patient's situation, legitimises the patient's illness experience, acknowledges the patient's expertise, and offers realistic hope. He or she also develops an ongoing partnership, provides advocacy for the patient in the healthcare system, and shares power and responsibility with the patient.⁴

Ten minute slots

The delivery of all of these qualities seems almost impossible given the current primary care workload in the UK. General practitioners face increasing demands to follow many clinical quality guidelines and to attain many clinical outcome measures. They are expected to do much more than they can deliver in 10 minute slots, particularly for patients with multiple conditions. No wonder that the NHS as a whole is still far from being patient centred.^{5 6}

One way to influence GPs' behaviour toward a person centred approach is through pay for performance schemes. The Quality and Outcomes Framework (QOF) was introduced in the UK in 2004 as part of the new General Medical Services contract. This voluntary process awards points for achievements in clinical care (mainly in managing common long term conditions), practice organisation, and providing additional services (such as child health and maternity services). Substantial improvements have been noted since the introduction of QOF, particularly in the management of risk factors for cardiovascular disease and diabetes.^{7 8}

Patient experience is one of QOF's domains, rewarding GPs for how well patients view



In the 2014-5 QOF not one of the more than 100 measures relates to patient experience

their experience at the practice. Four patient experience measures were introduced in 2004-5, totalling 100 points toward the 1050 possible QOF points. These four measures were retained in 2005-6 and increased to 108 points in 2006-7 and 2007-8 (out of a reduced total of 1000). An additional measure was introduced in 2008-9, increasing the patient experience domain to 146.5 points. However, since then these measures have been gradually removed, so that in the 2014-5 QOF not one of the more than 100 measures relates to patient experience.

A return to rewarding patient experience through the QOF does not necessarily mean spending more money; it might just mean that other measures are removed. Delivering person centred medicine may pay off because it provides a better understanding of the patient's needs. Person centred medicine has a therapeutic value by itself, which can be translated to clinical outcomes such as fewer diagnostic tests and referrals,⁹ reduced symptom burden,³ better quality of life, and less anxiety and depression.¹⁰ For example, better performance on the QOF measure of patient access has been shown to be associated with lower admission rates for long term conditions such as diabetes.¹¹

Overlooking patient experience and focusing entirely on clinical procedures, such as delivering more screening tests, may not

be the solution to some of the key challenges facing the NHS. A person centred approach may tell us if additional tests are really needed and why. Perhaps the patient tries to tell us something we're missing? Hence rewarding GPs merely for delivering more performance measures might be counterproductive.

Measures of patient experience

Measuring patient experience is more challenging than measuring other QOF measures. How should we reward a GP who has empowered a patient to take ownership of his or her health or made a decision together with the patient? Fortunately, the UK has valid measures for patient experience, such as those provided by the National General Practice Patient Survey.¹² This survey measures aspects of patient experience such as access, giving patients enough time, listening to their concerns, and involving them in decisions about their care. Several measures from this survey were used in previous versions of QOF to reward GPs who practice person centred care and could be used again in future.

QOF rewards are a practical reflection of values and priorities. If we want person centred medicine to become the norm in the UK we must reward GPs for it, just as we reward them for other aspects of good quality care. We need to provide GPs with the right conditions to deliver person centred medicine, including longer appointment slots. With the current demands on GPs' time, patient experience is likely to be given less priority than better rewarded measures of care. Ideally, patient experience measures should take at least a fifth of the total QOF measures. Adding patient experience to the QOF conveys a message of the importance attached to improving patient experience in line with the government's ethos to put patients at the centre of everything we do.

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Competing interests: I have read and understood the BMJ policy on declaration of interests and declare that I have no competing interests.

Provenance and peer review: Not commissioned; not externally peer reviewed.

References are in the version on thebmj.com.

Cite this as: *BMJ* 2014;349:g6422