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CSM thioridazine advice

I was interested to read Dr Wright's paper on the impact of the Committee on Safety of Medicine (CSM) advice on thioridazine prescribing in general practice in Leeds in the May edition of the *BJGP*.[1]

Working in a general practice of 5500 patients in Sheffield, we have an above average number of patients in either sheltered or supported accommodation, of whom 11 were well controlled on thioridazine at the time of the CSM advice. Owing to the forceful nature of the advice we did not feel we were able to continue prescribing thioridazine and the local advice in Sheffield was to convert patients onto promazine (in retrospect, bad advice). The effect on these patients was marked; of the 11, only one remained controlled on thioridazine, the number of consultations and hospital appointments increased and there was marked distress to the patients, their families, and their carers.

I would agree with Dr Wright's suggestions for how the CSM relates urgent advice regarding medication when there is emerging evidence of poor safety profile, but I would also add that there should then be clear guidance as to what the appropriate alternatives are, with the appropriate evidence.

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1. Wright NMJ, Roberts AJ, Allgar VL, *et al*. Impact of the CSM advice on thioridazine on general practitioner prescribing behaviour in Leeds; time series analysis. *Br J Gen Pract* 2004; **54:** 370-373.

Wright and colleagues report on the impact on GP prescribing of thioridazine as a result of advice issued in December 2000 by the Committee on Safety of Medicines.[1] They conducted a time series analysis and showed a significant reduction in the monthly number and cost of thioridazine prescriptions. Their paper is accompanied by a commentary on this type of before-and-after study, which does not really help the non-statistician to understand the method of analysis used. Although not subject to the same robust, high scientific standards as their paper, I prefer the interocular test (when data hit you in between your eyes).[2] This test, if applied to data for GP prescribing in Cornwall and Isles of Scilly (Figure 1), tells us all we need to know about how GPs acted following this CSM urgent cascade fax. The prescribing of thioridazine dropped dramatically from over 4000 items per quarter down to less than 1000 in the space of two quarters.

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Author's response

We welcome the letter by Paul Driscoll and were disappointed, yet not surprised to read of the increased number of consultations, hospital appointments and increased distress to patients, families and carers as a result of urgent facsimile advice to change prescribing practice. We would encourage both the primary care profession and the prescribing regulatory authorities to learn from this episode, and agree with Driscoll that clear guidance should suggest appropriate alternatives with the appropriate supporting evidence.

Regarding the letter by Wilcock, we always suspected that although only claiming generalisability of our findings to the Leeds area, that the picture we described would be representative of the national picture. Despite the obvious attractions of the interocular test, which are obviously in the eye of the beholder (excuse the pun), we felt it important to apply scientific and research methodological rigour to our study. Whereas Wilcock has given us some excellent descriptive data (and we do hope that the *BJGP* affords him space of a whole figure for a small letter) we do prefer to use comparative statistics wherever possible. Such statistics in the form of a time series analysis can account for any natural seasonal variation which can be missed by the interocular method. Comparative statistics are also both more sensitive and specific to detect small yet significant changes. Such changes can be missed by the naked eye. However, on this topic we feel that the most important point is that there is no evidence that thioridazine is more cardiotoxic than any other antipsychotic medication. The current evidence base would suggest that *all* antipsychotic medication should be prescribed with caution to the elderly

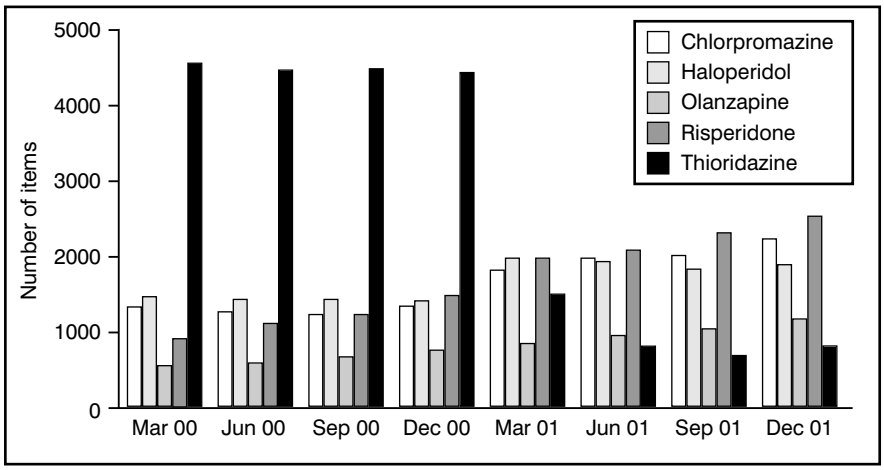

Figure 1. Number of items prescribed by GPs per quarter.

and those with pre-existing heart disease or those with behavioural disturbance where there could be a tendency or iatrogenic overdose in an over enthusiastic attempt to control behaviour.

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Performance indicator scoring

We read with interest the paper in the May issue on the theme of performance indicator scoring by Houghton and Rouse.[1] We were surprised that they did not refer to a conceptually similar attempt we made to develop a composite performance indicator — the National Health Service Practice Performance Index (NHSPPI) — in three areas of England (including their own) and one in Scotland.[2] As Houghton and Rouse assumed, we found that NHSPPI correlated significantly, and negatively with a weighted deprivation index (Spearman's correlation coefficient r = -0.57). It also correlated negatively with the proportion of other language patients in the practice (r = -0.44) and positively with list size (r = 0.25). The performance indicator was thus inherently unfair on practices working in deprived areas, whereas an alternative measure which we have called the Consultation Quality Index (CQI) appears independent of deprivation scores (r = 0.06).[3]

The CQI combines measures of enablement (a better outcome measure than satisfaction), consultation length (a proxy for holism), and how well patients know their doctor (a proxy for continuity). Current work in Glasgow by Mercer suggests that a measure of empathy — the consultation and relational empathy (CARE) measure — correlates well with both enablement (r = 0.66) and consultation length (r = 0.42), and raises the possibility of adding a fourth dimension to the CQI.[4]

We are concerned that many or most of the income-generating performance indicators in the 2004 Contract reward disease-centred measurements, but virtually none attempt to measure 'patient-centredness'. It is easy to understand why developing measures of patient-centredness has proved so difficult to do, and we have recently reviewed the problems in this field.[5] But just because the task is difficult, it does not mean that it is not important and well worth doing; indeed finding a way forward in this field is one of the outstanding opportunities for qualitative and quantitative researchers to work together.

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During a period of enforced idleness I have been attempting to catch up with my reading pile. May's Journal included a paper that made a sweeping generalisation in a throw-away fashion. I refer to Houghton and Rouse' paper on performance indicators as markers of GP quality[1] and the boxed 'How this fits in' comment that we already know that GPs 'tend to find externally imposed measurements irrelevant and threatening'.

The original papers referred to[2-5] do not support this assertion; the most relevant citation is from 1995 and has been superseded. The most up to date is an editorial. A quick search on Medline for 'performance indicators' and 'primary care' generated four more recent citations (not including the one being discussed). Indeed, more recent reactions to performance indicators are more favourable,[6] though admittedly there were concerns about the quality of the data itself. It is not Houghton and Rouse's paper per se that I object to — simply the over-generalisation and selective use of references. GPs need to be accountable and we need to find ways of ensuring that what is counted counts. Not that we count merely what can be counted. Such generalisation that all GPs feel threatened perpetuates the myth that we don't feel we should be accountable.

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Author's response

We accept the rebuke of Howie *et al* for not acknowledging their work on devising the National Health Service Practice Performance Index at practice level.