

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.

NAT WRIGHT

Clinical Director, Leeds Community Drug Treatment Services, Leeds.
E-mail: n.wright@leeds.ac.uk

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.

JOHN GR HOWIE

Professor Emeritus,
University of Edinburgh.

DAVID HEANEY

Senior Research Fellow, Highlands and Islands Health Research Institute, University of Aberdeen, Inverness.
E-mail: d.heaney@abdn.ac.uk

MARGARET MAXWELL

Senior Research Fellow in Primary Care Mental Health,
University of Edinburgh.

GEORGE FREEMAN

Professor of General Practice,
Imperial College London.

STEWART MERCER

Senior Clinical Research Fellow,
University of Glasgow.

References

1. Houghton G, Rouse A. Are NHS primary care performance indicator scores acceptable as markers of general practitioner quality? *Br J Gen Pract* 2004; **54**: 341-344.
2. Heaney DJ, Walker JJ, Howie JGR, *et al.* The development of a routine NHS data-based index of performance in general practice (NHSPPI). *Fam Pract* 2004; **19**: 77-84.
3. Howie JGR, Heaney DJ, Maxwell M, *et al.* Developing a 'consultation quality index' (CQI) for use in general practice. *Fam Pract* 2000; **17**: 455-461.
4. Mercer SW, Reynolds W. Empathy and quality of care. *Br J Gen Pract* 2002; **52**(suppl 1): S9-S12.
5. Howie JGR, Heaney DJ, Maxwell M. Quality, core values, and the general practice consultation; issues of definition, measurement and delivery. *Fam Pract* (in press).

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

quality¹ 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 to²⁻⁵ 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.

TINA AMBURY

Vice Chair RCGP.

E-mail: tina@thriveunderpressure.com

References

1. Houghton G, Rouse A. Are NHS primary care performance indicator scores acceptable as markers of general practitioner quality? *Br J Gen Pract* 2004; **54**: 341-344.
2. Houghton G. General practitioner reaccreditation: use of performance indicators. *Br J Gen Pract* 1995; **45**: 677-681.
3. Birch K, Scrivens E, Blaylock P, Field SJ. *Performance indicators: international perspectives and the development of indicators for general practice in the UK*. Keele: Keele University Press, 1999.
4. Majeed FA, Voss S. Performance indicators for general practice. *BMJ* 1995; **311**: 209-210.
5. McColl A, Roderick P, Gabbay J, *et al.* Performance indicators for primary care groups: an evidence based approach. *BMJ* 1998; **317**: 1354-1360.
6. Wilkinson EK, McColl A, Exworthy M, *et al.* Reactions to the use of evidence based performance indicators in primary care: a qualitative Study. *Qual Health Care* 2000; **9**(3): 166-174.

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.