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 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.

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 reaccredidation: 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.

Although I have heard Professor Howie expound eloquently the concept of the Consultation Quality Index (CQI), we considered this to be an organic internally derived professional exercise rather than an externally imposed assessment. Our object was not to set up a new performance framework as such, but to see if we could improve the acceptability of what appeared to be an arbitrary collection of government parameters. It was this very arbitrary nature that we felt could be alienating the profession rather than necessarily the concept of being subjected to performance review, which is where Dr Ambury is taking us to task. Since writing the study of course things have moved on and we now have a new GMS Contract with a further raft of quality and outcome measures, which will no doubt inform and stimulate this debate.

GUY HOUGHTON

General Practitioner and GP Education Advisor, West Midlands Deanery, Birmingham.
E-mail: guy@houghtons.org.uk

Accepting money from the Freemasons' Grand Charity

I see that Council has decided to accept a donation from the Freemason's Grand Charity. This was discussed at our Faculty Board; I expressed some reservations, and I understand there was considerable debate in Council before the decision was taken. Several colleagues have said that their initial instinct was to reject the offer; I feel bound to observe that, on the occasions when my instinct has said one thing and my head another, the head has usually been wrong!

My reservations about freemasonry stem from knowledge gained through conversations with patients who are masons, and from belonging to a healing community within the Church of England. I've read various publications, written by people who either have been freemasons themselves, or who have studied the organisation in some depth. My understanding is that it is an organisation with secrets, it has a layered structure, and members in the lower layers are generally ignorant of what goes on higher up. The vast majority of freemasons regard it as an enjoyable social club, that does a lot of good work raising money for charities — and so it does. Unfortunately, the argument does not end there. It is undoubtedly a quasi-religious organisation, though it welcomes members from any religion. That's fine, and at every lodge meeting there's an open Bible. However, the meetings profess to worship not only God as those attending recognise Him, but also entities such as Jabulon and others. This is a departure from worship as the rest of us know it — who or what is Jabulon? There is a mystical initiation ceremony, and a solemn oath is sworn, that the initiate's heart be cut out if he betrays the organisation's secrets — hence exposing the left breast. It may sound melodramatic, but many within the established Church are deeply concerned — hence the move recently to render priesthood and freemasonry mutually incompatible.

In our Faculty Board debate, we agreed that the College shouldn't accept money from, say, a drug baron. We feel uneasy about accepting it from pharmaceutical companies, though we do. We probably wouldn't accept it from Hare Krishna, or the Scientology movement. In defence of the argument in favour of accepting, I understand that the Grand Charity runs independently from the masonic lodges, and that there are no strings attached as to how it is spent. And the amount of money on offer is considerable. Nevertheless, the phrase 'wolf in sheep's clothing' niggles at the back of my mind, so I may reconsider whether to continue as a Fellow of this College, but that's my personal decision.

If I am in a small minority with these concerns, that's fine, but I would appreciate their being made available to more of our membership, so that the College can have a more informed debate.

CHRIS BARRY

General Practitioner, Cornerstone Practice, Chiseldon SN4 0PB.
E-mail: chris.barry@gp-J83649.nhs.uk

Response

It was always going to be the case that an offer of a donation from the Freemason's Grand Charity would polarise opinion and this short letter is unlikely to alter entrenched views. However, there are some important general points to be considered. The democratically elected College Council has, by a large majority, agreed to take consideration of this idea forward. The College has very clear guidelines about accepting donations and this offer is within those guidelines. To reject such an offer on grounds outside the guidelines would be to repudiate those guidelines. Freemasonry is perfectly legal and in the view of many is at worst harmless and at best respectable. The Grand Charity is itself a registered charity and, like the College, must work within the rules set by the Charity Commissioners. To equate the Grand Charity with a drug baron is frankly offensive. Every year thousands of ordinary freemasons give money to the Grand Charity in the belief that it will assist worthy causes. The idea that the upper echelons of freemasonry exist in a shadow world of plotting and intrigue will, I am sure, be news to HRH The Duke of Kent, who is the Grand Master, and to the numerous bishops and archbishops who have graced the order.

Freemasonry is certainly a society with secrets but since there have been a number of reasonably accurate televised exposures and since any member of the public can order books from any bookseller that deal with freemasonry in detail, it is hardly a secret society. Furthermore, most masonic halls have open days and are available for use by members of the public. The sort of blood-curdling oaths referred to in Chris Barry's letter were commonplace in all sorts of organisations when the masonic ritual was written several centuries ago but they have long been removed and are now of only historical interest.

I believe that the College needs to be very careful before passing judgements on organisations based on hearsay and incomplete understanding. The College officers have carefully investigated the Freemason's Grand Charity and the Council appeared to be much more anxious about appearing unreasonably prejudiced than about joining the Royal College of Surgeons in considering, and possibly accepting, money from this source.

TONY MATHIE

Council Member and Freemason.