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Methodological flaws exist in the study of patient-centredness of consultations

Sir,

Kinnersley *et al* (September *Journal*)[1] concluded from their study that patient-centredness styles of consulting produce benefits in terms of increased patient satisfaction for those consulting for new episodes of care in Britain. However, several issues relating to the study design and analysis should be addressed.

The unit of study was intended to be the patient in the initial design, but the GP was used as the unit of study in the analysis. This change of strategy gives rise to two problems. First, as the consulting style of a GP was assessed from the analysis of a single consultation, the specific consultation must be selected in such a way so that systematic bias is minimized. For example, among patients who were dissatisfied, those who received patient-centred style of consulting might feel more at ease to refuse to complete the last two questionnaires. This would give rise to systematic bias, which would account for the authors' findings. The degree of selection bias cannot be accurately assessed from the research procedure (Figure 1) since the patients were used as units for investigation, but is likely to be considerable. It is known that 12% and 22% of the cohort of patients refused to complete questionnaires 2 and 3 respectively, but it is not known the distribution of the number of patients excluded for each GP. Secondly, as the authors pointed out, this method of analysis investigates the variation between consultations by different doctors, and that GPs are relatively inflexible in their consulting style. Hence, one cannot conclude from the study that teaching this style of consulting would lead to an improvement of patient satisfaction.

There are two problems with the analysis. First, many GPs perceive that a patient-centred consultation generally takes longer than a disease-focused doctor-centred style consultation, and a longer consultation might lead to higher patient satisfaction. Hence, the length of consultation should have been investigated as a potential confounder. Secondly, the patient satisfaction and patient-centred scores are neither interval nor ratio variables. They are ordinal variables. Hence, it was inappropriate to use Pearson correlation coefficient and multiple regression using the actual scores. Appropriate techniques include Kendall's tau-b or Spearman's correlation coefficients and regression using the ranks of the scores.

Finally, we must be cautious in generalising the results to primary care in the UK in view of the highly selective nature of the GPs who participated in the study.

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Reference

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Time to go public on performance?

Sir,

Martin Marshall raises an important area of clinical governance in his editorial by demonstrating the pros and cons of public information and accountability (September *Journal*).[1] In particular, the dangers of misinterpretation of information, by lay and professional observers alike, are noted. Before any data enters the public domain it is crucial that the practitioners to whom it refers can have confidence in its quality; indeed, the Primary Care Act,[2] by imposing a statutory duty on PCGs to seek quality improvements, arguably requires them to present reliable data.

To provide a simple example, a recent PCG audit demonstrated that our practice had a higher than average request rate for hip X-rays. We analysed these results and found that over 50% demonstrated pathology, which in many cases warranted referral. Thus, our request rate would seem to be appropriately higher than average, and a case for encouraging more use of this investigation by other practices to detect and treat hip morbidity and make appropriate referrals to secondary care could be made. In addition, the quality of the audit data was found to be poor, in that only 50% of the requests attributed to myself had been made by me, the others being from my partners.

This example demonstrates how easily data can mislead. The danger of pressure to conform to the average is that good practice will be diluted. If the publication of performance indicators is to foster improved practice, then adequate resources must be devoted to defining and collating good quality data that we can trust, rather than reaching for existing flawed sources. Quality work of this nature will require greater funding than is currently available for clinical governance,[3] but, unless we strongly argue for such resources, we are more likely to suffer declining morale from ill-informed public criticism than to be able to celebrate reliably documented good performance.

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Pharmacist intervention in general practice

Sir,

Rodgers *et al* report that the use of a pharmacist did control prescribing expenditure

sufficiently to offset the employment costs (September *Journal*).[1]

I would like to report that, by comparison, we as a practice have also controlled our prescribing costs, and have converted a 7% overspend in our budget during 1997/8 to a 5% underspend in 1998/9. However, we did not use a pharmacist but a small individual group of GPs to disseminate information and motivate the other partners in a large group practice to change prescribing patterns.

One of the major hurdles was overcoming inertia and promoting a climate of change. We used a well-established model for the 'states of change'.[2] We recognized that, as a group, we were in a stage of pre-contemplation. This had followed a meeting with the prescribing department of our local PPSA. Although we left this meeting with an active plan, our next phase of contemplation (in the cycle of change) involved the writing of a practice formulary. Next in the cycle came a period of activity where individual prescribing patterns were addressed. A regular feature of practice meetings became the presentation of comparative performance by a partner in a given prescribing area that was quite a powerful monitor of change. We addressed a different prescribing area each month. Lists of patients on a given drug were easily generated by the computer and were returned to partners with suggestions (that were evidence based) to consider changes to a different drug that was more cost-effective.

While we acknowledge advice and support from our local prescribing department, most of our change has occurred at a practice level. The prescribing department is, in part, funded by top slicing the prescribing budget to the primary care group. I would suggest that this model is a far more cost-effective use of limited resources.

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Implications of the UKPDS study for general practice care of type 2 diabetes

Sir,

We refer to the editorial by Kinmonth *et al* in the September *Journal*.[1] In describing the treatment of the multiple risk factors for cardiovascular morbidity, the authors advocate the possible use of fibrates as treatment for the dyslipidaemia often seen in patients with type 2 diabetes. We would disagree with this, as the evidence would now support the treatment of hyperlipidaemia in this context with a statin.[2-4] Subgroup analysis of these trials in patients with diabetes mellitus has shown proven benefit both in morbidity and mortality. Apart from the recently published article in the *New England Journal of Medicine*,[5] which did confer an improvement in mortality by treatment with the fibrate gemfibrozil (but entry criteria for which would be somewhat atypical for the diabetic patient), the data for treatment of hyperlipidaemia, according to evidence-based medicine, weigh heavily in favour of statins. Therefore, we would suggest that this would be the treatment of choice of most diabetologists and, indeed, clinicians in general.

Interestingly, the research group behind UKPDS are currently involved in a trial comparing the benefits of statins versus fibrates in the treatment of dyslipidaemia associated with diabetes, but the results will take several years to be published and, until proven otherwise, we would advocate that therapy with a statin should be considered treatment of choice in this clinical situation, and commend this to all our colleagues in primary care.

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Use of HRT in an inner-city general practice

Sir,

The recent expert conference on hormone replacement therapy (HRT)[1] concluded that, although the short-term benefits on osteoporosis and relief of symptoms are well established, the benefits of longer term use are still unclear. Women's own attitudes towards HRT are therefore of prime importance. However, little is known about the factors influencing HRT use in women attending inner-city practices. A computer search of the records of women aged 40 to 65 years in one inner-London practice revealed that 14% were current and 7% were past users of HRT.[2] In April 1998, we conducted a postal questionnaire survey of 400 of these women, including all current and past users of HRT and a random sample of 200 never users. Our aim was to examine their use and knowledge of HRT.

The response rate was 67% (259/387) and was similar in those who had ever (67%) and never (63%) been users of HRT. A total of 80% of responders considered themselves to be white, 14% black, 2% Indian, 1% Chinese, and 3% other ethnic groups ($n = 256$). This is similar to the ethnic distribution in the same borough in the 1991 Census. Forty per cent of responders had university degrees, 24% were educated to 'A' level, 26% to 'O' level, and 10% had other qualifications ($n = 230$). A total of 63% had reached their menopause.

We found significant differences in knowledge of osteoporosis, cardiovascular benefits, breast cancer, symptom relief, quality of life, and weight gain ($P<0.05$) between current, past, and never users of HRT, with current users better informed than past or never users. We also found that women with 'A' levels and degrees were more likely to know about these

effects than women with fewer qualifications. However, the use of HRT was similar in all the educational groups.

Further research is necessary to evaluate more fully the factors influencing HRT use in this population. Meanwhile we agree with the expert conference that, in the face of uncertainty, shared decision-making between GPs and patients depends on good communication of the risks and benefits of HRT use.

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Small groups and preparation for FBA

Sir,

Many fellows by assessment have been helped by being a member of a small group of peers all preparing for Fellowship by Assessment (FBA). Since the FBA working group is keen to help as many College members as possible pass the FBA, we wanted to know how useful such groups are.

We sent a short questionnaire to all 148 members submitting their notification to apply for FBA in 1995 to 1997, of whom 57 replied: 35 having passed FBA, 20 having not passed, and two expecting to have done so before 31 March 2000. Membership of a small group working towards FBA is shown in Table 1.

Although small group membership is not necessary for success in FBA, membership was mentioned by many responders as helping them through such things as mutual accountability, motivation, maintaining impetus, dealing with practical problems, and overcoming isolation. Conversely, the inconvenience of having to travel and sometimes being constrained by the pace being determined by the slowest made it counter-productive for some.

Those who have not passed cited practice issues and FBA being 'just too much to do' in two-thirds of instances, with half stating personal and family matters as being important. Nevertheless, we were encouraged that 'insufficient local support' was not an issue despite specific enquiry on our part.

The evidence from this survey and the information we have from faculties suggest that small groups are usually there for those who want them. FBA is a substantial undertaking but it can bring commensurate benefits for those who succeed.[1] Leading a small group of those working towards FBA is demanding, although our experience is that few professional activities are so rewarding.

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Reference

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Table 1. Membership of a small group working towards FBA.

	Small group member	Not a member
Passed FBA	25 (71%)	10 (29%)
Not passed FBA	13 (65%)	7 (35%)

Not poetry, please…

Sir,

Bruce Charlton (August *Journal*; Back Pages)[1] states that 'poetry can enhance life'; I take this further and say that poetry always enhances life — in the writing, the reading, and the hearing.[2,3] Gaining the most from poetry is, however, not easy — but then none of the best things in life are, even if they are free. Charlton also asserts, I think equally correctly, that most poetry is not fit for an audience any wider than the poet themselves and possibly their nearest and dearest (thought this may even at times be stretching a point). This kind of poetry does have a value to this tiny audience. Although writers have been discovered to be a pretty mad bunch, poets are the most stable.[4]

I would, however, like to query Bruce Charlton's easy assumption of a knowledge of what 'real' poetry is. Working in the field of therapeutic writing[2] and reflective writing for practitioners,[5] writing poetry myself and reading it a great deal, I wish I could be so confident in my categories.

And does poetry always make the poet attractive to women, as he also states? Does it make me so, for example?

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Corrections

Two errors appeared in the Members' List included in the 1999 Members' Reference Book: Dr L Naftalin was incorrectly listed as Dr Jar, and Dr K Harley was incorrectly listed as Dr K Hartley. We apologise for any inconvenience.