LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Treatment of acute otitis media

Sir,
I was interested to read the article by Jones and Bain (August *Journal*, p.356) comparing three and seven day courses of antibiotic in the treatment of acute otitis media.

The summary suggests that a three day course of cefaclor 125 mg tds is as effective as a seven day course. However, I note that two cases, from the three day course group, were excluded from follow up and not included in the study because of recurrence of symptoms and the antibiotic was subsequently changed.

If these cases had been included this implies a failure rate of at least 2%. Extrapolating this further with the figures given of 1.5 million cases of acute otitis media per year would mean that 30 000 of these cases would be inadequately treated.

Surely further comprehensive studies on this subject should be undertaken before it is suggested that general practitioners change their management of acute otitis media.

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Doctors in South Africa

Sir,
I was concerned by Dr Murrell's letter objecting to the presence of South African doctors at the WONCA conference (July *Journal*, p.335). This was not because of the writer's main argument about the inequalities and the injustices that spill over even into the health care of this sad country, with which I agree, but because of the inaccuracies and the vindictiveness of the letter. My experience here is that a large number of doctors, not just a tiny minority as Dr Murrell describes, are deeply committed to improving health care for all. This is particularly true in the area of general practice where the newer faculties are often dominated by ex-mission hospital doctors, for example Professor Sam Fehrsen of Medunsa Hospital and University, who, with others, have been instrumental in developing the family institute training, similar to vocational training in the UK. This training includes a compulsory year spent in one of the many ex-mission hospitals, which, in theory at least, are multiracial, although in reality only the very occasional white patient is seen in them.

There is great respect among the profession as a whole for the 'general hospital practitioners' who run these rural hospitals, and in one sense, there is a unique situation in South Africa where teaching hospitals, designed to produce 'first world' doctors have such close contact with third world medicine. Ironically, compulsory military service has increased this contact as many young doctors work in these rural hospitals on a short-term basis as members of the army, or for a term of six years as conscientious objectors. So, I believe, suitably chosen members of South Africa's medical community do have a considerable contribution to make to the world-wide debate about health care.

It is easy to shout 'foul' from many thousands of miles away, but doctors here need support, not spite, in fighting for change. Many work in poor conditions, some face six years in gaol if they object to military service on any grounds other than complete pacifism. Nor is Dr Wendy Orr an isolated 'phenomenon'. So keep up the pressure, but until you have spent 30 years working in a mission hospital, and so proved your real concern for the welfare of the underprivileged, please do not exclude those that have from contributing to the improvement of world health.

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Clinical psychology in general practice

Sir,
We were interested in Espie and White's paper on the effectiveness of psychological intervention (July *Journal*, p.310). They are, however, incorrect in their claim that they are the first to compare independent ratings by general practitioners, patients and psychologists in assessing the outcome of psychological treatments in primary care.

We mounted a randomized controlled trial of 429 patients[1,2] assessing outcome by 9-point visual analogue scales completed by general practitioners, patients, significant others and a blind assessor. We also measured general practitioners' and patients' satisfaction with outcome, consumption of psychologists' time, drug costs and general practitioner consultation rates in the psychologist treated and normal general practice management conditions. We believe this to be the most comprehensive study on the subject to date and, apart from Earll and Kincey's,[3] the only published one to utilize a control group. Both our study and the important paper by Freeman and Button,[4] which points out the pitfalls of assessing outcome without considering the natural history of the patient's problems, seem to have escaped your authors' notice.

Our study had some similarities to the one reported as we used scales of improvement and Kincey's[5] categories. It differed in that it was controlled, used more sophisticated scales, additional outcome measures and multiple follow-up assessment times.

The results also found high inter-rater reliability but our general practitioners' rating of average improvement was higher than that of the patients. We also found a superior response to treatment in those patients with anxiety disorders. The whole subject population showed considerable significant short-term gains across the wide range of measures. The control group improved much more slowly but