LETTERS

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Cost considerations in otorrhoea treatment

Sir,

In the current financial climate the cost of prescribed medicines has assumed great importance. We believe that every patient should have the most appropriate treatment with cost a secondary consideration. However, if available treatments do vary widely in cost but are of similar efficacy, should the least expensive treatment be used?

We have recently conducted a survey of the prescribing habits of 200 general practitioners and 150 consultant ear, nose and throat surgeons to determine their prescribing habits in the treatment of otorrhoea.[1] The mainstay of the management of otorrhoea is careful aural toilet[2] with diagnosis and specific treatment of the underlying condition. However, we recognize that it is often necessary to use antibiotic/steroid ear drop preparations in the treatment of the underlying pathological condition.

In the United Kingdom, 18 different aural antibiotic/steroid ear drop preparations are available. The microbes most often associated with otorrhoea include pseudomonas in otitis externa, and diphtheroids, *Staphylococcus aureus, S epidermis, Escherichia coli,* proteus and bacteroides in chronic otitis media. We found that the ear drop preparations active against these bacteria vary widely in cost but differ little in their antimicrobial activity. Indeed the least expensive preparation, Betnesol-N (Glaxo) at 13.5 pence ml^{-1}, compares favourably with Otosporin (Calmic) at 78 pence ml^{-1}, the most expensive, when comparing their bacterial sensitivities.

Our survey shows that the more expensive preparations are prescribed as frequently as those which cost considerably less, despite little difference in their spectra of antibiotic activity. It is difficult to understand which factors determine the choice of eardrop preparations in either group of clinicians. Pharmaceutical advertising campaigns may influence the choice of individual doctors and, some clinicians do feel that certain preparations are more effective than others. Although no data has been published to support these preferences, it has been suggested that the steroid rather than the antibiotic may be the active component in the preparation.[3] In any case, cost does not seem to be a factor.

The Department of Health conservatively estimates that 1.2 million prescriptions for aural antibiotic/steroid ear drop preparations were issued in 1987 at a cost of £4 572 000. If the least expensive preparation had been prescribed solely, the cost would have been £1 620 000. It would, therefore, seem reasonable to develop a strategy for prescribing aural antibiotic/steroid ear drop preparations and it is our recommendation that, unless contraindicated, the least expensive preparation should be the clinician's first choice. This strategy compromises neither the best interest of the patient nor the practitioner's clinical freedom, since the best treatment is still being offered.

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References

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2. Browning GG. Pathology of inflammatory conditions of the external and middle ears. In: Kerr AG, Booth JB (eds). *Scott-Brown's otolaryngology.* 5th edition. Volume 3. London: Butterworths, 1987.
3. Browning GG, Picozzi GL, Calder IT, Sweeney G. Controlled trial of medical treatment of active chronic otitis media. *Br Med J* 1988; **296:** 1024.

The role of the medical adviser at the FHSA

Sir,

If a district health authority were to advertise a new consultant post, asking for a dermatologist with an interest in cardiac surgery, stating that no previous experience of cardiac surgery was necessary, I expect a few eyebrows would be raised at the Royal College of Physicians and the Royal College of Surgeons. Yet, a similar scenario is unfolding with the flurry of medical adviser posts at family health services authorities advertised last year in the appointments sections of the *British Medical Journal.*

The origin of these posts lies in the new contract for general practitioners[1] which states: 'To aid FPCs in carrying out their enhanced role, they will need to have medical advice from a number of sources, some of them independent of contractors. Possible sources of advice include the local medical committee, the Director of Public Health, the community physicians, local university departments, faculties of the Royal College of General Practitioners and the regional medical service.' Clearly, it was not envisaged that all medical advice would be provided by one individual.

Nevertheless, several of these advertisements outline a combination of tasks, requiring a wide range of skills, to be fulfilled by a single postholder. Naturally, the brief job descriptions given in the advertisements vary, but the tasks outlined have included some or all of the following:

1. The analysis of the health of populations.
2. The evaluation of primary care services.
3. Planning of services.
4. Advice on effective prescribing.
5. Analysis of referral patterns.
6. Development of medical audit.
7. Advice on standards of premises.
8. Advice on the use and quality of deputizing services.
9. Advice on and development of continuing education for general practitioners.
10. Advice on the development of health promotion in primary care.

From the advertisements it would appear that family health service authorities think that all the skills required to perform these tasks are to be found within the realms of general practice. Items (4), (7), (8) and (9) are certainly tasks for which experience of general practice is vital. However, I would argue that items (1), (2) and (3) are clearly within the remit of public health medicine. The Report of the Committee of Inquiry into the Future