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.

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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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

Development of the Public Health Function[2] defines one of the tasks of public health doctors as providing epidemiological advice on the setting of priorities, planning of services and evaluation of outcomes. Preparing an annual report on the health of the population is the responsibility of the director of public health, according to the same publication. Furthermore, it was suggested to family practitioner committees in health circular (FP) (88) 31 that 'in identifying issues relating to the health of the population they should draw on the advice from the Director of Public Health in the related district health authority and from any other appropriate source of advice or information'. Few practising general practitioners have the necessary epidemiological skills for advising on health service evaluation or health service planning. Hence my request that these three tasks should be performed by a specialist in public health medicine.

Similarly, many general practitioners may not possess the necessary experience in research for the analysis of referral patterns or the development of medical audit. For expertise in these activities family health services authorities would benefit from liaison with academic departments of general practice and local faculties of the Royal College of General Practitioners. Finally, I would advocate that item (10) would be best performed by a multidisciplinary team of general practitioners, practice nurses, public health doctors and health promotion officers.

Family health services authorities need good quality advice from several sources. It is vital that they build links with local academic departments of general practice and the local health authority departments of public health medicine. Admittedly, current organizational structures do complicate access to medical advice from different agencies. For example, the fact that the boundaries of health authorities and family health services authorities are not coterminous means many authorities relate to more than one health district. Also the funding arrangements for such medical advisers, who would not be directly employed by the family health services authorities, would need to be agreed with their employing organization. However, these problems should not excuse family health services authorities from seeking appropriate medical advice.

A plea must be made to all family health services authorities to reconsider the job descriptions for medical adviser posts, matching the skills required with those not only of experienced general practitioners, but also of public health physicians and academics. A request must also be made to all the applicants for these posts to be aware of their own limitations, so that this golden opportunity for creating wiser family health services authorities will not be lost.

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Burst sheaths

Sir,

Government advertisements advocating the use of the sheath as protection against human immunodeficiency virus (HIV) are having an unexpected side effect. In recent months I have had an uncharacteristically high number of patients requesting the postcoital contraceptive pill. It may be that patients obeying the call to use condoms as an HIV protectant believe that they are adequately guarding against pregnancy as well, and have abandoned regular use of the contraceptive pill.

The requests have consistently included three factors. Intercourse had taken place using a sheath. The sheath had ruptured. The female partner had been regularly taking the contraceptive pill but had recently discontinued it without any discussion with a doctor or family planning nurse. The reason for discontinuation was usually given as a broken relationship, and consequently 'I didn't need the pill any more'.

An alternative explanation is that intercourse took place unprotected with the 'burst sheath' explanation fabricated to facilitate the prescription of the postcoital pill. This was true for at least one of my patients who revealed it on direct questioning. Obviously the indication for the postcoital contraceptive pill remained.

The reasons for national educational advertising campaigns advocating the use of the sheath as a protection against HIV are well founded — but in many areas of the country there is still a greater morbidity from unwanted pregnancy and subsequent abortion than from HIV disease. Therefore, while use of the sheath should continue to be promoted as an HIV barrier, it should be made clear that a more reliable protection from unwanted pregnancy is the regular taking of the contraceptive pill.

Individuals whose sexual behaviour results in two potential risks — both an unwanted pregnancy and exposure to HIV infection — need educating in more sophisticated methods of contraception. Use of the contraceptive pill and a sheath may be an appropriate option. Others may need more instruction about the sheath and the interpersonal skills required for its effective use.

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Research for all in general practice

Sir,

The editorial 'Research for all in general practice' (September *Journal*, p.357) is a welcome addition to the debate on research in general practice.

General practice is a profession that draws on the findings of clinical and academic medical research disciplines which define and highlight events in cross sections of populations. The skills of general practice are, however, exercised on individual subjects longitudinally. Events can therefore be described but not defined, and are only suitable for study in an anecdotal form — a style which is no longer considered an acceptable method for communicating information. General practice is, at best, only an applied science and the methods of scientific research are not suitable for its use. This is recognized in part by the editorial and has been previously discussed in some detail by Professor Harris in the 1989 William Pickles lecture.[1]

General practice needs to reconsider its attitude to research and refrain from mimicking disciplines founded solely on scientific research. It should instead become a forum for discussing and integrating the findings of research based disciplines into its day to day activities. The editorial rightly states that literature review may provide more insight than data collection. The *Journal* should encourage such activities by commissioning more authors to submit literature reviews on subjects of relevance to general practice.

General practitioners may, however, cooperate with research based disciplines by becoming field workers engaged in data collection on a large scale.