Rational prescribing

Takes time

EDITOR,—The Audit Commission has highlighted the financial cost of what it terms overprescribing by general practitioners, and politicians have been prompt to condemn such practice.¹ Although sensible prescribing is good practice and should be encouraged, this issue brings into relief some important aspects of general practitioners' activity. Limitations in resources available to general practitioners—particularly time—predict, to some extent, their choice of clinical management. Moreover, in the present political and social climate our expectation, even in primary care, is at an unprecedented level. The promise explicit in numerous political statements, including the patient's charter, has further widened the gap between expectation and likely fulfilment.

General practitioners find themselves having to deliver results quickly in accordance with customer led demand, and in this context overprescribing is generally inappropriate. Restriction on prescribing in isolation, without more time and other resources being made available to the general practitioners, is not fair and is unlikely to yield higher satisfaction among patients. Measuring the cost of overprescribing is relatively easy, but the alternatives are unlikely to cost less if done properly. In addition, an element of risk taking is often involved when a doctor chooses not to prescribe but to observe or use alternative methods. Where the possibility of litigation is high and the slightest hint of medical negligence is pounced on, doctors are expected to play safe. If a limitation on prescribing is imposed without due consideration of the consequences the human cost could be much higher but, at the same time, harder to measure.

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1 Tonks A. GPs' prescribing is irrational, says Audit Commission. *BMJ* 1994;308:675. (12 March.)

Generic drugs may be poorer quality

EDITOR,—The Department of Health intends to start discussions with general practitioners about generic substitution. This would allow community pharmacists to substitute non-branded drugs even if the doctor had written the proprietary name of an agent. Family health services authorities are instructed to encourage the use of generic products. A recent report by the Audit Commission considers that there is scope for further generic prescribing.¹² The commission considers that generic products must undergo the same rigorous licensing and inspection procedures as the original brands and that it should make no difference to most patients whether they receive a branded or non-proprietary drug.

General practitioners may well remain sceptical about a move that gives blanket dispensation to community pharmacists to impose purely generic named drugs on their patients. The track record of community pharmacists in this is questionable: commercial concerns have often driven them to use the cheapest source of generic products. Such

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products are usually imported, and, while they may have received an initial licence, they are rarely batch tested for quality control. If doctors are to be persuaded to prescribe more generic drugs they need far more persuasion of these drugs' high quality. Many overseas manufacturers of generic drugs claim "essential similarity" with a brand leader when applying for a licence and provide only limited data on issues of quality and usually none on research.

The general practitioners may consider that on clinical and economic grounds blanket generic substitution is wrong. This is particularly true of agents with complex release systems. The Department of Health needs to know of general practitioners' concern over generic substitution. Therapeutics in the community is becoming a matter of convincing our patients to accept alternative low cost agents even against our better judgment.

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- 1 Audit Commission. *A prescription for improvement. Towards more rational prescribing in general practice*. London: HMSO, 1994.
- 2 Tonks A. GPs' prescribing is irrational, says Audit Commission. *BMJ* 1994;308:675. (12 March.)
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Screening for hearing loss

EDITOR,—The National Deaf Children's Society launched its document *Quality Standards in Paediatric Audiology* at a one day conference on the early identification of hearing impairment in children.¹ The conference was a tribute to the determination of this voluntary society to raise standards in screening of hearing but did not make clear that the standards cover only sensorineural hearing impairment. (Sensorineural hearing loss affects about 1-5/1000 children, whereas over 80% of children have at least one episode of conductive hearing loss (glue ear or otitis media with effusion during childhood).² Otitis media with effusion merits only one paragraph in the quality standards (by contrast, other guides to screening of hearing have devoted little attention to sensorineural hearing loss).³

The two types of hearing loss cannot be screened for in isolation. Screening for sensorineural hearing impairment will detect large numbers of children with conductive hearing loss in districts that do not have the resources to offer neonatal screening and have to rely on distraction hearing testing at 8 months. Effective treatment of conductive hearing loss is still debated,⁴ and untargeted screening may generate expense for the NHS, parental anxiety, and inconvenience, which is not cost effective.

Guidelines setting clear targets and procedures and published in attractive glossy documents (price £10) are likely to be welcomed by busy purchasers. Rather than adopting these guidelines uncritically, purchasers need to ensure that they have guidelines for managing all children with hearing impairment. Guidance is urgently needed on many issues, such as whether all districts should have audiological scientists; whether distraction testing at 8 months should be continued; and the opportunity costs of meeting any guidelines. The closing discussion at the conference rightly suggested that the quality standards should be regarded as a "green paper" to be put out for wider consultation.

Voluntary help in raising standards and producing consultation documents is to be welcomed but should not be allowed to short circuit the national review process outlined by Calman to ensure that all screening meets rigorous standards.⁵

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- 1 National Deaf Children's Society. *Quality standards in paediatric audiology: guidelines for the early identification of hearing impairment*. Vol 1. London: NDCS, 1994.
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Actinic keratoses induced by a sunbed

EDITOR,—In response to David Shuttleworth's editorial on the risks of sunbeds¹ E L Speight and colleagues report on a patient with actinic keratoses due to use of a sunbed.² I report an additional case of this adverse effect.

A 50 year old woman had a six month history of pruritic rash on the legs which had been unsuccessfully treated as eczema. Examination showed hundreds of discrete hard scaling lesions—clinically actinic keratoses—which were virtually confluent on the lower legs and extended on to the buttocks; there were a few on the chest and arms, but the face was spared. The skin was heavily tanned, and she had numerous stellate lentigines in the same distribution as the keratoses. A skin biopsy specimen showed histological features of actinic keratoses. The patient admitted that she had used a domestic ultraviolet tanning sunbed daily for the previous 15-20 years; before that she had always burnt in natural sunlight, but she could now take foreign holidays. She had not exposed the buttock skin on holiday. Treatment with topical fluorouracil and cryotherapy and stopping exposure to the sunbed produced sustained improvement over the next two years, with some lesions resolving even in untreated areas.

The causative role of sunbeds cannot be proved as the patient acquired considerable exposure to natural sunlight once she could tolerate it. Several features suggest, however, that the association was causative—namely, the patient's age; the remark-

able extent of the lesions; the fact that "double covered" skin of the buttock was affected; the lack of lesions on habitually exposed sites; the association with profound tanning and lentiginosis in the same distribution; and the spontaneous resolution of some lesions when the patient stopped using the sunbed. Recent reports of sunbed-induced porokeratosis^{3,4} (a histologically identifiable disorder of keratinisation, which is occasionally associated with squamous cell carcinoma) support the argument that ultraviolet A sunbeds can cause discrete keratinising skin lesions.

The current concerns in this patient are itch and cosmetic, but the small risk of malignant change in actinic keratoses may be important in relatively young patients with hundreds of lesions. Interestingly, appreciable itch is a feature of the hyperkeratosis that precedes the development of tumours in mice exposed to ultraviolet A.⁵

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- 1 Shuttleworth D. Sunbeds and the pursuit of the year round tan. *BMJ* 1993;307:1508-9. (11 December.)
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Compliance in screening programmes

EDITOR,—Two recent letters^{1,2} highlight the points we were trying to make in our article on compliance as an objective of screening programmes.³ D Jenkins and colleagues argue that high compliance is the most effective method of reducing the overall incidence of cervical cancer.¹ They show that increasing compliance by 10% results in a 24% fall in the incidence of cancer. This may justify the extra costs of using the method of having fixed appointments to increase compliance. Alternatively, a screening programme could use a method of recruitment that avoids almost all non-attendance and still achieves high compliance.⁴

Julietta Patnick and Joan Austoker argue that high compliance is necessary to achieve the targets set out in *Health of the Nation*.² Such targeting can lead to less health gain for the nation rather than more.⁵ The *Health of the Nation* is beguiled by big or important health problems. A health problem that is small in terms of overall morbidity to society, such as phenylketonuria, but is effectively and cheaply treated would not be given high priority if such criteria were used. A low cost intervention that achieves only 45% compliance and consequently reduces breast cancer by 15% may be efficient. What counts is benefits relative to costs, not blind adherence to the targets in the *Health of the Nation*.

Value for money must take into account fixed costs such as equipment and the skill of staff. These are included in our analysis. We agree that such resources should not be left standing idle, which they are when the method of having fixed appointments is used. We proposed a solution: first use a technique of recruitment that is not associated with substantial non-attendance and then use the screening slots saved to screen other target populations.³

Patnick and Austoker argue that increasing compliance may be necessary for equity.² Equity for whom? The current breast screening service is clearly unfair to older women. The authors

point out that older women can request the service, but the few who do will be largely from the non-manual social groups. Using scarce resources to increase uptake among younger women may deny older women equality of access. Provision of such access may be efficient as well as equitable. By implication, Patnick and Austoker argued that equity of use for younger women is more important than equity of access for older women. On whose values is this judgment based? To us Patnick and Austoker do not justify either increasing compliance with breast screening or using compliance as an objective of screening.

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- 1 Jenkins D, Gallivan S, Sherlaw-Johnson C. Compliance in screening programmes. *BMJ* 1994;308:652. (5 March.)
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Forfeiting the right to clinical freedom?

EDITOR,—As John Warden highlights,¹ the medical profession is worried about the erosion of clinical freedom—and rightly so. In the face of the encroachment of budgetary stringency, closed formularies, higher profile management, and all the other pressures facing the health care system the professional independence of doctors is slowly ebbing away. Many people feel strongly that this is not a good thing. If taken to extremes, the reduction of the healing art to a mere technical formula will inevitably lead to a loss of impetus to extend the boundaries of medical knowledge and professional capability. But I must ask whether the medical profession's behaviour truly warrants a defence of this independence or whether standards of behaviour and practice have slipped so far that doctors have forfeited the right to clinical freedom.

The actions and attitude of some physicians have tainted the image of the profession as a whole. We are all well aware of numerous cases of poor and uncaring medical practice that are inexcusable yet never brought to book. There are too many cases of professional collusion to cover up mistakes by colleagues, some of which have made headline news but most of which remain buried. The General Medical Council has been accused of giving the impression that it spends more time dealing with adultery and such like than with medical matters and professional standards that genuinely affect the quality of care. Furthermore, medical leadership has been conspicuous by its silence in addressing these issues.

Many medical voices attack politicians, managers, bureaucrats, and civil servants for the ills facing the NHS. Doctors seem to blame virtually everyone involved in health care—except themselves. Until doctors face up to the deficiencies in their own behaviour the rampant arrogance and remoteness of a minority will continue to blight the entire profession. The inevitable result will be the imposition of even more managers to organise, supervise, and dictate practice in health care according to market forces, cost effectiveness, or whatever other management fashion or political dogma holds sway.

If the sloppy standards, unfeeling behaviour, and cavalier attitudes of the few cannot be eradicated it is uncertain whether medical practitioners will merit the privilege of retaining any appreciable clinical freedom and the status they have enjoyed in the past.

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Vascular surgery in smokers

Smokers must be allowed to decide

EDITOR,—J T Powell and R M Greenhalgh continue the debate on whether the medical profession has a right to decide whether smokers should be entitled to bypass operations.¹ They point out that smoking is related to heart disease and to less successful bypass surgery and are therefore justified in asking "on the basis of this evidence what advice should we give?" But they are not content to advise smokers: they feel justified in advocating coercion. They state that continuing smokers "with inconvenient arterial disease which is not life or limb threatening but in whom surgery could improve the quality of life," should be denied surgery because "the operative risk and chance of bypass failure remain too high to justify surgery," although "if the disease progresses no smoker should be denied urgent surgery to prevent amputation, stroke, or death."

Findings of significant differences between smokers and non-smokers in operative risk and bypass failure do not, however, justify anything; they simply show a difference that is unlikely to have occurred by chance. Given that an operation could improve the quality of life, it is smokers who should decide, on the basis of the available information, whether they want to proceed: it is their life. Moreover, the authors refer to a study that showed that one year after peripheral arterial bypass surgery the patency of femoropopliteal vein grafts was 63% in continuing smokers compared with 84% in non-smokers—but this still constitutes the majority. Furthermore, the recommendation that, until their condition becomes critical, smokers should be exposed to an increased risk of amputation, stroke, or death when they assert their legal right to carry on smoking is incredulous and disturbing; so is the declaration that "sometimes the patient needs a nasty shock before heeding advice to stop smoking," which followed an appreciation of the numbers of smokers who stop smoking after myocardial infarction and resection of the lung for cancer.

How much longer is society prepared to let members of the medical profession take it on themselves to decide who gets treatment? Society funds a national health service that is supposed to be there for all. Discrimination against smokers undermines this; if it goes unchallenged, which group is next?

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- 1 Powell JT, Greenhalgh RM. Arterial bypass surgery and smokers. *BMJ* 1994;308:607-8. (5 March.)

Systemic review of studies is needed

EDITOR,—J T Powell and R M Greenhalgh suggest discriminating against patients on the basis of their smoking status.¹ Although they would not withhold lifesaving or limb saving surgery, they advocate bargaining with patients and offering