More therapeutic conservatism

Sir—In his latest article, (April 1993, pages 121–6) Dr Griffin attempts to panic the profession with quotes from *The Financial Times* written by a journalist asserting that doctors in the USA risk law suits if they do not use 'the most effective drug available, even if it is only a little better than its rivals'. It is quite disgraceful that the *Journal* of the College should be prepared to repeat in print such nonsense. While many of us will appreciate that Dr Griffin is being paid by the organisation he represents to promote its views, it should also be made quite clear that prescribing doctors' first responsibility is to their patients and to their wider interests. These interests will include the rational use of resources in the NHS. Clearly some new medications offer advantage to the patient: unfortunately the pharmaceutical industry, in its attempts to maximise its profits and market, overemphasises the theoretical advantages of new drugs at the expense of old ones. While Dr Griffin may be concerned about the economic implications of therapeutic conservatism, history suggests that there is as much research investment put into capturing parts of an existing market (eg 19 non-steroidal molecules) as to developing the innovative medicines he is so worried about.

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Sir—As a general practitioner who daily has to make many prescribing decisions I was interested in the article on the economic implications of therapeutic conservatism by J P Griffin and T D Griffin (April 1993, pages 121–6) and the subsequent responses by Tom Walley, M McKee *et al,* and Paul Turner (July 1993, pages 337–9).

Tom Walley claims that the pharmaceutical industry spends £250 million a year on promotional activities and contrasts this with the £1.2 million that the Department of Health spends on the *Drugs and Therapeutics Bulletin* and the *Medicines Resource Bulletin* which he claims are the main sources of independent advice on pharmaceutical products for most doctors. I cannot vouch for the accuracy of his estimate of pharmaceutical promotional spending but his second figure is widely inaccurate. He ignores the cost of the Scottish Medicine Resource Centre and its publications, the cost of *Prescribers's Journal* which is sent regularly to every GP in the country, the employment costs of all the independent medical advisers to the Family Health Service authorities and the medical prescribing advisers to the Scottish Health Boards, the costs of their offices, secretaries, cars and inducement packages. He ignores the employment costs of pharmacist facilitators, pharmacist advisers, their cars, secretaries and inducement packages; he ignores also the massive investment in computer technology which enables GPs to learn the exact cost of all the drugs they have prescribed and whether they are staying on course to remain within prescribing cost targets for the year. We are already deluged with independent advice and would be totally submerged if Dr Walley's suggestion of a levy to produce a 200% increase came to pass.

Rational prescribing in general practice is the result of a creative tension between the claims made by companies for their products and the words of caution from academic clinical pharmacologists, independent medical advisers and the like. Conservative prescribing is not always for the best. I remember the horror amongst some academics when GPs started to prescribe beta blockers for their hypertensive patients rather than rely on more familiar drugs like methyldopa, or prescribed H2 antagonists instead of antacids for duodenal ulcers. The suggestion by M McKee *et al* that no new medicines should be prescribed on the NHS until they have been proved to be better than existing preparations ignores the fact that it is often only after years of widespread clinical use that the true value of a medicine is established.

The danger is no longer that naive doctors will be beguiled by unscrupulous representatives into prescribing unnecessarily expensive medicines. Now that there is so much emphasis on reducing prescribing costs, and also the possibility of unpleasant sanctions against those who exceed cost targets set for them, prescribers may resist prescribing new, more effective but expensive medicines long after the time when they would have prescribed them in the past. They may salve their consciences by claiming the virtues of therapeutic conservatism, but cost will be the dominating factor.

Surely the correct way of making a rational prescribing decision is for a prescriber to ask how he or she would like to be treated in similar circumstances. For example, if a doctor would like his moderate hypertension treated with an ACE inhibitor or his shingles treated with systemic acyclovir he is in a rather weak ethical position if he withholds these treatments from his patients on the grounds that there is insufficient proof of their efficacy. Similarly a doctor should not prescribe a new drug he would be reluctant to take himself or give to his family in similar circumstances. This test is not, of course, infallible but does avoid the extremes of cost-driven conservatism and reckless experimentation.

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Sir—Therapeutic conservatism has been defined by Griffin and Griffin [1] as a phenomenon whereby prescribing doctors, in response to budgeting constraints, restrict their prescribing to fewer and older active substances. This means that patients do not receive the benefits of therapeutic advances.

Many premature baby units are not routinely using

lung surfactant. The charity BLISS found that fewer than a third of 207 hospitals routinely used surfactant for the treatment of respiratory distress syndrome. In a further study of 45 special baby care units conducted for Wellcome, only one third of such units used surfactant for the treatment of respiratory distress syndrome within three hours of babies' admission. In many cases surfactant was used as a last ditch measure rather than as a main line therapy. Cost restraints seem to affect therapeutic decisions.

Is this lack of high-cost, effective treatment a reflection of the recent comment by Dr Kenneth Calman, Chief Medical Officer, at the International Congress of Ethics in Medicine, that 'shifting resources to one patient may mean they cannot be used for others'?

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References

1 Griffin JP, Griffin TD. The economic implications of therapeutic conservatism. *J R Coll Physicians Lond* 1993;**2**:121–6.

Sir—The view of your correspondents from the London School of Hygiene and Tropical Medicine (July 1993, page 338) typifies the very problem of why new medicines are not being widely used in the UK.

As long as politicians, academics, health managers or doctors expound the theory, as your correspondents' letter does, that prescribing new medicines means treating fewer patients, there is little hope of improving either treatment or cost-effectiveness in the NHS.

Even Mrs Bottomley has declared that the government's interest 'lies in cost effective prescribing not cheap prescribing' and claims to be 'quite prepared to pay the price for innovative medicines which will significantly improve the quality of patients' lives' [1].

Government downward pressures on prescribing costs, however, mean doctors believe they are positively discouraged from adopting innovative medicines, since these penny wise, pound foolish controls make no allowance for consequent savings elsewhere in the Health Service, let alone benefits to patients' well-being.

Doctors, therefore, need to be in a position to learn as much as possible about the advantages of new medicines, and patients have every right to expect to receive what their doctors then choose as the best treatment—a judgement which should not be clouded by the cost of the medicine as a sole or main determinant.

In comparing spending by the pharmaceutical industry with other sources of information for doctors, Dr Walley (July 1993, pages 337–8) omits to mention the government funding of nearly £1.5 million for *Prescribers Journal* and *BNF*, and the £6 million spent on maintaining the indicative prescribing scheme [2]. Ironically, the considerable cost of PACT (itself a cost monitoring system) cannot be identified by the DoH.

Reluctant prescribing of newer medicines by doctors cannot be defended as a mark of good training. Doctors have simply not kept pace with the many advances made in pharmacology. Dr Hugh McGavock [3] recently pointed out that therapeutics is often left to the idiosyncratic personal preferences of individual clinical teachers. 'There is no final examination in therapeutics; no formal teaching of therapeutics and pharmacology during the pre-registration year or vocational training period.'

While Dr Walley criticises some practises of prescribing in other countries where spending is more than in the UK, it is notable that countries with the greatest increase in health service spend per head most significantly have also seen the greatest improvement in life expectancy and infant mortality. OECD figures show that Britain, which trails behind Germany, France, Italy, Sweden, Japan and the USA in pharmaceutical spending per head, has been overtaken by most of these countries since 1960 in terms of life expectancy for men and women, and in reducing infant mortality.

References

1 Bottomley V. DoH/PAGB Symposium, London, 30 November 1989.
2 Hansard, 17 December 1992, col 412.
3 McGavock H. A great thirst for knowledge. ***Br J Clin Pharm*** 1993;**35**:217–8.

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Sir—Griffin and Griffin (April 1993, pages 121–6) have produced interesting statistics which confirm increasing reluctance by British doctors to use newer medicines. Letters to the Editor have not disputed the figures but attempt to justify increasingly conservative prescribing behaviour.

I would like to sound words of caution about present trends from a base in general practice. There have been major changes in recent years to produce prescribing data for doctors in primary care. Family Health Service authorities are actively pursuing policies of encouraging doctors to increase the proportion of prescriptions for generic agents and producing other incentives for doctors to reduce prescribing costs. Fund holding practices show an enthusiasm for using the cheapest generic products to stay within budgets and have money to spend on practice development.

What are the major concerns in prescribing in the community? Cost is now second only to concern regarding side effects [1]. Prescribing costs are increasing because of a rise in volume which reflects demand [2]. The Family Health Service Authority has specific delegated power to contain costs and is developing mechanisms to ensure that it succeeds [3].