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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Good medicine is cheaper than bad

SIR,—The review of clinical budgeting and costings by Dr Iden Wickings and colleagues (12 February, p 575) makes the distinction between these two methods of financial control with great clarity. The main question, however, is not which method of financial control is appropriate for doctors but whether any method is appropriate. I have recently argued the case against exposing doctors to financial information for resource control.[1] I concluded that it is better to encourage more economical use of resources by getting doctors to practise better medicine than by giving them financial information.

The acquisition of any skill demands some interest in that skill, a period of training or orientation, and regular use of it. To anyone who deals regularly with financial information the effort needed to appreciate that information is minimal, but for a group not regularly exposed to it the extra effort may be considerable. It is not sufficient to read a column of figures. Their implications have to be appreciated and judgments made upon them. Is it reasonable to expect most doctors, and if these methods are to have any appreciable impact it has to be most doctors, to acquire and maintain the skill of financial management? Would it not be more appropriate for them to spend their time learning how to be better doctors? An activity which will bring with it better use of medical resources and hence justification for their deployment.

Poor health care involves a waste of resources: too many investigations are ordered; ineffective or inefficient treatments are prescribed; hospital stays are prolonged; and numbers of visits to the doctor are excessive. By the practice of better medicine both the quality of care is improved and more economic use of resources is achieved. In the paper by Dr Wickings and others the following example is given to justify clinical budgets as a way of improving the use of resources. "For instance, it becomes worthwhile for the clinician to screen out unnecessary or expensive prescriptions written by his junior staff because the unused funds could be redeployed." Unnecessary prescriptions are bad medicine. Expensive prescriptions should be changed only if there is a cheaper and effective treatment, which is often the case.

In the same issue of the *BMJ* (Clinical Research edition) as the article by Dr Wickings and others appeared, there were advertisements for two anaerobic agents: tinidazole (Fasigyn) (opposite p 519), new and expensive costing £9·20 for seven days' oral treatment; and metronidazole (Flagyl) (after p 557) very long in the tooth at £4·03 for the same seven days' course. Apart from the reduced frequency of dosage there is no overwhelming advantage of tinidazole over metronidazole, which is a drug widely used for many years and whose effectiveness and side effects are very well known. It is better medicine at this time to use metronidazole then tinidazole. Economic implications do not enter into the decision.

Economic considerations are important in health care, but they do not relate to individual patients but to the planning of services, the provision of special units, and the introduction of large capital items such as scanners and computers. Within the overall framework of the Health Service as determined by the government and regional and district authorities doctors should be encouraged to practice the best medicine, which almost always will be the most economic.

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[1] Young DW. Cost and clinical decisions. *J R Coll Phys* 1983;17:86-7.

Computed tomography in dementia: an expensive innovation?

SIR,—It is a strange feature of many articles published recently on medical practice that studies of clinical effectiveness are augmented by casual and unsubstantiated references to the resource implications of such practice. Dr J R Bradshaw and others (22 January, p 277) add to this unfortunate trend by recommending brain scans for certain demented patients on the basis that both the costs and benefits are favourable. We suggest that the article provides no such evidence.

They state that computed tomography is cheap relative to care in an institution, but this is surely meaningless. The relevant comparison to be made is between the total cost of scanning all patients to be investigated plus the cost of treatment where appropriate and the savings made on long term care for the patients who are treatable. Nowhere has this calculation been performed. In view of the low average survival times for undiagnosed but treatable patients, however, these savings would be concomitantly low, and it is not evident that there would be a net saving of resources.