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# BRITISH MEDICAL JOURNAL

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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

### Why doctors must grapple with health economics

SIR,—Mr John Appleby (7 February, p 326) writes of arriving at an informed decision about using society's resources. A characteristic of general practice is the wide variation in practice between individual doctors, even when practice characteristics such as demography and socio-economic patterns are taken into account.<sup>1,2</sup>

The figure shows a repertoire of general practitioner management options (based on studies of general practitioners at work<sup>3,4</sup>) in relation to their costs. The seven modes are not necessarily mutually exclusive, but observation suggests that many general practitioners tend to work most often in one mode. As an illustration each mode may be considered in relation to a common presentation—for example, a 50 year old married master baker presenting with a 10 day history of dry irritant cough.

**Prescribing**—This is the stereotype of the general practitioner in action. History is usually accompanied by examination and followed with a prescription, possibly for an antibiotic. Follow up may be left to the patient's discretion.

**Investigating**—The general practitioner may want to exclude lung disease, especially if there is a history of cigarette smoking and a few adventitious sounds on auscultation. A chest radiograph may be arranged and the results discussed at a follow up consultation.

**Referring**—May be an extension of the decision making involved in investigating, with the doctor "prescribing" an appointment at a chest clinic. The patient will usually undergo chest radiography and make at least one follow up visit to the

specialist clinic. Admission to hospital is an option (though unlikely in this example).

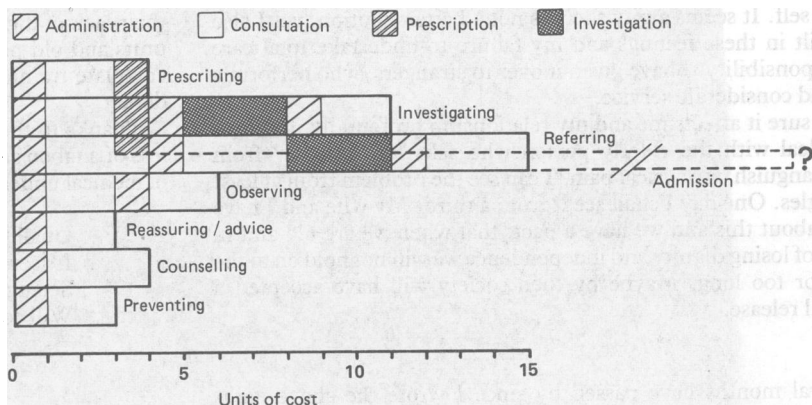
**Observing**—Mild or acute bronchitis in the context of an increased prevalence of respiratory illnesses in the practice may prompt the doctor to use time as a diagnostic and management agent. The patient will be asked to return in a week and a prescription may or may not be issued.

**Reassuring advice**—If there is no systemic upset the doctor may draw on his knowledge of the patient and the current wave of mild respiratory illness to suggest that the worst is over and illness is not important. No further follow up is envisaged.

**Counselling**—The doctor may explore possible

meanings the condition has for the patient. Why might an intelligent previously healthy man give priority to consulting about a minor illness already prevalent in the community? Uncovering a fear about cancer and helping the patient to come to terms with his fears are likely to take longer than the other modes and might be associated with the prescription of a "therapeutic" chest radiograph.

**Preventing** may be incorporated into several of the modes or be free standing. A diagnosis of a mild lower respiratory tract infection might be used as a focus to explore possible causal factors amenable to modification such as dust pollution at work and cigarette smoking.



Cost of various management decisions on general practice. One cost unit = administrative costs of a consultation = one item on prescription.