Editorial

Jennifer's ear: airing the issues

Few people would have imagined that a general election campaign in the midst of a recession and with the future role of Britain in Europe at issue would have been dominated for a week by a story about a child having to wait for a minor elective operation. Yet that is exactly what happened in March, as the battle of Jennifer's ear was waged between the main political parties. The principal issue they focused on, apart from the legitimacy of using such a case for political purposes, was why it had taken 12 months from referral to surgery – was it lack of resources or an administrative error? Politicians, expert commentators, and journalists, almost without exception, failed to address the underlying issues. In this respect, the episode was a faithful portrayal of the usual level of health policy debate in parliament and the media. Three questions in particular should have been considered. Did Jennifer need the operation? If so, did it need to be done as an inpatient procedure? Did she need to wait so long?

Was an operation needed?

This is a difficult question to answer and one that the latest Effectiveness Bulletin addresses (p 266).¹ Glue ear (otitis media with effusion), the condition she had, has been the commonest reason for surgery in children in England and Wales for over a decade.² Despite the popularity of surgery there is still considerable uncertainty as to the appropriate indications for operating. Drawing firm conclusions from the 17 randomised controlled trials that have been published is complicated as they used different inclusion and exclusion criteria, methods of control, and outcome measures.³ This has meant that a meta-analysis has not been possible.⁴ Until a large, well designed trial is conducted clinicians and policy makers will have to base their decisions on consensus views⁵ and literature reviews.^{6,7}

Although a new large trial would help to define the outcomes associated with various preoperative factors more accurately, the decision as to what constitute appropriate indications will still require clinical and managerial judgments. The findings of one of the existing trials serves to illustrate this.⁸ That study showed that if children were operated on only if they had a hearing loss of at least 30 dB, 45% of those undergoing the operation would benefit (defined as an improvement of 10 dB persisting for at least six months) whereas 14% of those refused surgery would have been denied that benefit. The proportion denied benefit could be reduced to 6% by lowering the inclusion criterion to a hearing loss of 20 dB. However, the proportion of surgical cases benefiting would also drop, to 33%. The decision is complicated further by also considering the risks of adverse outcomes associated with surgery – another subject of controversy. Finally, even when the probabilities of all these factors have been quantified, a utility or value for each outcome has to be assigned before a rational decision as to whether or not to operate is made. Whose utilities should be used? At present it is,

implicitly, the surgeon's with the patient's agreement. However, this may change as commissioning becomes more advanced.

Was inpatient treatment necessary?

Assuming that Jennifer needed an operation, did she need treatment as an inpatient? There are two principal ways in which glue ear can be treated surgically: by insertion of a tympanostomy tube (grommet) alone or in combination with an adenoidectomy. Randomised controlled trials that have compared these treatments suggest that the only advantage of including an adenoidectomy is that it may prolong the effects of surgery and thus reduce the likelihood of needing repeat insertion of grommets. Inserting grommets can be safely performed as a day case procedure⁹ whereas adenoidectomy is generally thought to require inpatient care, though it is undertaken on a day basis in the United States,^{10,11} and at least one British surgeon has questioned the need for inpatient care.¹²

In England and Wales the use of day surgery for treating childhood glue ear by inserting grommets is far from universal. An audit in 1991 of 152 health districts revealed that only half performed more than 62% of cases on a day basis.¹³ Apart from any additional psychological stress that children might suffer from an unnecessary overnight stay in hospital, the financial disadvantages of inpatient care are considerable. The average extracontractual price in Yorkshire region for 1992–3 for grommet insertion as a day case is £237 compared with £420 for inpatient care and £1044 for grommet insertion plus an adenoidectomy as an inpatient.⁷ Even allowing for the greater likelihood of the need for repeat surgery if an adenoidectomy is not performed, clear financial advantages would still result from day case insertion of grommets. These advantages would be even greater if instead of inserting grommets under general anaesthesia, the procedure was performed with topical anaesthesia in outpatients.¹⁴

Was waiting prolonged?

Jennifer should certainly have waited a few months while her surgeon established that her condition was persistent and would not remit spontaneously. Once that had been established she need not have waited for her operation if her surgeon had been prepared to treat her as a day case. The waiting time would also have been shorter if a system of priority classification had been used correctly. Unfortunately, inappropriate use of prioritisation can actually worsen the situation. For example, in one study of general and orthopaedic surgeons' patients those in the highest priority category actually waited longer than those in a less urgent category.¹⁵

Without more knowledge of the clinical details of Jennifer's case, it is impossible to judge how best she should have been treated. What is clear, however, is that politicians and journalists missed an excellent opportunity for bringing some key health policy issues to

the electorate. Instead of irrelevant discussions about who said what to whom, uncertainties about the effectiveness and appropriateness of health care interventions, methods of rationing, and deciding between competing demands could have been aired. But there again, the very existence of such uncertainties may have been why such issues were avoided.

NICK BLACK

Senior Lecturer in Public Health Medicine,
Health Services Research Unit,
Department of Public Health and Policy,
London School of Hygiene and Tropical Medicine,
London WC1E 7HT

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