Reduction in the use of surgery for glue ear: did national guidelines have an impact?

N Black, A Hutchings

**Background:** It is widely accepted that the passive dissemination of national clinical guidance has little or no effect on practice.

**Objective:** To assess the impact in England of an *Effective Health Care* bulletin on childhood surgery for glue ear issued in 1992 and to understand the reasons for any change (or lack of change) in practice that ensued.

**Method:** Time series analysis of the rate of use of surgery by children under 10 years of age from 1975 to 1997/8 in 13 English health districts.

**Results:** Following a rise in the rate of surgery in public (National Health Service) hospitals from 1975 to 1985, the rate declined by 1.6% a year from 1986 to 1992/3. Following publication of the guidelines in November 1992, the rate of decline increased to 10.1% a year. Even after allowing for a slight increase in the use of independent (private) hospitals between 1992/3 and 1997/8, the overall rate of decline was at least 7.9%. It appears that the rate of referral of cases by primary care physicians (general practitioners) halved during this period. Several contextual factors are thought to have contributed to the effect of the guidelines, including pre-existing professional concern about the value of surgery, the introduction of an internal market into the NHS, and growing apprehension among parents fuelled by scepticism in the mass media. During this unprecedented period of rapid change in usage, staff delivering the service remained unaware of the alterations in their own practice.

**Conclusions:** Passive dissemination of national guidelines can accelerate an existing trend in clinical practice if the context is hospitable. Policy makers should identify and target such situations.

The primary aim of this paper is to ascertain whether or not the passive dissemination of national guidelines to typical service providers (district general hospitals as well as teaching hospitals) had any impact on clinical practice. Studies of such interventions in other areas have reported either no clinically significant effect or only a modest impact. If the guidelines were shown to have had an effect on this occasion, our secondary aim was to establish why this was so.

**METHODS**

Annual numbers of surgical operations for glue ear performed in NHS hospitals for residents of 13 health districts (as defined in 1975) in the Oxford and East Anglian health regions had previously been obtained for 1975 to 1990. Data had come from the Hospital Activity Analysis (HAA) system up until 1986 and then from the District Information System. Data for 1991/2 to 1997/8 were obtained from Hospital Episode Statistics supplied by the Department of Health. Population denominator data were obtained from the Office for National Statistics. To ensure consistency in the resident populations being studied over the 23 years, more recent data were mapped onto the geographical areas defined in 1975 by means of patients’ postcodes.

Cases were included if they were aged under 10 years and had undergone myringotomy or tympanostomy tube insertion, with or without adenoidectomy, and with or without tonsillectomy. From 1975 to 1987/8 procedures were coded according to the OPCS 3rd revision (193.1–193.4; 193.1–193.4 with 235; 193.1–193.4 with 233) and from 1988/9 the OPCS 4th revision (D15.1–15.4, 15.8, 15.9; D15.1–15.4, 15.8, 15.9 with E20; D15.1–15.4, 15.8, 15.9 with E20 and F34). Care was taken to avoid double counting when surgery was bilateral. Adjustments were made for shortfalls in the clinical coding in otolaryngology, which never exceeded a few percent in any...
Table 1 Glue ear surgery rates in children aged under 10 years in East Anglian and Oxford regions and interdistrict range (1975 to 1997/8)

<table>
<thead>
<tr>
<th>Year</th>
<th>Overall</th>
<th>Interdistrict range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>53.2</td>
<td>29.2–77.7</td>
</tr>
<tr>
<td>1976</td>
<td>58.9</td>
<td>22.6–103.9</td>
</tr>
<tr>
<td>1977</td>
<td>63.4</td>
<td>15.4–100.6</td>
</tr>
<tr>
<td>1978</td>
<td>70.6</td>
<td>26.1–113.5</td>
</tr>
<tr>
<td>1979</td>
<td>76.8</td>
<td>30.0–123.0</td>
</tr>
<tr>
<td>1980</td>
<td>93.9</td>
<td>41.6–132.0</td>
</tr>
<tr>
<td>1981</td>
<td>99.2</td>
<td>47.7–154.0</td>
</tr>
<tr>
<td>1982</td>
<td>100.0</td>
<td>43.4–154.3</td>
</tr>
<tr>
<td>1983</td>
<td>116.9</td>
<td>54.6–172.5</td>
</tr>
<tr>
<td>1984</td>
<td>129.3</td>
<td>47.9–207.3</td>
</tr>
<tr>
<td>1985</td>
<td>129.5</td>
<td>71.7–205.8</td>
</tr>
<tr>
<td>1986</td>
<td>131.8</td>
<td>68.7–229.6</td>
</tr>
<tr>
<td>1987/8</td>
<td>127.9</td>
<td>56.9–206.4</td>
</tr>
<tr>
<td>1988/9</td>
<td>121.4</td>
<td>63.4–215.2</td>
</tr>
<tr>
<td>1989/90</td>
<td>117.8</td>
<td>71.4–190.2</td>
</tr>
<tr>
<td>1990/1</td>
<td>115.2</td>
<td>71.4–214.3</td>
</tr>
<tr>
<td>1991/2</td>
<td>121.8</td>
<td>84.5–184.2</td>
</tr>
<tr>
<td>1992/3</td>
<td>119.9</td>
<td>90.6–165.3</td>
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<tr>
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<td>105.5</td>
<td>70.3–161.1</td>
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<tr>
<td>1994/5</td>
<td>91.8</td>
<td>70.8–137.1</td>
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<tr>
<td>1995/6</td>
<td>84.0</td>
<td>59.3–130.8</td>
</tr>
<tr>
<td>1996/7</td>
<td>74.1</td>
<td>68.6–112.2</td>
</tr>
<tr>
<td>1997/8</td>
<td>68.4</td>
<td>45.4–90.2</td>
</tr>
</tbody>
</table>

Figure 1 Rates per 10 000 of glue ear surgery in children aged under 10 years in the Anglia and Oxford regions showing fitted Poisson regression line and 95% confidence limits. Years 1975–86 are calendar years; years 1987 onwards are the 12 months from 1 April to 31 March the following year.

The modest but steady decline in the rate of surgery for glue ear which started in the mid 1980s accelerated after 1992. Between 1992/3 and 1997/8 the rate in NHS hospitals almost halved, although there was considerable variation between the 13 districts that constituted the study population. If these changes resulted even partly from the dissemination of national guidelines in November 1992, this is in sharp contrast to previous reports from the USA,\(^\text{14}\)\(^\text{15}\) Canada,\(^\text{13}\) and the UK\(^\text{18}\)\(^\text{19}\) which found little or no effect of such an intervention. Before discussing why, on this occasion, passive dissemination of national guidelines may have been so effective, it is necessary to consider other possible explanations for the decline in the rate of surgery—namely, statistical artefacts, supply factors, and demand factors.

The observed changes in the surgical rate might have been due to statistical artefacts. This is unlikely as there were few missing data (and adequate adjustments were made when data were absent). Although management of routine data on hospital use changed twice during the 23 years, the method of data collection remained the same. We have no reason to believe that the validity of the data recording and coding declined systematically over the time period studied. One other possible artefact would be a rise in the rate of surgery in independent hospitals (privately funded cases performed in NHS hospitals were included in the data analysed). While the rate did rise in independent hospitals from 18 to 22 per 10 000, this was insufficient to cancel the significant overall decline in the use of surgery during this period.

If the observed decline in surgical rate has been real (rather than apparent), it could have arisen as a result of a reduction in the supply of services, either through a decrease in available services (otolaryngologists, hospital beds, operating theatre time) or through a change in clinicians’ judgement as to the appropriate indications for surgery. With regard to the former, far from a reduction in the availability of services, the 1990s witnessed an annual 4% increase in the number of hospital consultants.\(^\text{17}\) With regard to clinician judgement, no quantitative data exist on changes in the severity of surgical cases over time. It is therefore possible that clinicians became increasingly restrictive in their advocacy and use of surgery for treating glue ear, in particular by more appropriate use of investigations and watchful waiting as suggested in the Effective Health Care bulletin.

A decrease in the use of surgery could also have resulted from a reduction in demand—fewer parents approaching their GPs who, in turn, may have been less inclined to refer
children to an otolaryngologist. There are no national routine data on referral rates, although researchers carrying out a randomised trial during this period have reported a 50% decline in the number of children referred to the 13 hospitals included in that study between 1994 and 1998 (Mark Haggard, personal communication). These three factors may therefore have contributed to the accelerated decline in the use of surgery which began in 1992/3: a reduced demand from parents, a fall in the GP referral rate to otolaryngologists, and the adoption of more stringent indications for surgery by surgeons.

It seems reasonable to believe that this dampening down of both of demand and of supply which started in the year following publication of the Effective Health Care bulletin was related, at least in part, to that intervention. However, GPs, otolaryngologists, and other relevant staff (audiologists, health visitors, school nurses) did not share this view when interviewed in 1996–8. In a qualitative study carried out in the same geographical area as the present study, researchers concluded that “the Effective Health Care bulletin has not proved to be particularly helpful for our group of interviewees in clarifying appropriate practice”. Most had not heard of it, and those who had claimed it had had little or no influence on their practice. On the basis of their respondents’ opinions, the authors concluded that “our findings in this case study suggest that we cannot expect guidelines such as the Effective Health Care bulletin alone to lead to change in clinical behaviour”. Interestingly, the respondents seemed unaware that a significant change in clinical behaviour had been going on for at least three years.

What other factors might have contributed to the dramatic decline in surgery following the dissemination of the bulletin? One major organisational change to the NHS could have contributed—namely, the introduction of GP fund holding. This was implemented in annual waves; the first wave of pioneering GPs was in April 1991 with successive waves each April. Although they were only a minority of GPs over the first few years (1990/1 to 1994/5), some evidence suggests their patients made less use of minor discretionary surgery. Fund holding could therefore have contributed independently to the observed changes, although it offers only a partial explanation and the bulletin may have contributed to fund holders’ behaviour.

The other factor that needs to be considered is the impact that adverse publicity about the effectiveness of surgery for glue ear might have had on the public and, in particular, on parental views. Even before the launch of the bulletin, the mass media had been interested in the topic. Public awareness was heightened when glue ear surgery became a high profile issue in the British General Election in spring 1992. Following publication of the bulletin later that year, newspapers and television reported that doubt had been thrown on the value of the operation. Media interest was further stimulated a few months later when an Audit Commission report on hospital services for children concluded that “too many children are being operated upon for glue ear”. All this adverse publicity may well have affected parents and GPs, making them more reluctant to seek a surgical answer. This was certainly the view of one medical commentator and, by 1995, these views were also affecting the formal purchasers of health care—the district health authorities. A survey of annual purchasing plans revealed that 23 of 129 health authorities were limiting their support for surgery for glue ear or even attempting a complete ban.

Given the apparent lack of impact of the passive dissemination of national guidance, the relative impact contributed by each of these five factors but, given the apparent lack of awareness of the contents of the bulletin among healthcare professionals, one might speculate that changes in the attitudes and behaviour of parents played a key role. In turn, such changes are likely to have been influenced significantly by mass media reports.

Our findings of a dramatic alteration in the speed of change in the use of surgery suggests that passive dissemination of national guidance can contribute to change in clinical practice if the context is appropriate. This implies that bodies responsible for producing voluntary guidelines should focus on those topics for which the environment is likely to be conducive to change. A preliminary analysis of the context might help to avoid expending effort in areas where change is unlikely in the situation that pertains.

ACKNOWLEDGEMENTS

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