to point out that although the authors have used the heading 'Nurse salary' in the section 'Direct costs', a careful reading of the subsequent paragraph will reveal that the amounts used for calculations are in fact the cost to the hospital of employing a Grade E and F nurse which is higher than the salary of these nurses. However, Mr Jones has himself used consultant's salary and not the cost to the hospital of employing a consultant of performing the comparison in his letter. This is likely to bias his results making the nurse-led clinic appear less cost-effective, this is misleading.

A third point raised is that like has not been compared with like and that the analysis of the cost of a doctor-led clinic should be the same as the nurse-led clinic. The authors considered this fact prior to their analysis. However, we were advised by the finance director that such a calculation would be inappropriate as data on the cost of a doctor-led ENT clinic is already available from the National Database of Reference costs for NHS. This data is directly applicable to York Hospital. Had the authors not used the available data they risked being heavily critiqued. Thus the authors were not being cavalier in quoting a personal communication of the Director of Finance. On the other hand the facts quoted were based on National Database of Reference costs for NHS. We also wish to point out that the figure of £181 and £81, respectively, for a new and follow-up appointment with a doctor includes the cost of investigations and the indirect costs incurred during a doctor-led out-patient appointment. Moreover, this figure reflects the support extended by colleagues from audiology, nursing, speech and language therapy and various other departments. These services and support are not available to the same level in the private sector and hence a direct comparison between the two sectors is not appropriate. In fact, most of the consultants in the private sector are not supported by an audiologist. However, should one be very keen to make such a comparison, then the cost cost of the above-mentioned services along with the cost of performing investigations etc, needs to be taken into account. This will suddenly tilt the balance in favour of the NHS.

Mr Jones has calculated incorrectly that a doctor would be paid up to £250 per hour or more according to our figures. He has obviously not taken into account the fact that the cost of a doctor-led clinic includes the cost of the investigations and also the cost of one or more nurses helping the doctor either directly in the clinic or in providing support services in the treatment room. The nurse-led clinic has the advantage of avoiding these ancillary costs and hence is more cost-effective. Thus his reasoning and logic does not hold true and the calculations proposed are not valid.

The assertion that the indirect costs of a doctor-led clinic and a nurse-led clinic must be the same is not correct for the same reason that the nursing and ancillary medical staff support available at the time of a doctor-led clinic is not available at the time of a nurse-led clinic. Hence, it is clear that these indirect costs are not the same and one cannot simply ignore these differences in the indirect costs between these two groups as proposed in his letter.

Mr Jones has suggested a hypothetical situation that if the rate of investigation of a consultant-led clinic was 50 per cent, and one was to ignore the consumables, investigations and indirect costs then the cost advantage of the nurse-led clinic would be neutralized. We wish to point out that the nurses in our nurse-led clinic follow a strict protocol for arranging audiological assessment following grommet insertion and mastoid surgery. Similarly there are guidelines for arranging pus culture and sensitivity in cases of recurrent otitis externa referred directly to this clinic. Consultants and other junior medical staff in our department follow the same guidelines. This decreases to a great extent any difference in the investigation rates amongst the two groups studied.

He is right in pointing out that it is well documented that more experienced doctors review fewer patients and perform fewer investigations than less experienced doctors. Since the patients in the doctor-led clinic in our hospital were seen by both a consultant otolaryngologist and other junior members of the medical team, we expect that the difference between a nurse-led clinic and a doctor-led clinic is not likely to be as high as suggested in his letter. In fact, the two nurses have been running this service for 7 years in our hospital, and hence are much more experienced than some of the trainees in the department. They are therefore less likely to bring the patients back unnecessarily as compared to some junior members of the medical team, especially since they are well versed with the departmental protocols that are adhered to strictly. The indirect costs incurred due to investigations in our paper are based on actual figures. Mr Jones is right in pointing out that these costs form a high proportion of cost incurred in running such a service. The fact that these costs account for a high proportion of the cost incurred in running a nurse-led service reflect the fact that there is a potential to reduce the cost of such a service further thus making it more cost effective.

We agree that there may be a variation in the actual costs incurred depending on the method used for economic analysis. However, it is unlikely that the difference will be a great as that has been suggested. Our extensive calculations suggest that the variation is likely to be small and hence the nurse-led clinics are significantly more cost-effective than has been suggested by Mr Jones. This should not distract ones attention from the fact that the message conveyed by the paper is twofold. Firstly, that the nurse-led clinic is more cost-effective and secondly, and more importantly, that this service frees up the otolaryngologist's time to see other patients with more pressing and complex problems. Thus nurse-led clinics for common otological procedures have the potential for reducing outpatient access time in the NHS.

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Location, Location, Location

Dear Sirs,

Ear reconstruction in microtia patients is one of the greatest technical challenges facing a reconstructive plastic surgeon. Tanzer[1] introduced the use of autologous costal cartilage and Brent[2], Firmin and Nagata[3] refined the technique to produce consistent and high quality auricles. In microtia, the final result is highly dependent on the baseline condition of the surrounding skin. To produce a quality auricle from a microtic ear, the quality and quantity of the available skin and consequently the pocket into which the carved framework is inserted is highly significant. In the classic form of microtia (Figure 1) with good quality skin and a high hairline an excellent result can be achieved (Figure 2). If, however, the surrounding

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FIG. 1
Classic lobular microtia.

skin is scarred then the outcome of the reconstruction will be compromised. In addition more complicated surgical techniques such as tissue expansion or the use of a temproparietal fascial flap may be needed.

Hearing needs to be restored in some children with microtia and a common and appropriate technique is to use a bone-anchored hearing aid. One great problem is that the titanium fixture and abutment is sometimes positioned at a site where the child's ear should be reconstructed. Whether a bone anchored prosthetic ear or an autogenous ear is to be created the hearing aid must be positioned correctly. We illustrate the case of a six-year-old boy with conchal microtia in whom the bone anchor for a hearing aid was placed superior and posterior to the microtic ear within the skin that would normally be utilized for auricular

FIG. 2
Autologous reconstruction; immediate post-operative result.

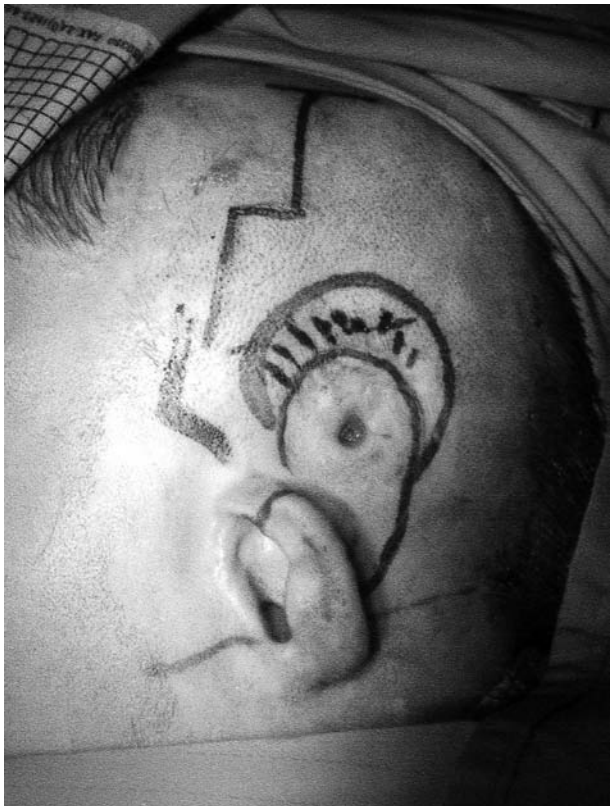

FIG. 3
Conchal microtia. The bone anchor hearing aid positioned at the site to be utilized for ear reconstruction. The patient also has an abnormally low meatus.

FIG. 4
The temperoparietal fascial flap overlying the cartilaginous framework.

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FIG. 5
Post-operative result, two months.

reconstruction (Figure 3). This necessitated the use of a temproparietal fascial flap for the reconstruction to cover the upper half of the framework (Figure 4). The fascia in turn was covered by a thin split thickness skin graft transposed from the adjacent scalp (Figure 5). It is important to consider future ear reconstruction when positioning a hearing device. The estate agents have always stressed the importance of location. They are right.

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