in which a nurse practitioner undertook outpatient clinics for patients with breast cancer interchangeably with a senior house officer.⁴ Randomised trials of follow up in breast cancer are needed in which the clinical and cost effectiveness of specialist nurses and doctors are compared.

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- 1 Grunfeld E, Mant D, Yudkin P, Adewuyi-Dalton R, Cole D, Stewart J, *et al.* Routine follow up of breast cancer in primary care: randomised trial. *BMJ* 1996;313:665-9. (14 September.)
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Open door and listening ear are best support for patients

EDITOR,—The data presented by Eva Grunfeld and colleagues confirm clinical experience that most recurrences of breast cancer are diagnosed by the patients themselves, who present to their general practitioner between routine hospital visits.¹ The question therefore raised is not whether routine follow up can equally well be done in general practice but whether it should be done at all.

The only justification for routine follow up is when—as, for instance, in bladder cancer—the early detection of asymptomatic recurrence offers the patient appreciable benefit. Before devolving the discredited “no sign of recurrence” clinic to general practice we must address the fundamental question of what it is we are trying to achieve. I suggest that if we want to help and support our patients with breast cancer then an open door and a listening ear are better than the traditional follow up ritual.

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Most recurrences after breast conservation are detected by regular hospital visits

EDITOR,—Eva Grunfeld and colleagues state that most recurrences of breast cancer (18 out of 25) were detected by the women themselves between routine visits.¹ One must be clear why patients with breast cancer have regular follow up. It is not to detect metastatic disease, as there is clear evidence that early detection and treatment of such disease do not produce benefits.² The aim is to detect local recurrence so that treatment can be introduced at a stage that optimises the probability of maintaining long term locoregional control.

We have recently reviewed recurrences occurring in the breast after treatment by wide local excision and radiotherapy. In a series of 55

patients 10 such recurrences were detected by patients themselves, 23 by regular clinical examination in our follow up clinic, and 22 by annual mammography. Recurrences detected by patients were larger than those in the two other groups. Of the 23 detected by regular clinical examination, eight were not visible on mammography. All but one patient with an asymptomatic recurrence were free of metastatic disease and were suitable for a further excision or a mastectomy, compared with six of the 10 with symptoms.

Our data show that regular clinical follow up does detect local recurrence after breast conservation. After surgery and radiotherapy breasts are difficult to assess, and detecting local recurrences requires specific training. In the Edinburgh Breast Unit trained breast physicians undertake long term follow up of these patients. Each patient is assigned to a specific doctor, and this gets round the biggest complaint of patients attending long term follow up clinics, which is that they see a different doctor each time they visit. It is also a cost effective use of resources, with each doctor seeing 20-24 patients per session.

As Grunfeld and colleagues point out, their study “provides only limited information about local recurrence.” Our data suggest that, in contrast to metastases, over 80% of recurrences that develop after breast conservation are detected by regular hospital visits. Before regular hospital follow up is abandoned for patients with breast cancer a further study looking specifically at the problem of local recurrence is clearly required.

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Audit Commission's report was based on large samples and up to date data

EDITOR,—Kenneth Scott criticises the Audit Commission's recent report, *What the Doctor Ordered*, for relying on small sample sizes and out of date information.^{1,2} His comments are factually incorrect. The main information about the benefits for patients associated with fundholding derives from the largest survey of general practice fundholders yet carried out, with 1256 replies. The survey was carried out between November 1995 and January 1996 (not 1994-5 as Scott suggests). This makes the survey both more recent and much larger than the survey by the National Association of Fundholding Practices to which Scott refers. Given that the Audit Commission's report was published in May 1996, the four month gap between the end of the survey and publication of the data in a nationally available report may well be some kind of record for timeliness.

Other sources of information included 1308 replies to a survey of fundholding managers in 1994-5 and data on savings and overspending for 1156 fundholding practices in England and Wales, drawn by the Audit Commission's appointed auditors from end of year accounts. These data are unique in both their timeliness

and their ability to show individual variation in performance between general practice fundholders across England and Wales, since the only other sources of data—standard financial returns to the NHS Executive—aggregate fundholders' savings and overspending at health authority level and are published at a much later date.

Other information includes the first nationally published survey of multifunds (in which fundholders pool together a proportion of their management allowance to run a central secretariat), carried out in mid-1995; and information about the growth of fundholding supplied by a survey of health authorities, last updated in late 1995. The least timely data, referred to only briefly in the report, are from 1993-4 (information about the training status and the performance in terms of general medical services of every practice in England, drawn from the NHS Executive's general medical services database; and prescribing data for a sample of practices supplied by the Prescription Pricing Authority and the Welsh Office).

Scott is correct in stating that the information from the large scale survey was supported by visits to 56 practices, during which we discussed fundholding with doctors and managers; to my knowledge, this is the largest number of practices visited by any single study. Finally, the study team visited 27 health authorities (not 15) and 15 NHS trusts (not 12).

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- 1 Scott K. General practice fundholding has improved services. *BMJ* 1996;313:752. (21 September.)
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Child protection

Referrals to social services may be damaging

EDITOR,—The ethical debate highlighting the problems of the child protection system discusses a particularly difficult case.¹ The child protection system is the social services' equivalent to the consequences of defensive medicine. Social services research shows large variations in practice^{2,3}—for example, in 1992, registrations for abuse in 110 local authorities varied from 0.8/1000 children to 18/1000, with a mean of 3.5/1000. Gloucestershire, with the lowest rate, includes a considerable industrial area. What is so special about its practice? The research calls for social services to develop their services to be more “family friendly.”

Why do parents complain of being intimidated and not helped? One reason is the case conference. Here parents face a proliferation of professionals: representatives from social services for every field of contact with families, each with a supervisor; legal representation for the social services (never mentioned in any government guidelines); and police officers, even when the police have not been involved in the case. Professionals involved in a case often change between meetings, so that continuity is lacking.

Professionals promote their own practice. A particular concern is the degree to which solicitors push conference plans to a legal solution. Humanity, time, and money (from uncapped budgets) are lost in the law courts. These practices are long overdue an inspection by the Audit Commission.

With more serious issues the role of social workers becomes clearer: they are acting as the

social worker for the child. Who looks after the family? A guardian ad litem may be appointed (with his or her own costly legal representation), but the guardian's role is specifically to ensure the welfare of the children. There is a desperate need for a social worker for the family, to provide unbiased advice, explain parents' rights, and support the family at complex conferences.

Current practice undermines not only the family but also the key social workers, whose therapeutic relationships and opinions are not valued. Overspent, uncapped budgets are used to obtain assessments and therapy from outside social services. Practice varies enormously between teams in the same authority. Foster care is overflowing with children, and its use should be audited.

Professionals reading of the heartbreaking cases in which a child has died realise that social services have addressed the causes thoroughly: they now use this system for all disclosures. Referrals to social services are not neutral and may not remain confidential; they may be very damaging. I would support any doctor who thinks carefully before making a routine referral to social services.

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Child's needs should be central

EDITOR,—I am concerned about some of the issues raised in the case discussed in the ethical debate about child protection.¹ Given the nature of the case, it is entirely appropriate that social workers should have investigated it, as it was indeed an abuse of parental responsibility towards a child. I am not surprised at the child claiming that she must have slept through anything that happened. I have seen a teenage girl who denied the possibility of being pregnant despite having had no period for three months and having recurrent bouts of morning sickness, a positive result on pregnancy testing, and a viable first trimester fetus visible on ultrasonography. I suspect that the response of the child in the case debated reflects the human psyche's ability to deny unpleasant facts and should not be taken at face value.

The author tries to take an overview of his or her relationship with the entire family, with the result that the child's needs have become more peripheral than they should be. As medical professionals, we can manage only certain aspects of such complicated cases, and I believe that we are doing a disservice to the child if we do not involve other professionals more capable of continuing the investigations. It is by no means always the case that incest is disclosed at the time of a teenage girl's pregnancy being discovered. I would caution against the belief that "careful advice coming from a trusted doctor" is the input that a sex abuser needs.

Iona Heath's remark in her commentary on the case—that the outcome of these interventions rarely seems adequate—reflects a natural desire for a solution to what is an almost irreconcilable situation. My experience in paediatrics suggests that it is important not to ignore evidence that contradicts an apparently plausible explanation of such situations. I think that we do a disservice to young people, who need a voice

and an advocate on their behalf. All too many victims of familial sexual abuse suffer in the long term; they are likely to leave home, which puts them at risk from other dangers, such as prostitution, drugs, and violence. We want to prevent the abused person from becoming a potential abuser. We protect the perpetrator at great risk to the victim.

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Girl should have been offered a chance of safety

EDITOR,—I read the recent ethical debate on child protection with increasing uneasiness.¹ Although the priority of the child's welfare and the danger of professionals "going it alone" are pointed out, other important issues are not addressed.

Did it not seem worrying to the general practitioner that the girl behaved as she did when the allegations were made? Phrases such as "she offered no explanation" indicate to me a lack of insight into her experiences. Children subjected to sexual abuse, especially over a long period, may be unable to confirm that it occurred, even when there is irrefutable medical evidence. In this case, fetal DNA from samples obtained after termination of her pregnancy matched that of her stepfather. Her denial probably arose out of fear of her abuser. It would take a long time for such a child to trust any adult to keep her safe. In this case she was right not to "offer an explanation": hopefully, that provided her with some protection when the judge decided that this family should remain intact.

The general practitioner talks of the "so called abuser." Impregnating a 14 year old girl would count as sexual abuse to most people; having been sexually abused as a child is an explanation but not an excuse. It seems that the abuser was not asked to take any responsibility for his actions but was allowed to remain at home. What message did this give him for the future?

Did the general practitioner see no way of supporting the mother in protecting her children?

If anything, this case report is an example of how child abusers can seduce and split professionals, no matter how experienced they think they are. No one says that the system we have now is perfect, but it is, as it must be, child centred. Not all residential care units or foster homes are abusive. I wonder if this girl, if given a chance of safety, would have been able to offer an explanation to satisfy her general practitioner.

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- 1 Child protection: medical responsibilities. *BMJ* 1996;313: 671-3. [With commentaries by F N Bamford and I Heath.] (14 September.)

Prodigy, a computer assisted prescribing scheme

Interim data show that it is worth taking the scheme further

EDITOR,—I wish to address the criticisms of the computer assisted prescribing scheme Prodigy that Iain E Buchan and colleagues raise.¹ Prodigy is an innovative project that seeks to involve

practising general practitioners in evaluating and refining a product intended for use by general practitioners. The primary role of the Sowerby Unit for Primary Care Informatics at the University of Newcastle is to evaluate rigorously and objectively the results of the various phases of testing and to highlight their implication for improving the prototypes. I believe that the collaborative methodology that has been used is new to the NHS and has merit (I N Purves *et al*, annual conference of primary health care specialist group of British Computer Society, 1996). The Prodigy team has received, sought out, and welcomed criticism from health service researchers and people working in health informatics around the world.

An interim report on Prodigy was written to inform the community in a politically charged atmosphere.² The report is clearly a snapshot of currently available information, with conclusions based on a number of evaluations (I N Purves *et al*, annual conference of primary health care specialist group of British Computer Society, 1996).² Quotes by Buchan and colleagues originate from the conclusions of the report but were not immediately linked to the data in the way that their letter suggests. Buchan and colleagues juxtapose the quoted conclusion of "confirming [the] desirability" of Prodigy to the responses to the question "How much would you want to continue with Prodigy?"¹ but the text that was juxtaposed in the report was "94% ... consider Prodigy to be a concept worth developing (16% being extremely happy, and 78% endorsing its development as long as either 'some improvement' or 'significant improvement' is made)."² This is not confirming desirability but supporting a concept. Similarly, the interim report does not claim that Prodigy's "effectiveness" is confirmed¹ because of "relative reduction in the rise of expenditure of 1.1%." In fact it states, "At this early stage we have insufficient data ... to make any statistical inferences."² Finally, Prodigy has been "thrust" on no one: all 137 sites using it volunteered.

Prodigy is a combination of active and passive systems. It is not ready to be rolled out: the data in the interim report suggest only that the concept is acceptable and worth taking further. Prodigy is an innovative yet practical step in clinical computer systems, and one has to start somewhere. Reliable and statistically robust conclusions will be possible once the study is completed; only then will we be in a position to judge the merit or otherwise of Prodigy.

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Decisions will be taken after receipt of final report next autumn

EDITOR,—I wish to provide some background to the computer assisted prescribing scheme Prodigy, which Iain E Buchan and colleagues criticise.¹ Prodigy is a three year research and development project whose main aim is to test the likely acceptability of decision support for prescribing in general practice. The evaluation aspects of the report are the responsibility of Dr Ian Purves and his team at Newcastle upon Tyne. No decisions will be taken on whether to proceed to any form of national implementation until the NHS Executive has received the final evaluation report, due next autumn.