care do the women want? Some women certainly seem reassured after a follow up visit (even if they find the days before the visit stressful). This reassurance may be less solidly based than they imagine, given that routine follow up has not been shown to improve survival. Conversely, some women may find that the visits serve only to remind them of their disease and remain a continuing source of anxiety. There is a paucity of data on the effect of follow up on the quality of patients' lives. There are certainly financial costs for the patients—such as time off work and the costs of travel—and also for any accompanying relatives or friends.

For the medical and nursing staff, the sheer numbers of patients attending follow up clinics can reduce the time available for patients with problems. Conversely, the presence of fit women in the clinic may serve as a useful counterbalance to the negative effect of their continuously seeing patients whose disease has relapsed. In addition, data on the morbidity of treatment can be acquired only if all patients are seen.

The final section of the consensus statement recommends three main areas for further research. Firstly, more effective salvage treatments for breast cancer are needed, but this will depend on advances in the overall treatment of the disease. Secondly, there is a need to define the most effective diagnostic tests to be used in follow up. Currently, the only one of any established value is mammography for both the treated breast and the contralateral breast, but the optimal frequency needs to be defined. Thirdly, what sort of clinical

follow up (if any) do women need? Should this be regular attendance at a specialist centre, shared care with the patient's family doctor, or simply advice to the patient to return to the clinic if she has any problems?

We have performed numerous trials of primary treatment; it is now time to embark on trials of different follow up regimens and to apply the rigours of the assessment of screening programmes to follow up practices. The resource implications of follow up would alone justify such studies, but, more importantly, these studies would offer the opportunity to evaluate the needs of the patients themselves.

JOHN DEWAR

Consultant radiotherapist and oncologist

Department of Radiotherapy and Oncology,
Ninewells Hospital and Medical School,
Dundee DD1 9SY

- 1 Special Project Oncologia Femminile. Consensus conference on follow up of breast cancer patients. Bari: ONCOFEM, 1994.
- 2 Dewar JA, Kerr GR. Value of routine follow-up of women treated for early carcinoma of the breast. *BMJ* 1985;291:1464-7.
- 3 del Turco R, Palli D, Cariddi A, Ciatto S, Pancini P, Distanti V, for the National Research Project on Breast Cancer Follow-up. Intensive diagnostic follow-up after treatment of primary breast cancer: a randomised controlled trial. *JAMA* 1994;271:1593-7.
- 4 GIVIO Investigators. Impact of follow-up testing on survival and health-related quality of life in breast cancer patients: a multicentre randomized controlled trial. *JAMA* 1994;271:1587-92.
- 5 Kurtz JM, Amalric R, Brandone H, Ayme Y, Jacquemier J, Pietra J-C, et al. Local recurrence after breast-conserving surgery and radiotherapy: frequency, time course and prognosis. *Cancer* 1989;63:1912-7.
- 6 Mellink WAM, Holland R, Hendricks JHCL, Peeters PHM, Rutgers EJT, van Daal WAJ. The contributions of routine follow-up mammography to an early detection of asynchronous contralateral breast cancer. *Cancer* 1991;67:1844-8.
- 7 Orel SG, Troupin RH, Patterson EA. Breast recurrence after lumpectomy and irradiation: role of mammography in detection. *Radiology* 1992;183:210-6.

Rationing: the debate we have to have

Britain needs a nationwide, prolonged, systematic debate on rationing

Britain was transfixed last week by two stories that were primarily about the rationing of health care. In one case a court ruled that Cambridge Health Authority did not have to offer a second bone marrow transplant to a 10 year old child dying of leukaemia (p 0000). In the other case a man with a severe head injury was flown 320 km by helicopter to a neurosurgical unit because none of the many nearer units could take him (p 0000). The media were filled with these stories, and the debate over rationing exploded into life once again. Unfortunately—because the government is unwilling to be candid on rationing—the debate is likely to die down until we have yet another dreadful case. We need a much better debate.

The medical press has been debating rationing in health care for more than a decade, and two years ago the BMA, the *BMJ*, the King's Fund, and the Patients Association organised a conference on rationing.¹ The secretary of state for health, Virginia Bottomley, opened the conference and was careful to avoid the word rationing. Government, she said, had a role in broad strategic shifts of resources but not in "priority setting": that had to be done locally. This failure of leadership has meant that Britain has not had the broad, deep, informed, and prolonged debate on rationing that is needed.

What Britain has had is a series of brief, heated, and often uninformed debates about particular episodes. Debates have arisen in response to stories of surgeons refusing coronary artery bypass operations to smokers, people being denied various treatments on grounds of age, older women being treated for infertility, and a woman being given a breast

enlargement while other patients were denied apparently more "worthy" procedures. Each of these cases has illustrated different aspects of rationing, but most people have not had an opportunity to understand the scale of the problem and to give their opinion on issues such as trading off quality against quantity of life. And when it comes to such questions there are no experts: everybody's opinion is as good as everybody else's.

Perhaps these latest cases will prompt the debate we need. Those who know about the fascinating experiments in Oregon may remember that they started after patients on Medicaid were denied transplant operations. Economic pressures forced this step, but medical ethicists and others said that it was foolish to deny transplantation when it might often be much more cost effective than many other—perhaps less spectacular—treatments. So, with the state's encouragement, began a process of consulting the public and merging its opinions with technical measures of the cost effectiveness of all treatments. The outcome was a radically new system for rationing care.

Britain must find its own way of engaging the public in the debate on rationing, but this debate will lead to constructive outcomes only if the government takes the lead. One outcome may of course be an irresistible pressure to increase public expenditure on health care.

RICHARD SMITH
Editor

BMJ
London WC1H 9JR

¹ *Rationing in action*. London: BMJ Publishing Group, 1993.