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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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