

practices where additional clinical support is needed for service development. Variations to the vocational training scheme are also being piloted. Some general practitioner registrars will spend more of their three year course in general practice; others will have a fourth year of academic training in a department of general practice. Funds have been allocated to these departments and to the relevant family health services authorities in proportion to the number of general practice principals in their area.

Good collaboration will be essential if this scheme is to succeed. Local education boards, comprising representatives of all interested parties, will consider applications for funding; in some districts these exist already, in others they have had to be created. Boards should not merely respond to bids from practitioners and from education providers: a proactive approach is needed. However, it is difficult to commission a programme of education when it is uncertain whether funding will be available after two years.

Doctors in the programme will need substantial academic support from university departments of general practice—to provide training in research, teaching, and information technology—and from the postgraduate education network. For example, clinical tutors in general practice will visit practices to discuss the opportunities offered by the London Initiative Zone educational incentives programme, an important and innovative role. The programme presents an excellent opportunity to develop an integrated approach to education.⁶ It could create the exciting prospect of a continuum for general practitioners in London: from undergraduate education, through a stimulating vocational training scheme, towards a well planned programme of continuing professional development.

The second initiative is the workforce flexibilities programme, which has just been introduced to general practitioners within the London Initiative Zone through an amendment to the Statement of Fees and Allowances.⁷ It provides a guaranteed income for doctors newly appointed to singlehanded vacancies and encourages singlehanded and twohanded practices to work together, share resources, and develop a wider range of services. There are also new allowances for general practice assistants. To qualify for the programme, practitioners must agree practice development plans with their family health services authority. The requirements can be locally negotiated, but might include a commitment to develop a practice formulary, undertake clinical audit, or organise and summarise patients' records. These are

tougher conditions than those required of doctors taking part in the educational incentives programme, and it will be interesting to see how practitioners respond.

Both the programmes are welcome. However, the timescale is unrealistic. In an ideal world the educational incentives programme would grow out of a London-wide assessment of the educational needs of general practitioners and the barriers to meeting them; but in the real world the money has been announced first and guaranteed initially for only two years, and it has taken six months to prepare for local implementation and receive authority to spend. The remaining 18 months are not long enough to give all general practitioners in the London Initiative Zone, especially those who are most disillusioned and overburdened, an opportunity to take "time out" for further education. It is likely that the first to take up the scheme will be the younger and more enthusiastic practitioners who have already decided on the education they would like.

The present time frame may be too short for the programmes to achieve their prime objectives: to improve the morale and expertise of a significant number of established general practice principals in London and attract more than a handful of new doctors to work in the inner city. Both programmes need to be extended for at least a third year. If successful they should lead to similar projects for recruiting and invigorating general practitioners in other urban areas.

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Outpatient follow up

Who benefits: doctors or patients?

One of the first questions that trainee surgeons learn to ask a new boss before the first outpatient clinic gets under way is, "Do you routinely follow up all your patients?" The reason the question needs asking is that some consultants do and others don't. The paper in this issue by Alison Waghorn and colleagues (p 1344) confirms this impression.¹ According to their survey of 100 randomly selected general surgeons, the decision to offer an outpatient appointment depended largely on the consultant's view of outpatient visits in general. The bimodal distribution of responses showed that some surgeons offered appointments to almost all their patients, irrespective of diagnosis or procedure, while others followed up almost none.

In keeping with this observation, a recent review of individual urological services in the South West Thames area of London showed that from 1991 to 1994, urological provider units were remarkably consistent in the ratio of new patients to follow up patients seen in their clinics.² However, there was substantial variation between providers. A ratio of one new to one follow up patient in one unit contrasted with a ratio of 1:4.9 at another, despite the two hospitals being only six kilometres apart and serving similar communities.

How is it that surgeons are able to adopt this all or nothing approach with regard to outpatient review? One way of justifying such behaviour is to suggest that routine surgical outpatient review is an unnecessary luxury, otherwise half the

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patients—those being denied follow up—would be getting worse care. Evidence is accumulating to support the idea that routine follow up confers little benefit to patients. Certainly, the benefit of outpatient review after one of the commonest urological procedures, transurethral resection of the prostate, has recently been questioned.³ Perkins *et al* found that 92% of patients were discharged at their first postoperative visit and only 2% remained under review at one year. Moreover, 90% of general practitioners and 78% of patients expressed confidence in a system without routine hospital review.

Similar questions now exist with regard to longer term follow up in other specialties. Colorectal surgeons have become increasingly pessimistic about the usefulness of routine outpatient follow up compared with opportunistic detection of early recurrence of colorectal cancer by general practitioners.^{4,5} In the only randomised study across surgical specialties that compared follow up by general practitioners and hospital outpatient departments, reoperation rates, mortality, and cost to providers were similar for the two groups.⁶ The cost to patients in terms of time and money was greater for the group attending hospital outpatients. Despite acknowledging that more work would result, general practitioners were in favour of immediate hospital discharge.

Two themes emerge. Firstly, these reports and others⁷ highlight the fact that patients, if well informed, are good at detecting and reporting complications or clinical deterioration—and, importantly, they tend to report them to their general practitioner. The second relates to access. It is ironic that provider units that decide to provide a comprehensive outpatient follow up service are likely to have no spare capacity to respond quickly to a phone call or letter from the

patient or general practitioner requesting an early unscheduled appointment.

These two areas will require attention if community follow up is to be widely adopted. At present, patients find that written information on their postoperative recovery and possible complications is inadequate for their needs.⁸ In addition, there is increasing recognition of the importance of access to outpatients departments and of patients' perception of access, since better access improves health care outcomes.⁹ With a little imagination surgeons could do much to improve access to urgently requested appointments. Both the general practitioner and patient need to know that, should an outpatient appointment be necessary, it is no more than a phone call away.

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Psychosocial interventions in cancer

Should be part of every patient's management plan

Growing awareness of the many psychosocial problems associated with malignant disease and its treatment has led to the development of a myriad of supportive interventions for patients and their families. These interventions range from traditional approaches such as psychotherapy to the less orthodox music therapy and aromatherapy. They may be offered formally or informally by health care professionals or by lay volunteers, including patients themselves. Some psychosocial interventions, such as counselling by specialist nurses in breast cancer units, have been incorporated into the routine care of patients with cancer. Other interventions may be provided outside hospitals by a wide variety of self help groups or national and local cancer support organisations. In addition, private practitioners offer everything from psychotherapy to therapeutic massage on a fee paying basis.

The mere existence of so many different approaches shows that the demand for this form of support is considerable. The question for patients and purchasing authorities is: what impact do these forms of psychosocial intervention have on the wellbeing of patients with cancer? Despite considerable anecdotal evidence attesting to their benefits, objective evidence of efficacy has not been compelling.¹⁻³ Significant and non-significant results from methodologically inadequate studies purporting to evaluate psychosocial interventions have, if anything, hampered their integration into the formal care and management of patients with cancer.⁴ The dearth of good empirical data can be partly explained by the

fact that the activities covered by the term psychosocial intervention vary widely with regard to the training and ability of therapists, their relationship with the patient, the nature and content of the intervention, the primary goals, and the predicted outcomes.⁵ However, a review of the literature that focuses on the four mainstream psychosocial interventions—behavioural therapy (including relaxation, biofeedback, and hypnosis); educational therapy (including training in coping skills and providing information to enhance a patient's sense of control); psychotherapy (including counselling); and support groups (which help patients to express their emotions)—shows that there is increasing evidence of efficacy.⁶⁻⁹

Published controlled studies have shown positive benefits. Examples include a reduction in the side effects of chemotherapy after biofeedback and relaxation therapy¹⁰; a significant reduction in psychological morbidity after cognitive and behavioural therapy⁸; improved coping skills after psychoeducational approaches⁷; and a reduction in pain, less mood disturbance, and fewer maladaptive coping responses after supportive group therapy.¹¹ More contentiously and provocatively, some researchers have suggested that psychosocial interventions not only improve the quality of patients' lives but also extend their survival.^{7,11} The fact that controlled studies of psychosocial interventions show beneficial effects is remarkable, given the small numbers of patients in such studies and innumerable confounding factors influencing the