LETTERS

Management of primary breast cancer: a patient's perspective

In my capacity as technical editor of *Quality in Health Care*, reading the effectiveness bulletin *Management of primary breast cancer*¹ stimulated many memories and anecdotes that have been dimming with time. Most of these would be of no interest to readers of the *Journal*, but my thoughts on one subject seem relevant. I was interested to read the results on the studies of follow ups, either at hospital or with the general practitioner, that have been carried out in Italy, the United Kingdom, and the United States.

My opinions are of course subjective and relate to my own case history. Four years ago I had a total mastectomy and axillary clearance, followed by six months of CMF chemotherapy, after diagnosis of a 4.5 cm multilobular non-oestrogen dependent tumour and one positive axillary node.

My treatment and the staff who administered it have been excellent throughout, but despite this, after about the first year, half my follow up visits have been frustrating. At the end of the chemotherapy I was put on monthly follow up visits, alternately to see the surgeon the first time and the oncologist the next, and so on. The monthly visits soon became two monthly, then three monthly, etc. The visits to the oncologist have always been reassuring, and except for one occasion when he was on holiday I have always seen the highly experienced man that I know (and, I think, who knows me).

The surgeon who treated me is a general surgeon with a large weekly breast clinic. I have complete faith in him too. For the first few visits I saw him, then as my health bloomed and my illness receded into the past, I was happy to go down in the list of priorities and see more junior doctors in the department of general surgery. This is as it ought to be, and I have no criticism of any of these people, but, as the article states, most secondary problems are first found by the patient herself, and it seems to me that the more junior the doctor, the more likely this is.

To attend an outpatient clinic takes me between four and five hours with resultant considerable loss of earnings as I am self employed. On the other side of the coin there is the cost to the NHS of my outpatient appointment, which I am sure is not negligible.

For these reasons I stopped attending the surgeon's follow up clinics, and now only see the oncologist.

I was not aware that some breast cancer patients were followed up by their general practitioners. Although I was glad to return to hospital for follow ups for at least the first year to be reassured that I was well, there came a point when the inconvenience of attending the hospital to see the more junior doctors outweighed that reassurance. At that point I would certainly have chosen to transfer my follow ups to my general practitioner had I been given the choice, because we already know one another, and his clinic is much nearer my home. As I usually see him occasionally about other matters, it would be easy for him to keep tabs on me regarding breast cancer without nearly as much cost to the NHS or to me.

I am sure that there must be many breast cancer patients like me, particularly those who are still earning, and who do not have blind faith in all doctors, who would appreciate a shake up in the traditional follow up system.

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1 A Melville, A Liberati, R Grilli, T Sheldon. Management of primary breast cancer. *Quality in Health Care* 1996;5:000-000.

Quality in Health Care is pleased to receive letters (to be considered for publication) that refer to articles published in the *Journal* and are from patients or other consumers of health care.

Quality improvement a multiprofessional commodity?

In her editorial in this journal, Alison Kitson raised the following points

- Of the 498 contributors to this journal over four years, only 28 (6%) are nurses.
- From these figures, it seems that few nurses involved in quality improvement and in multidisciplinary audit initiatives, are submitting their work to this journal.
- Clinical audits done without the involvement of nurses, physiotherapists, managers, or pharmacists significantly outweigh multidisciplinary audits.

Although I would agree in principle with these comments on the lack of true multidisciplinary audit, I would like to point out that most departments of clinical audit are staffed mainly by nurses and a small proportion of professional audit staff.

The reason for this is mainly economic (audit funding doesn't run to doctors' salaries) but what this means, certainly in our trust, is that almost all our audit projects are being designed, carried out, analysed, and presented by nurses. However, in many instances, certainly when it comes to publication, these nurses are credited merely as contributors or as having supported certain projects.

Alison Kitson raised the question of authorship of multiprofessional projects. I think we should promote joint coauthorship in these circumstances. It seems patently unequitable, that one profession, more used to publishing their work, should consistently be credited as lead author, when in most cases the work has been a collaborative effort, with the actual audit, being carried out by other professional groups.

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Clinical audit and the purchaser-provider interaction: different attitudes and expectations in the United Kingdom

Thomson *et al* clearly describe the views of purchasers and providers in northern England on the role of clinical audit and its interaction with the contracting process.¹ Divisions ran through and across purchaser and provider organisations, with very little involvement of purchasers, or even provider managers, in audit. These views have been documented in several studies since the

introduction of the national audit programme.²⁻⁴ In 1993, during a series of workshops in the South West Thames region, purchaser and provider managers and clinicians expressed a very similar mixture of hopes and fears.⁵ We now have a reasonable understanding of the barriers to mature shared audit; however, understanding does not seem to be enough. Audit is a victim of wider tensions. The United Kingdom National Health Service has suffered from divisions between professional groups for many years, and more recently, divisions between purchasers and providers. Thomson *et al* argue for purchaser-provider dialogue to test differences of opinion over audit, but in the absence of trust simple exhortations to cooperate will not be enough. We need to consider the underlying causes of conflict, and tackle deeply ingrained attitudes. In the short term these differences need to be recognised and appropriate organisational structures created.⁶ It has been suggested that public health may be able to provide a bridge.⁷ But public health doctors have had limited impact through membership of local audit committees, and to be more effective they need greater integration with commissioning and quality departments within purchasing organisations, while maintaining the support of provider colleagues. Another approach might lie with the non-medical clinical professions, who tend to have a more positive view of clinical audit,⁸ but unless they can bring the doctors with them progress will be limited. In the meantime, we need to have realistic expectations and focus on the quality rather than the quantity of shared purchaser-provider audits. Better to have one good shared audit project, seen to be successful by all parties, than numerous impractical quality specifications.⁵ The recommended 40:40:20 split between purchaser initiated, provider initiated, and national and primary-secondary interface audits is a long way off in many places.

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- 2 Kerrison S, Packwood T, Buxton M J. Monitoring medical audit. In: Robinson R, Le Grand J. eds. *Evaluating the NHS reforms*. London: King's Fund Institute, 1993:155-77.
- 3 Hopkins A. How well are audit committees working? In: Hopkins A, ed. *Professional and managerial aspects of clinical audit*. London: Royal College of Physicians of London, 1994:111-20.
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- 5 Lord J, Littlejohns P. Are purchasers ready for clinical audit? In: Walshe K, ed. *Evaluating clinical audit: past lessons, future directions*. London: The Royal Society of Medicine: 1995.
- 6 Lord J, Littlejohns P. Links between clinical audit and contracting systems. *International Journal of Health Care Quality Assurance* 1995; 8:15-24.
- 7 British Medical Association Clinical Audit Committee. *Guidance for the commissioning of clinical audit*. London: BMA: 1996.
- 8 Lord J, Littlejohns P. Impact of hospital and community provider based clinical audit programmes: perceptions of doctors, nurses, and other health professionals. *Int J Qual Health Care* 1996;8:(in press).