GP-led melanoma follow-up: the practical experience of GPs

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Objectives. To explore how GP-led melanoma follow-up had actually worked from the perspective of GPs by exploring in detail the practical experience of GPs running the programme.

Design. Semi-structured audio-taped telephone interviews with GPs delivering a GP-led follow-up programme for people with cutaneous malignant melanoma.

Subjects. Seventeen GPs currently delivering structured GP-led routine follow-up for people with cutaneous melanoma.

Results. GP-led melanoma follow-up worked well from the perspectives of GPs. The GPs felt that they were well equipped and supported in undertaking the follow-up consultations and recognized that they were freeing up hospital consultant time. They felt that patients appreciated the convenience of GP-led follow-up. The GPs felt that a robust recall system, initial training with regular refreshers and effective consultant backup were vital components of a successful long-term programme.

Conclusions. GP-led melanoma follow-up is feasible and, provided certain concerns can be addressed, GPs are willing to provide it.

Keywords. Aftercare, cancer, malignant melanoma, primary care.

Introduction

Patients who have received potentially curative treatment for cutaneous malignant melanoma are at risk of recurrence and structured follow-up is recommended in existing guidelines.1–4 Such recommendations, however, are based on limited evidence and expert opinion, rather than definitive trial evidence.3,4 Similar to most cancers, there are no universally accepted guidelines for melanoma follow-up, and none are specific about where it should take place or which health professional should undertake it.3–5

Programmes of GP-led cancer follow-up have been the subject of successful randomized trials.6–8 A questionnaire-based study has also suggested that a significant proportion of patients would consider primary care-led follow-up for melanoma but suggested that many GPs would be unwilling to take on this role.9 For these reasons, we designed, piloted and implemented a programme of GP-led follow-up for cutaneous melanoma in Northeast Scotland.10 We believed that it was vital to achieve a detailed understanding of how GPs had perceived the programme and how it had worked in practice. This paper presents the results of qualitative interviews conducted with GPs delivering GP-led melanoma follow-up. The interviews were conducted in parallel to a randomized controlled trial.

Qualitative methods have been used several times in the past to explore patients’ experience of cancer follow-up.11–17 The approach has not previously been used to explore the perspective of GPs that are delivering a novel model of GP-led cancer follow-up care.

Qualitative research methods have been said to have ‘an unrivalled capacity to constitute compelling arguments about how things work in particular contexts’.18 It has also been argued that qualitative data should be collected routinely in research studies implementing new interventions in primary care since such data can aid the understanding of the factors that facilitated or hindered change at the practice level.

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with major consequent implications for the wide-scale implementation of research data.\textsuperscript{19}

In this qualitative study, we aimed to explore how GP-led melanoma follow-up had actually worked, so employed semi-structured interviews with GPs to explore in detail their practical experience of running the programme.

**Methods**

**Participants and recruitment**

This study was conducted in Northeast Scotland in conjunction with a randomized trial of integrated GP-led follow-up for cutaneous melanoma. The GP-led melanoma follow-up programme has been described elsewhere\textsuperscript{10} but briefly consisted of patients receiving regular, scheduled and protocol-based follow-up examinations by GPs in general practice surgeries, underpinned by a rapid-referral pathway to secondary care. The GP-led follow-up programme was an alternative to traditional hospital-based follow-up. All 17 GPs who received training and delivered melanoma follow-up during the study year took part in interviews.

A single audio-taped telephone interview, with informed consent, was conducted with each GP. The interviews were semi-structured using a topic schedule, which evolved over time in the light of information emerging from the initial interviews. The topic schedule explored the practical experience and feelings about GP-led follow-up for melanoma, practical problems with the intervention, pros and cons of different models of follow-up and views on what was required to optimize follow-up. Data collection continued until all 17 GPs had been interviewed. The interviews were conducted by P.M., a GP who designed and ran the intervention.

**Analysis**

Interviews were transcribed verbatim for manual systematic analysis. Paper manuscripts were produced and an entire initial reading was conducted. During subsequent first-order analysis, the key broad themes (e.g. practical difficulties and personal feelings) were identified. A corresponding colour coding system was devised in accordance with each identified broad theme. This was applied to relevant passages of text throughout all of the paper transcripts. Second-order analysis was thematic.\textsuperscript{20} Across the entire set of annotated manuscripts, coded text was grouped into the specific broad themes and analysed in detail. The similar and divergent perspectives of different participating GPs in each theme was noted. Further detailed analysis compared the views of GPs from different practice settings and with different personal characteristics. Knowledge gained while running the trial and making practice visits was integrated with the interview data during analysis.\textsuperscript{18} A second GP researcher (E.K.D.) independently read and coded a random sample of 10 transcripts to explore ‘inter-rater reliability’.\textsuperscript{21} Comparison revealed high concordance in the key themes identified, with no areas of major discordance identified.

**Results**

The characteristics of participating GPs are summarized in Table 1. Thirteen male and four female GPs participated. Nine GPs were based in rural practices, six in suburban practices and two in urban practices. List sizes ranged from 650 to 19 000. The GP interviews lasted between 7 and 48 minutes. The interviews tended to be conducted during the working day, for example at the conclusion of a surgery or during administration or lunchtime.

**The process**

The vast majority of GPs stated that the clinic had been ‘straightforward’ to run. The appointments themselves had run smoothly with no practical difficulties:

We used double appointments to begin with, because of unfamiliarity with the paper work meant it took a little bit longer, but second time around I think ten minutes was fine to get the patient in, undressed, do the history and examination, and answer any queries. They fitted nicely into our standard appointment system. (GP 4)

Five GPs had made use of the rapid access referral pathway into secondary care. This had operated smoothly in each case. In one instance, the doctor was

### Table 1 Characteristics of participating GPs

<table>
<thead>
<tr>
<th>Sex</th>
<th>Distance of practice from ARI</th>
<th>List size</th>
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<tr>
<td>GP 1</td>
<td>Male</td>
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<tr>
<td>GP 2</td>
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<td>GP 3</td>
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<td>GP 5</td>
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ARI, Aberdeen Royal Infirmary.
aware that the patient had not been seen quite within the proposed 2 weeks, but this was viewed as acceptable since he had been in two minds as to whether to make a non-urgent referral anyway:

I referred one person. We didn’t think it was absolutely essential to refer him through the quick pathway, but we used it anyway. I think it took a little more than three weeks to be seen, but they were seen very effectively and efficiently and quite quickly, so it worked well. (GP 4)

When viewed in context with GPs’ age, sex and practice location, there was perhaps a tendency for those in smaller rural settings to appear more enthusiastic about how few problems there had been with the intervention.

Practical problems
Several practical problems had arisen. Broadly, these related to the recall and appointment system and the characteristics of particular patients. On two occasions, the lead GP had been on holiday when the reminder letters had been issued to the patients and practices. This had resulted in patients not being contacted on time and them having to wait until the lead GP returned. This had created some anxiety for patients which the GP acknowledged:

There was one patient saying, ‘well why have I waited cause they said they’d be in contact within 2 weeks’ so that was one minor problem. But they were OK when we explained what had happened. (GP 8)

In another case, the patient was registered blind and was therefore unable to undertake self-examination. In this instance, the patient’s partner was also registered blind and so was not able to help. The GP felt that she had been required to make modifications to the study protocol in this situation but was quite happy to do so:

Having this particular chap with this particular problem really, is the only thing, but eh, I just didn’t feel comfortable sending him away to check his skin. In fact he’s married to a lady who is also visually impaired, so I thought would change the system a little bit myself. (GP 7)

Another issue that seemed to be important to some of the GPs related to patients introducing matters unrelated to their melanoma follow-up during the consultation. The GPs seemed to vary in their response to this. One appeared very relaxed about it and remarked that this was the nature of general practice:

Och you know, of course. The patients always mention other things, they never come in with one problem, do they? That’s just the nature of general practice. (GP 8)

while another seemed to find it more of an irritation:

Well most of them behaved themselves, but there was one who was always wanting other things, repeat prescriptions and so on. (GP 4)

In one case, a patient was reported to have attempted to pre-empt the recall system by asking for their follow-up review to be conducted when they had attended for another matter. The GP reported feeling a little thrown by this but in the event felt that the patient was satisfied by his explanation that he did not have the appropriate paper work to hand and that it was important to stick to appropriate time intervals.

One of my patients happened to come in for another reason, and he asked could he have his check up while I’m here, and I had to say well I’m sorry I hadn’t got the paper work yet. So a minor problem, but that was because the patient was early rather than a major problem with the system. (GP 10)

In another case, the GP reported having to provide one patient with three appointments because she was particularly anxious and brought a large number of issues for discussion to each appointment. Characteristics of the GP or practice did not appear to influence the perception of practical problems.

Advantages
The GP interviewees identified several potential practical advantages of the programme. These related mainly to their positive experiences of delivering the intervention and their confidence in their ability to do so. It was mentioned by several GPs that they were well placed to deliver follow-up and that this could potentially relieve skin specialists of work. One GP considered that the new system created more sensible use of consultants’ time, which would free them up to some degree. This was perceived as an advantage since specialist appointments were hard to get, resulting in long delays for patients with suspicious lesions:

It’ll take some of the pressure off them and they should be able to speed up. Plastics appointments are notoriously difficult to get, a nightmare really, so anything that speeds that up has to be a good thing. (GP 13)

Concerns
Several practical concerns were mentioned during interviews. The main concern was that of maintaining a suitable level of expertise to function effectively in the follow-up role given the small number of patients in most practices:

Well that does concern me, the small numbers. It’s like fitting coils, you wouldn’t put in one or two a year, you put in one or two a week to keep your
skills up. So that’s why I’m saying a refresher would be useful. (GP 13)

Although many interviewees acknowledged that the number of patients involved was small, a few GPs expressed concerns that the intervention took up appointments and other resources:

Well it is taking up valuable appointments and I suppose you’ve got to take into consideration that there’s administration and secretarial time, booking appointments and sending out letters, to be considered. (GP 9)

Some interviewees were also concerned that by taking on the role, GPs may ‘open the flood gates’ to the transfer of other activity into an already busy workload:

I mean if we take this on, and do it well, what’s next? (GP 3)

What made it work?
Given that almost all the GP participants had a positive experience of running the clinics, they were asked to reflect on what had made it work and what implications this would have for the wider implementation of such a follow-up system. In general, the central recall system was thought to have worked well, with only minor problems. An effective recall system was viewed as absolutely crucial for an effective system in the future:

It’s got to be completely water tight from the recall point of view. I mean to me that’s the absolute lynchpin. (GP 6)

Those who had used the rapid access referral process to secondary care were positive about the experience and emphasized that its continuing effectiveness was vital for future success:

It worked really well. It would have to continue to do so though, couldn’t slip. (GP 7)

Training was also viewed as essential for successful implementation in the future. Several GPs said they would not have been equipped to deliver the programme without training:

I couldn’t have done this without the training, wouldn’t have been happy at all. It was really good. (GP 7)

Several participants also regarded that initial training, along with regular refresher, would be vital to wide-scale implementation of a GP-led follow-up programme.

Influence of GP experience
Opinion was divided on the issue of what level of pre-existing expertise was required when delivering the intervention. Some of the participating GPs indicated that they had a particular interest in dermatology, with some individuals having undertaken specific training in the field, such as the diploma in dermatology. Some of these GPs thought that this was an advantage and one GP expressed the view that the programme was most likely to be embraced and successful, with GPs who had a special interest in dermatology and/or minor surgery:

I think it depends on having someone who’s got a particular interest in dermatology and/or minor surgery in the practice. I think it works really well then. Without that, I’m not so sure. (GP 8)

Another participant felt that GPs might need expertise in order to feel confident about providing follow-up care:

No, I mean I think if I hadn’t done the diploma I probably would be less sure of what I’m seeing, not so happy. But with that expertise I’m very comfortable with it. (GP 8)

On the other hand, several participants stated that although they did not have a particular interest in dermatology, they were able to function effectively in the role:

No, it’s not a major interest of mine. I mean it’s an interesting area where you can actually physically see stuff but I wouldn’t say it’s at the top of my list of favourite topics. But you just need to be a GP on the lookout for this. (GP 9)

Feelings of GPs
Many of the participants stated that they were comfortable and unconcerned about undertaking the follow-up:

I felt kind of comfortable enough and well enough prepared to deal with what I was feeling. (GP 9)

I felt happy and comfortable and I think the patients were happy and comfortable. (GP 4)

Participants generally felt that this feeling arose from being well equipped by the training, having clear, structured protocols and from a feeling of being well supported by specialists. Furthermore, the GPs appeared to enjoy the atmosphere within follow-up consultations. They conveyed a sense of enjoying a structured, uncomplicated consultation:

It’s a no challenge consultation, which is always welcome. (GP 9)

One participant’s satisfaction in participating in the study arose from a feeling of delivering quality care in a structured, relaxed way:

I personally found that it was quite a rewarding way of spending an appointment. I find it less
pressurised and it felt good to be providing a good service. (GP 10)

One GP mentioned a feeling of guilt at having to refer two patients via the rapid access pathway:

I suppose I felt a little bit guilty that I was meant to be doing this review and both of the patients have ended up fast tracking back, but I think it was pertinent. (GP 7)

Whether a GP was concerned or unconcerned did not appear to be related to their practice setting, age or sex.

Perceptions of patients’ experience
Almost every GP thought that their patients had experienced GP-led follow-up in a positive way. In many instances, this was supported by things that the patient had actually said. It was thought that the patients liked the convenience of the process, including requiring less time, providing greater flexibility in appointment arrangements, giving fewer travel and parking problems and providing greater continuity. Importantly, greater convenience was thought to apply to urban patients, just as much as rural patients:

Well he’s been very positive about it. He finds it helpful to see the same person. Often when he goes to hospital it’s a different person who’s never seen him or his skin before and so I think he finds it reassuring that I’ve got to know his skin and his condition. It’s great you know, you get to know the individual. (GP 5)

All of them have been really keen on it. It’s just very convenient for them. It’s close to their home, they can get parked easily, they’re in and out in 20 minutes from the time they park their car until they leave again. Compare that with spending half a day getting to Aberdeen, getting parked, getting across to the clinic, waiting, being seen and so on, all for probably a very short consultation. And I think at least two of them have asked me can this not continue afterwards. (GP 8)

Participating GPs also expressed the view that certain aspects of primary care enhanced the quality of follow-up care. This included not only practical aspects such as appointment systems but also deeper aspects such as the patient–GP relationship.

They’ve got added flexibility here. Within limits they can come when it suits them. (GP 3)

We’ve got a very good relationship. He knows he doesn’t need to be afraid to ask me questions. I can spend plenty of time and follow it up, phone him back if necessary. (GP 12)

This one particular patient can be quite anxious. But I know her very well, I think that helps. (GP 17)

Practice characteristics and their influence
Generally speaking, the follow-up system had caused little disruption within practices. Several GPs at smaller practices wondered whether this would be the case in larger practices, although the views expressed by GPs in the study with more patients did not differ. In one practice with large numbers, however, double appointments were required for the first round of appointments, which had raised some problems when one of the other partners was on holiday.

Interestingly, GPs from rural and urban settings agreed strongly that the model of melanoma follow-up was equally applicable to either setting:

The principle here is to give a better service and to relieve pressure on secondary care. That applies equally in city practices as much as rural ones. (GP 16)

If it’s a system that’s benefiting people here in the country, then equally it could benefit people in the city. (GP 17)

If it can be done by a GP then it should be done by a GP irrespective of whether the patient is at a surgery next door to the hospital or at a surgery in the back of beyond. (GP 6)

There was one important instance in a practice where the intervention did not appear to have worked well, in that one follow-up visit had been delegated to a GP registrar and several appointments had not taken place. In interviewing the GP involved, he admitted that he had not carefully screened the potential recruits at the beginning. As a result, two patients had been recruited who were housebound. Initially, he stated that he thought he would conduct these reviews as home visits but that that had not really happened. In interviewing this particular GP, I had considerable difficulty arranging the interview, largely through messages not being returned, and when the interview did take place, I felt it was brief, rushed and subject to interruptions. These impressions were supplemented by data from interviews with two patients followed up by this particular GP, one of whom questioned the GP’s interest during the follow-up appointment. Taken together, this information suggested that the commitment of this individual doctor could have compromised the intervention in that practice rather than it being due to weaknesses in the intervention itself.
What would make the system better or underpin implementation?
Participants were asked which parts of the programme could be improved and what might be needed to aid its wider implementation. A view, strongly held by some, was that the programme should be introduced as an enhanced service under the terms of the current General Medical Services (GMS) contract. This would recognize the transfer of workload and responsibility to primary care:

I guess with my GP political hat on I should be saying well, with the new contract I shouldn’t be taking on any extra work, without some extra resource, but I don’t really feel that strongly about it. (GP 8)

A few of the GPs suggested that the system eventually adopted might be better as a shared care model. For example, rather than devolving all follow-up to primary care, the system should perhaps alternate visits between primary and secondary care, or each patient might see a consultant annually:

I think long term my preferred model would be a kind of shared care with infrequent but regular hospital review, say once a year or every third visit. Or maybe joint GP-specialist clinics. That might work. (GP 5)

In general terms, issues of remuneration, workload and resources were discussed at greater length by male GPs from large urban or suburban practices.

Discussion

Summary of main findings
With a few exceptions, the GP-led melanoma follow-up was thought to have worked well, from the perspectives of GPs. The GPs felt that they were well equipped and supported in undertaking the follow-up consultations and recognized that they were freeing up hospital consultant time. They felt that patients appreciated the convenience of GP-led follow-up. The GPs felt that a robust recall system, initial training with regular refreshers and effective consultant backup were vital components of a successful long-term programme. Some felt that the new work should be treated as an enhanced service under the new GMS contract.

Strengths and limitations
This qualitative data complements quantitative randomized controlled trial data regarding the acceptability of GP-led integrated follow-up for cutaneous malignant melanoma. Mixed methods approaches have been used before to evaluate another primary care-based intervention from the perspective of health care providers, nurse-led clinics for the secondary prevention of coronary heart disease. PM spent time observing the joint melanoma clinic in Aberdeen and visited each participating practice, enabling him to analyse the GP interviews in context with current practice. Further strengths include the good purposive samples from which the data are drawn, the opportunity afforded to engage with GPs, and the way in which negative, as well as positive, viewpoints were elicited.

Several limitations must be acknowledged. The study only involved GPs from the Northeast Scotland. Urban, suburban and rural practices took part, so the results are likely to be widely applicable to the Grampian region. However, the results may be less applicable to areas outside Grampian, especially if factors such as population density, larger practice list sizes, ethnic diversity and socio-economic deprivation were important influences in the acceptability of GP-led follow-up.

Interviews with GPs were done mostly during the working day and did tend to be quite brief. Consequently, it is possible that richer and more comprehensive data may have been available from face-to-face interviews. Another important point related to PM’s status as study interviewer, as well a GP (a fact known to the GP participants). Furthermore, PM personally knew many of the GP participants. This may have influenced the participants, perhaps by making them more reticent to air negative views. This would bias the data in favour of a positive view of the intervention.

The analysis was conducted manually rather than by using a computer package. There are advantages and disadvantages of using such packages. The manageable number of interviews permitted manual analysis to be undertaken and allowed us to allow for the context within and between practices. A further limitation relates to the relatively short time-scale of the study. The intervention appears to have succeeded over the course of 12 months. Nevertheless, questions remain about the long-term sustainability of the intervention. It might be that the positive effects of the intervention would wane with time. The data presented are also limited to the views of GPs, and we did not conduct interviews with any other health care workers who could have been affected, such as practice receptionists, nurses or specialists. Finally, the analysis of qualitative data is necessarily subjective. The fact that the data were collected and analysed by a GP mean that there is a possibility that his views, prejudices and personal experiences could have influenced how the data were analysed and interpreted. A second person coded a subset of transcripts in an attempt to minimize this problem.

Context of this study
This study is the first to report qualitative data on GPs’ experiences of delivering a structured routine cancer follow-up service.
In an Australian qualitative study of 13 patients with haematological cancer participating in a pilot shared care programme, many patients had a long-term relationship with an individual GP who provided support, clarification and reassurance outside the hospital setting. The patient–GP relationship was regarded as invaluable to patients during the management of their condition. The study also suggested that communication difficulties between primary and secondary care doctors led to the patient–GP relationship being underutilized. A qualitative interview study conducted among 20 Swedish GPs also identified poor communication between GPs and specialists as undermining cancer follow-up care. In the current study, GPs who used the rapid access pathway expressed high levels of satisfaction with the way it had operated. Although only considering one aspect of GP–specialist communication (referral from practice), the approach provided a way of ensuring that one crucial aspect of communication between GPs and specialists was optimized. Related to this, qualitative interviews with 10 Canadian oncologists suggested that GP involvement in cancer follow-up is inhibited by variable and unpredictable interest, poor communication and patients’ preferences. The model tested in our study may have addressed at least some of these concerns.

An important finding of our study was the GPs willingness to undertake follow-up provided that they received training and support from specialists. This corresponds with the findings of qualitative interviews with 17 Norwegian GPs, which indicated that GPs are happy to take a more prominent role in the management of cancer patients provided that there is good access to specialist advice. Implications of findings

In general, the GPs who took part in the interviews reported the study to be a positive experience and had positive views of GP-led melanoma follow-up. The findings support the view that effective routine follow-up can be carried out for patients with cutaneous malignant melanoma by their GPs and that such a programme is acceptable to GPs provided certain caveats can be addressed. This is further supported by the findings of the randomized trial, yet to be reported, that patients followed up by GPs did not suffer poorer outcomes than those continuing to receive traditional hospital-based follow-up.

The GPs conveyed a sense that they felt appropriately trained, resourced and supported in delivering follow-up. Most of them appeared to believe that they had done so effectively and that this had been the impression of their patients. They also conveyed an impression, in most cases, of having found the process satisfying personally and perceiving that their patients found this to be the case also. In some cases, they stated that unique aspects of primary care facilitated the provision of higher quality care.

In practical terms, it appears that the intervention functioned well. The appointment system operated effectively and to the satisfaction of GPs. Nevertheless, an issue arose when the lead GP was on holiday, suggesting that a clear system of delegation and perhaps deputization (not used in the trial) might be needed. An effective recall register to underpin such a service must be robust, able to detect when appointments have not taken place and alert GPs and patients when this occurs.

The qualitative interviews confirmed the importance placed by GPs on rapid access to specialist advice when a need arose. This would be an important part of any new system, which should be amendable to large-scale implementation. The small amount of data available on this from this qualitative study, together with the quantitative process of care data, suggest that the mechanism derived for the study, though simple and relatively ‘low-tech’, was effective.

The protocol called for a full skin examination at the initial, but not subsequent, GP follow-up appointments. It appeared that GPs were happy to undertake this although several felt a double appointment was needed to accommodate this. The GPs felt that subsequent visits should be shorter at 10 minutes (i.e. a standard appointment) while still giving time for an unrushed consultation in which patients had the opportunity to ask questions and raise concerns. This has implications for the time and resources that would be required to maintain the programme within a practice and initiate new patients into the system.

Most of the GPs felt that the system had few financial or resource implications for their practice. Some GPs suggested that additional resource was unnecessary. On the other hand, a small number stated that they felt that their work should be recognized, perhaps as an enhanced service by the terms of the new GMS contract. This would suggest that any large-scale implementation of GP-led melanoma follow-up should be informed by discussions with GP leaders, ensuring a full understanding of the resources required, so that conditions can be established to ensure that the maximum number of GPs provide the service.

If these prerequisites can be met, it seems likely that GP-led melanoma follow-up will be valued by patients and GPs. Previously reported negative views of GP-led cancer follow-up by people with cancer might be assuaged by actual experience of high-quality GP-led cancer follow-up. As with all health care, however, it is important to recognize that these new services will suit most, but not all, patients.

Declaration

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Ethical approval: full ethical approval for the study was granted by the Joint NHS Grampian and University of Aberdeen Research Ethics Committee (reference number: 04/50801/75) on 11 November 2004.

Conflict of interest: none.

Copyright statement: The Corresponding Author has the right to grant full copyright on behalf of all authors and does grant full copyright on behalf of all authors.

Contributorship: P.M., P.C.H. and N.C.C. designed the study. P.M. ran the study day to day and conducted the interviews. P.M. and E.K.D. analysed the data. P.M. and E.K.D. wrote the paper with comments on drafts from P.C.H. and N.C.C. P.M. is the guarantor of results.

Trial registration: this randomized trial, of which this was a parallel investigation, was registered with the International Standard Randomised Controlled Trial Number Register (ISRCTN 71577271).

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