

## REFERENCES

1. Brett T, Arnold-Reed D, Phan C, *et al.* The Fremantle Primary Prevention Study: a multicentre randomised trial of absolute cardiovascular risk reduction. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X616337.
2. MacPherson H. Pragmatic clinical trials. *Complement Ther Med* 2004; **12(2-3)**: 136–140.
3. Young J, Manea-Walley W, Mora N, *et al.* Practice nurses and research — The Fremantle Primary Prevention study. *Aust Fam Physician* 2008; **37(6)**: 464–466.

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## Why bother talking to teenagers?

We applaud Samir Dawlatly's exhortation 'why bother talking to teenagers?'<sup>1</sup> and would like to offer further commentary and clarity for those interested in working more effectively with young people consulting in primary care.

Dr Dawlatly refers to the RCGP Adolescent Primary Care Society. This group has been through numerous name-changes but is in fact known as the Adolescent Health Group [AHG [formerly the Adolescent Task Force]]. The group has a long history upon that we build today. We are now part of the College's Clinical Innovation and Research Centre and more can be found out about our activities at [http://www.rcgp.org.uk/clinical\\_and\\_research/circ/priorities\\_\\_commissioning/adolescent\\_health.aspx](http://www.rcgp.org.uk/clinical_and_research/circ/priorities__commissioning/adolescent_health.aspx) including accessing the brand new Confidentiality Toolkit and a summary of the recent symposium on young people's mental health, a key priority area of the group.

Our three main areas of focus are education, informing policy development, and advocacy. The group's members lead on a number of different initiatives around the country that think 'outside of the box' and seek to make primary health care more youth friendly.

Young people deserve a better deal from general practice. They visit us regularly: around half of Year 10 pupils (14–15 year olds) had visited their GP in the 3 months preceding a recent survey<sup>2</sup> but 25% of the girls reported feeling uneasy when consulting with their GP.<sup>2</sup> The health needs of young people are also rising; with increasing use of alcohol, rates of STIs, and obesity.<sup>3</sup> In the last few decades it is only adolescents who have seen no improvement in mortality rates with an associated rise in long-term conditions.<sup>4</sup> Health inequalities

further complicate the picture and remain a significant barrier for all young people to enjoy better health.

While we accept doctors cannot overturn the structural obstacles and transform health through the practice of medicine<sup>5</sup> we at the AHG are committed to making changes to improve the care of young people's health in primary care. We invite you to learn more about us from our webpage and our chair's blog.<sup>6</sup>

For those readers who are interested in joining the group please contact Jane Roberts.

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## REFERENCES

1. Dawlatly S. Why bother talking to teenagers. *Br J Gen Pract* 2012; **62(595)**: 94.
2. The Schools and Students Health Education Unit. *Young people into 2010*. Exeter: SHEU, 2010.
3. Coleman J, Brooks F, Treadgold P. *Key data on adolescence 2011*. London: The Association of Young People's Health, 2011.
4. Viner R, Barker M. Young people's health: the need for action. *BMJ* 2005; **330(7496)**: 901–903.
5. Edgcombe D. Good health has little to do with doctors, Mr Lansley. *Br J Gen Pract* 2012; **62(595)**: 95.
6. Roberts J. *Chair's blog for the RCGP Adolescent Health Group*. <http://chairrcgpahg.blogspot.com/2011/05/welcome-to-rcgp-adolescent-health-group.html> (accessed 8 Mar 2012).

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## The one and the many

I welcome Kramer's reflective paper<sup>1</sup> on our work and its funding. I think he asks the right starting question, and that the answering questions go deeper still. They are obvious to any astute observer of general practice, and they are begging to be answered in every surgery we each do. Medical and other politicians are begging not to answer them as they are too difficult, and so stop them being 'pragmatic'.<sup>2</sup>

They centre around the old philosophical problem of how we balance the needs and wants of the one with the needs and requirements of the many. So for example in morning surgery should we give our first patient an excellent thorough consultation

and then be playing catch up with subsequent patients? Should we be aiming at one excellent consultation or several reasonable quality ones? Can we set a clear standard of quality that does not collapse under the weight of quantity? Is running late a sign of good listening or poor quality?

In public health and evidence-based medicine we see these themes in the Rose Paradox.<sup>3,4</sup> This can be briefly stated as a small change in a modifiable risk factor (for example, reduction in population average blood pressure) will produce a major gain in public health outcomes (many fewer strokes and heart attacks) whereas a major change in the health of one individual (for example, after a heart transplant) is great for that individual, but makes almost no difference to overall population health. In terms of medical reward systems should we value doctors who do detailed operations (for example, a maxillofacial surgeon spending many hours taking out an oral cancer) more than those who persuade people not to smoke in the first place?

At the level of health economics or commissioning we then have to work out how many acts of individual good we can afford to allow our doctors to deliver. And the question is unavoidable as we only have a finite sized economy, and a finite sized budget to work with, and we are a finite workforce, of finite personal capacity. We cannot either individually or collectively do everything. How much is it reasonable to ask of us and the system we work in?

As a speciality and as a profession, and as the NHS as a whole system, we have not really acknowledged this tension between the deontology of each individual clinical interaction and the increasing utilitarianism that comes as we discuss the workings of the system.<sup>5</sup> We still cling to the wreckage of Nye Bevan's rhetoric of 'all care necessary from the cradle to the grave' and hope that we, whether individually or via the system, will be able to achieve this.

At some stage we will need to try and answer the questions of quality versus quantity and the question as to whether our activity and interventions are really aimed at individuals or populations. We may not get a perfect answer to these problems, but at least acknowledging that currently unstable, and often poorly considered<sup>6</sup> balances are being struck would be a start.

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## REFERENCES

1. Kramer G. Payment for Performance and the QOF: are we doing the right thing? *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X630151.
2. Davies P, Glasspool J. Patients and the new contracts. *BMJ* 2003; **326(7399)**: 1099.
3. Rose G. Sick individuals and sick populations. *Int J Epidemiol* 1985; **14(1)**: 32–38.
4. Davies P, Jenkinson S. Interpreting the evidence. *Student BMJ* 2008; **16**: 26–27.
5. Davies P, Garbutt G. Should the practice of medicine be a deontological or utilitarian enterprise? *J Med Ethics* 2011; **37(5)**: 267–270.
6. Gubb J, Li G. *Checking up on doctors. A review of the Quality and Outcomes Framework for general practitioners*. London: Civitas: Institute for the Study of Civil Society, 2008. [http://www.civitas.org.uk/nhs/download/Checking\\_Up\\_on\\_Doctors.pdf](http://www.civitas.org.uk/nhs/download/Checking_Up_on_Doctors.pdf) [accessed 8 Mar 2012].

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## Aiming to reduce late detection of head and neck cancer

Head and neck cancers are rare malignancies with presenting symptoms often being relatively non-specific. The 2-week wait (2WW) referral system was implemented to fast-track patients suspected of having a malignancy. The majority of patients are referred by GPs using specific criteria. We aimed to look at the 2WW referrals for suspected head and neck cancer to a district general hospital over a 1-year period. A total of 362 patients were referred using the GP 2WW pathway with 358 (98.9%) seen within the 14-day target, but only 2.76% (10/362) of referrals were subsequently diagnosed with head and neck cancer. This shows a very low pick-up rate when compared to other 2WW referrals audits.<sup>1,2</sup> In the 97.24% of patients not found to have a malignancy, there were a vast proportion of patients that did not meet the referral criteria. Interestingly, we identified that a further 10 malignancies were detected in the same period that were not referred through the 2WW pathway, but rather as urgent or routine referrals. Many patients will be given the diagnosis of 'no cancer detected' at their initial specialist clinic review while in some cases a malignancy is excluded after relevant investigations. It has been suggested that GPs may be inappropriately using the 2WW referral system in order for their patient to be seen sooner, taking priority over other

general ENT referrals. We understand that symptoms of head and neck cancer (such as unexplained new neck lumps, unexplained persistent sore or painful throat, hoarseness of voice for greater than 3 weeks and, unexplained otalgia<sup>3</sup>) can be vague and be the same for many benign conditions. For example, up to 98% of patients with a hoarse voice will not have a laryngeal malignancy.<sup>4</sup> The surprising find is the number of malignancies that were not referred under the 2WW pathway. If we take into account the low pick-up rate and the fact that there were an equal number of malignancies in both groups, it suggests that there are a large number of patients that should have been referred under the 2WW pathway but were not. In our clinical practice we are occasionally receiving clinic referral letters that we have requested the referring GP to upgrade to the 2WW pathway based on the patients' symptoms.

We recommend our GP-colleagues to use their clinical suspicion and refer patients under the 2WW pathway as necessary. This way, even if pick-up rates stay the same or reduce, we will hopefully reduce the number of diagnosed malignancies being detected at a late stage.

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## REFERENCES

1. Potter S, Govindarajulu S, Shere M, et al. Referral patterns, cancer diagnoses, and waiting times after introduction of two week wait rule for breast cancer: prospective cohort study. *BMJ* 2007; **335(7614)**: 288.
2. Matthew A, Desai KM. An audit of urology two-week wait referrals in a large teaching hospital in England. *Ann R Coll Surg Engl* 2009; **91(4)**: 310–312.
3. National Institute for Health and Clinical Excellence. *Referral guidelines for suspected cancer*. Clinical guideline 27. London: NICE, 2005.
4. Cohen SM, Kim J, Roy N, et al. Prevalence and causes of dysphonia in a large treatment-seeking population. *Laryngoscope* 2012; **122(2)**: 343–348.

DOI: 10.3399/bjgp12X636038