Letters

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Are the serious problems in cancer survival partly rooted in gatekeeper principles?

As an experienced GP, I disagree with two aspects of this interesting paper.[1]

First, rather than being an 'unexpected ... side effect' of gatekeeping, more numerous delayed diagnoses are the inevitable price of fewer unnecessary investigations, that is one of the goals of gatekeeping. We need a study comparing the harm done by investigations (though this could never include patients' unnecessary worry and waste of time) in countries with and without gatekeepers, before deciding which system is superior.

Second, I do not believe that the authors' suggested explanations for delayed investigation and referral, such as financial constraints and fear of being 'negatively judged by doctors in the secondary sector as referring unnecessarily', are likely to be supported by the future research they wisely recommend. Instead, I think it will show that most of us try to work with individual patients to weigh up the chance of benefit from an investigation against its possible harms. Thus we already act as advisers who counsel the patients on what to do, as the authors recommend, with cost-effectiveness a very secondary consideration.

The public perception of our role as '"keepers" simply rationing care' is already growing more prevalent in anticipation of GP commissioning. I hope this paper will not be cited in support of this unhelpful and ill-founded view.

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1. Vedsted P, Olesen F. Are the serious problems in cancer survival partly rooted in gatekeeper principles? An ecologic study. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X588484.

DOI: 10.3399/bjgp11X606500

Thank you for this important and interesting paper.[1] Can I ask at what point in the course of the illness and by what criteria cancer was diagnosed? In my practice in Edinburgh, the diagnosis of cancer is based on histological examination of tissue obtained by a specialist. Imagine two patients: one patient in a system without a gatekeeper presents directly to a specialist who takes a biopsy that shows cancer; the patient dies 53 weeks after presentation and is therefore alive at 1 year. The other patient, in my practice, sees me initially and is referred and, 2 weeks later, sees a hospital specialist who takes a biopsy; this second patient dies 53 weeks after presentation to me, that is 51 weeks after seeing the specialist and having cancer diagnosed. Apparently the first patient survives 53 weeks and the second patient 51 weeks. I'd be grateful for a comment on this.

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1. Vedsted P, Olesen F. Are the serious problems in cancer survival partly rooted in gatekeeper principles? An ecologic study. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X588484.

DOI: 10.3399/bjgp11X606519

The paper by Vedsted and Olesen[1] raises serious questions about GPs and their gatekeeper role. Clearly, if the gatekeeper function is acting simply as a delaying tactic then it is difficult to justify its presence. If the delay leads to harm, such as delayed diagnosis and increased mortality, then it is an example of a medical system causing harm, and that would need to be reviewed, and maybe removed.

The data that Vedsted and Olesen use are from some time ago, reflecting practice conditions and outcomes in the 1990s. Is no more recent data available to see what is happening currently?

In the UK, GPs now have access to the 2-week rule system for urgent referrals and growing access to detailed diagnostic scans and tests. Our means to diagnosis are improving, but we do not yet know if we use them well.

Perhaps the key need now for primary care in the UK, and the world, is to focus its effort more clearly on the diagnostic activity, and its accuracy of problem definition. The current short, crowded primary care consultation in the UK is an obstacle to allowing doctors sufficient thinking time to assess symptoms and their significance, both to the patient and in terms of likely pathology.[2,3] The problem of delayed diagnoses may not be gatekeeping, but rushing, and thereby failing to define the problem properly. Perversely, we seem to have built a UK medical system based on rushing rather than thinking and in doing so achieved a reduction in both our sensitivity for and specificity of diagnosis. This may appear cheap, but it may actually be costing more to run, as referrals may become a displacement mechanism for time stressed doctors, rather than a carefully formulated question to ask a specialist.

Have we overvalued speed and quantity in medicine thereby actually reducing our quality and effectiveness?

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2. Esmail A. Longer appointments for all. *J R Soc Med* 2006; **99(12):** 644–645.
3. Davies P. The beleaguered consultation. *Br J Gen Pract* 2006; **56(524):** 226–229.

DOI: 10.3399/bjgp11X606528

Authors' response

We are grateful for the debate about positive and negative aspects of gatekeeping raised in three responses to our paper,[1] and we agree with the important research questions raised in these. First, let us stress that we are strong advocates of the gate-adviser or gatekeeper system, meaning that if any decision-makers will use our paper as an argument for removing the gate-adviser they have simply misunderstood the paper.

We want research that contributes to improving a basically good system. All three