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.^{3,4} 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.⁵ 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 considered⁶ balances are being struck would be a start.

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DOI: 10.3399/bjgp12X636029

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.^{1,2} 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 otalgia³) 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.⁴ 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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