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Editor's choice

Primary health care: what role for occupational health?

We were interested to see the editorial by Buijs et al on primary health care: the role for occupational health?¹ It is clear that there is now a growing momentum across Europe to improve physicians' awareness of the importance of work as a contributory factor towards health and wellbeing.

Following the Black review in 2008, the UK Government response, and the introduction of the new fit note there has been an important shift in attitudes among health professionals in the UK. A proactive approach and carefully designed programme of work, we believe, has been central to this shift.

The programme consists of collaboration across general practice, occupational health, and employers, providing a range of training materials to suit all learning styles. The training highlights the evidence base about the benefits of work as well as providing useful resources and strategies for GPs and other healthcare professionals when managing the work and health consultation. More than 3500 GPs across the UK have now attended face-to-face training run by the RCGP and many have downloaded e-Learning resources. All the resources, training, and information sit within one website created as part of this initiative in collaboration with UK and Welsh Government called Healthy Working UK.² The next stage in this work is to embed the resources into specialist training and appraisal and work is being undertaken in collaboration with the RCGP in the UK to see how this may be achieved. Resources and 'champions' across all medical schools in the UK have also been developed and support the undergraduate curriculum. Further resources are also being developed to support key messages across all medical specialties. We believe that this work alongside the new fit note (and the launch of the electronic fit note in July

this year) will support physicians in the UK to embed 'health and work' into their clinical management.

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REFERENCES

1. Buijs P, Gunnyeon B, van Weel C. Primary health care: what role for occupational health? *Br J Gen Pract* 2012; 62(605): 623–624.
2. Health working UK. www.healthworkinguk.co.uk (accessed 5 Feb 2013).

DOI: 10.3399/bjgp13X664108

Outside the Box: Proactive care: the patient's right to choose

Greenhalgh asks 'If it's ethical for someone to decline an offer of an opportunistic check or an invitation to screening, surely it is also ethical for a patient to ask not to receive such offers in the first place?'.¹ First, whether or not a patient should be allowed to ask not to receive offers of opportunistic screening is hardly an ethical one. It is clearly ethical for a patient to make such a request.

The real ethical issue relates to the targets of the Quality and Outcomes Framework that are related to uptake. The evidence that any of these opportunistic tests have net benefits either for an individual (informs the individual decision whether to opt to take up the test or not) or for a population (should the test be offered by the NHS or not) is scanty at best. It is thus entirely rational and reasonable for a person (not a patient) to choose not to have the test. It then becomes unethical

for uptake of that test to be a criterion by which quality is measured as it creates conflict of interest in the clinician which is clearly counter to the concept of informed patient choice and decision making. The only reasonable target in such a situation would be the proportion of patients making a decision (yes or no) based on informed consent. That the NHS persists in having targets for uptake of tests of debatable value to the population or to the individual is simply unethical.

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REFERENCE

1. Greenhalgh T. Outside the Box: Proactive care: the patient's right to choose. *Br J Gen Pract* 2012; 63(606): 37.

DOI: 10.3399/bjgp13X664117

Professor Greenhalgh makes a valid point about the pitfalls of opportunistic screening in general practice.¹ There will always be patients who find opportunistic health checks intrusive and entirely superfluous to their consultation with their GP. However, as Dr Greenhalgh points out herself, proactive care of this kind is often based on robust evidence and contributes significantly to practice income too. Allowing patients to entirely opt out of participating in these health checks could therefore have serious long-term clinical and cost implications.

There are also practical problems in implementing any 'opt-out' systems. Presumably any decision to opt out of routine health checks would have to be based on informed consent. But such informed consent would surely have to be regained at fairly regular intervals in order to be ethical and fair. If a 50-year-old woman, for example, opts out of ever receiving letters inviting her for annual blood pressure or urine-dip screening, is it ethical to regard this consent as indefinite and not re-offer the screening as she ages, her cardiovascular risks increase,

or if her social circumstances/medical comorbidities change?

There are also other advantages in sending 'unsolicited mail' to our patients that Dr Greenhalgh overlooks. For example, such offers of screening, even if they are declined, can serve to remind infrequent attenders of the existence of their GP and encourage attendance for other problems.

Dr Greenhalgh refers to a few of her patients 'who have negative attitudes towards proactive care' and one patient in particular who felt that 'her biometric data in the absence of symptoms are none of anyone's business'.¹ Surely it is our role as primary care clinicians to challenge attitudes of this sort and, so far as it is reasonable, encourage all patients to participate willingly and actively in taking responsibility for their long-term health, rather than allowing a select few to opt out of health checks on a default basis.

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REFERENCE

1. Greenhalgh T. Outside the Box: Proactive care: the patients' right to choose. *Br J Gen Pract* 2013; **63**(606): 37.

DOI: 10.3399/bjgp13X664199

Symptoms and risk factors to identify people with suspected cancer in primary care

Julia Hippisley-Cox and her team have made great progress in their continuing process of helping GPs estimate a patient's risk of cancer.^{1,2} I do suggest caution in the use of their current QCancer® risk calculators^{3,4} for three reasons though.

First, the risk calculators don't as yet include important data such as the doctor's clinical examination findings or recent negative results of screening by mammography, cervical smears, and colonoscopy.

Second, predictive values of symptoms, signs, and test results (indicants) depend on the context in which the data were collected.⁵ Predictive values for indicants in the QCancer risk calculators were derived and validated using coded data recorded

during general practice consultations. These predictive values therefore don't necessarily apply to data recorded by patients themselves or by doctors on checklists, nor to uncoded indicants. This isn't made clear to members of the public visiting the QCancer website who are told: 'You can use this calculator to work out your risk of having a cancer as yet undiagnosed by answering some simple questions'.^{3,4} Nor is it made clear to doctors who are told that 'the template would then help structured data entry of other related symptoms including significant negative findings and the results generated automatically'.^{1,2}

Third, a digital risk score replacing or accompanying the traditional analogue clinical note will have unpredictable, perhaps undesirable, consequences. Diagnosis and risk assessment are improved by looking at the clinical information available from different angles. These calculators provide an additional perspective. How clear a view they give us is questionable.

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REFERENCES

1. Hippisley-Cox J, Coupland C. Symptoms and risk factors to identify men with suspected cancer in primary care: derivation and validation of an algorithm. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X660724.
2. Hippisley-Cox J, Coupland C. Symptoms and risk factors to identify women with suspected cancer in primary care: derivation and validation of an algorithm. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X660733.
3. QCancer-2013-male. <http://www.qcancer.org/male/index.php> (accessed 5 Feb 2013).
4. QCancer-2013-female. <http://www.qcancer.org/female/index.php> (accessed 5 Feb 2013).
5. Treasure W. *Diagnosis and risk management in primary care: words that count, numbers that speak*. Milton Keynes: Radcliffe Publishing, 2011.

DOI: 10.3399/bjgp13X664126

Authors' response

Thank you for the opportunity to respond to Dr Wilfred Treasure's letter¹ regarding our two papers.^{2,3} The QCancer® algorithms are an evolving set of risk algorithms to quantify the risk of a previously undetected cancer. They are intended to support clinical decision

making and we are currently carrying out a pilot to inform how best to implement them. The algorithms currently combine multiple risk factors and symptoms to give a global risk of cancer and risks of individual cancer types. Dr Treasure is correct in saying that the QCancer algorithms do not currently include results of clinical examinations; it's possible these could be added in a future version of the tool should the relevant data be coded in the clinical record. However, as we say in the paper, QCancer is intended for use in a primary healthcare setting to help doctors assess which patients to send for investigations such as colonoscopy. Therefore the tool does not include the results of colonoscopy or other diagnostic tests as that is not the purpose of the tool.

In response to Dr Treasure's second point we agree that the predictive values are based on data recorded during general practice consultations. The information on the QCancer website states the following 'This website is primarily intended for doctors and nurses working in general practice and for academics who are interested in the underlying research. Patients are welcome to read this information and use the calculator together with their doctor so that any symptoms or concerns can be addressed within a healthcare setting. All medical decisions need to be taken by a patient in consultation with their doctor. QCancer works out the risk of a patient having a current but as yet undiagnosed cancer taking account of their risk factors and current symptoms. It does not give a diagnosis of cancer, but a risk'.

The paper offers possibilities on how QCancer can be implemented into clinical settings as Dr Treasure points out. The paper is not a detailed guide on the implementation but does offer several possibilities including the use of structured templates. Such templates are already commonly used to assist in data entry across a wide range of clinical areas including risk-assessment tools and their use is likely to improve the ascertainment and recording of positive and negative symptoms over time. This will enhance both the medical record in its primary purpose but also future updates of the QCancer tool.

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