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MAIN ARTICLE

Views of general practitioners and head and neck surgeons on the referral system for suspected cancer: a survey

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Abstract

Background: The two-week wait referral system for suspected cancer was introduced in the National Health Service in 2000. This study aimed to identify areas for improvement to the two-week wait system by seeking the opinions of doctors working in primary and secondary care.

Method: A questionnaire was distributed to general practitioners and head and neck surgeons within North West England with ethical consent.

Results: Twenty-seven general practitioners and 15 head and neck surgeons responded. Of the general practitioners, 59.3 per cent declared that they never attend training on referrals in this specialty. Overall, 59.3 per cent of general practitioners and 86.7 per cent of head and neck surgeons felt that the two-week wait system could be improved.

Conclusion: The main areas for further work are development of pre-referral communication between primary and secondary care along with development of practical educational measures for general practitioners.

Key words: Neoplasm; Interprofessional Relations; Interdisciplinary Communication; Teaching; Primary Care; Secondary Care; Gatekeeping

Introduction

Following the reports of unfavourable mortality rates for many cancers in the UK compared to other countries in Europe, the two-week wait referral process was introduced nationally for all cancers in 2000, and is currently used around a million times per year.[1–3] For the head and neck specialty, 10.9 per cent of these referrals result in diagnoses of cancer,[4] and there is evidence to suggest that this percentage is decreasing in line with an increase in the number of referrals being made.[4–8] Hence, there is more pressure than ever to ensure that patients are only referred using the two-week wait referral system when there is genuine suspicion of malignancy, and that these urgent clinic appointments are not filled by patients who could attend a routine appointment or even not see a specialist at all.

There have been many papers across all specialties reporting experiences using the two-week wait referral system, but most of these papers focus on quantitative outcomes such as how many referred patients are seen within two weeks and what proportion of referrals are diagnostically accurate.[7,9–11] There has been little work investigating clinicians' views on the system, whether they feel it is effective and their views on how improvements could be made to the process.

This study aimed to survey both general practitioners and head and neck surgeons in terms of their experience of the two-week wait referral system. The head and neck specialty was selected as, although a relatively uncommon cancer, in the UK there are still around 8000 cases per year, and the authors have experienced specific criticism of inappropriate referrals within this field.[4]

Materials and methods

Ethical permission for this study was obtained from The University of Liverpool committee on research ethics (reference 201410144). The names of 50 general practitioners and 50 head and neck surgeons who practice in the northwest of England were obtained using National Health Service (NHS) trust and practice websites. A focused questionnaire specific to each group was created using web-based survey software (SurveyMonkey, Palo Alto, California, USA) and distributed. In total, there were seven questions, and free text comments were encouraged.

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The 'nhs.net' e-mail addresses were obtained for the relevant individuals in each group, and an invitation to participate in the study was distributed along with a link to the survey. Two reminders, over subsequent weeks, were sent to each group and the survey was closed after one month. Results, expressed as percentages to allow comparison between the groups, are reported below. Free text responses have been included where a theme was demonstrated from multiple respondents.

Results

Overall, 27 general practitioners and 15 head and neck surgeons completed the questionnaire. In the group of general practitioners, it was apparent that two-week wait referrals for suspected head and neck cancers were rare, and 88.9 per cent of general practitioners reported making equal to or less than four referrals per year.

General practitioners reported that their preferred method of referral was the current referral form, accounting for 63.0 per cent of responses. However, there was no clear consensus amongst the head and neck surgeons over which method they preferred to receive these referrals by, with 33.3 per cent preferring the current form and 40 per cent stating they would prefer a letter with more clinical details (Figure 1).

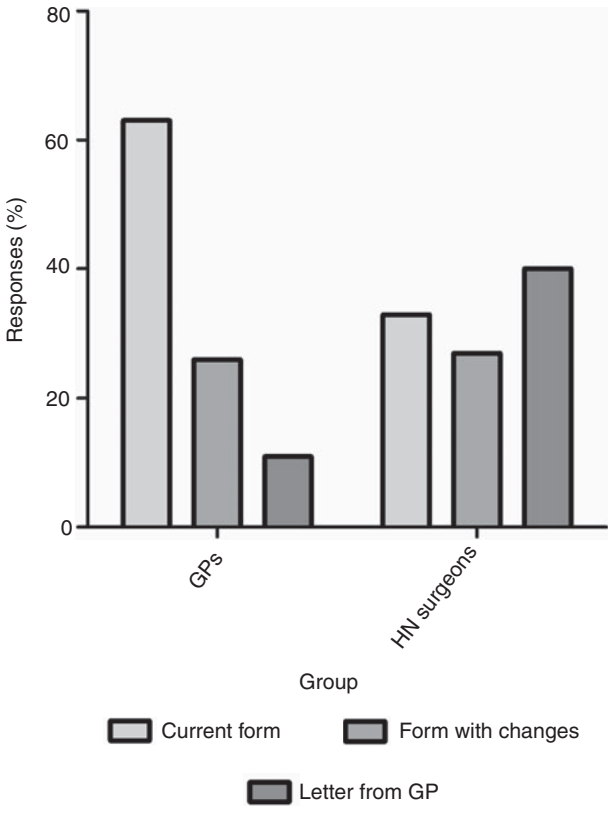

FIG. 1

Desired method of referral for general practitioners and head and neck surgeons for suspected head and neck cancer cases. Expressed as percentage of total responses for each group. GP = general practitioner; HN = head and neck

Despite their reported preference for the referral forms, many freehand comments from the general practitioners were in agreement with the consultants' desire for more clinical information to be relayed with the referral. One general practitioner's comment, which illustrated this frustration with the forms, stated: '[I] think it is almost a "please see this patient" form with no real clinical information [and it] could do with a section to put a bit more clinical info [information], if it was relevant'. The head and neck surgeons expressed the same concerns regarding the referral forms, with one surgeon stating: 'the tick box form encourages a tick box mentality. Intelligent doctors who normally write helpful detailed letters are referring patients in whom they suspect a malignancy with a tick in a box and no other clinical details…'.

It seemed that it was not unusual for general practitioners to make and head and neck surgeons to receive two-week wait referrals when in fact head and neck cancer was not suspected. The majority of general practitioners (51.9 per cent) responded that they sometimes made two-week wait referrals when they did not have a strong suspicion of head and neck cancer, with only a small minority (11.1 per cent) saying that this was never the case. Correspondingly, the majority of head and neck surgeons (60 per cent) said that they often receive two-week wait referrals where they feel that the general practitioner did not have a strong suspicion of head and neck cancer.

The general practitioners reported a number of reasons for making referrals when they did not have a strong suspicion of cancer. Defensive concerns were cited: 'even if I think it is probably a benign lump, because it might fit the criteria for a two-week rule I feel I have to send it this way for medico-legal reasons'. Some of the head and neck surgeons recognised these medico-legal pressures faced by their general practitioner colleagues, as reflected in their comments: 'I often feel that the GPs [general practitioners] are either manipulating the system or are frightened that because the patient has a symptom that appears on the list (in some cases despite a history extending over many years), they will be criticised if they don't send the patient up as a two-week [wait] rule'. However, others were more concerned about the two-week wait rule being used to make up for resource problems within the NHS, with one commenting that general practitioners were: 'knowingly blurring the description of the presenting problem [of patients] they wish to have seen fairly urgently in secondary care'.

The majority of general practitioners (70.4 per cent) reported that they always or often inform the patient of the reason behind a two-week wait referral, although a minority of the respondents (7.4 per cent) reported that they rarely tell their patients that they are concerned about cancer. In contrast, 80 per cent of the head and neck surgeons reported that the patients they saw following a referral were either rarely or only sometimes

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informed of the nature of the referral (Figure 2), with one respondent stating: 'most patients are surprised when they are told the GP [general practitioner] has sent them up urgently as a suspected cancer patient'.

Most general practitioners (59.3 per cent) reported that they never attend training for referral for head and neck cancers, with only one respondent stating that they attended this training more than annually. Equally, 40 per cent of head and neck surgeons never delivered training to general practitioners, whereas the same number (40 per cent) provided training less than annually (Figure 3).

The majority of respondents from both groups (59.3 per cent of general practitioners and 86.7 per cent of head and neck surgeons) felt that the two-week wait referral system could be improved (Figure 4). There were some constructive suggestions for improvement of the system. One general practitioner suggested: 'it would be useful to have a quick same-day discussion with [an] ENT consultant to confirm [the] correct referral (or advice on investigations you could arrange yourself urgently)'. A common theme from general practitioners was that: '[there should be] more scope for clinical suspicion which don't exactly fit the criteria'. Another general practitioner expressed the concern that: 'There is a gap between the 2/52 rule referrals and an "urgent" referral where index of suspicion is not that high but exists'.

As well as agreement regarding the need for reform of the system, there was recognition that both sides need to be involved, with one head and neck surgeon stating: 'any proposed changes need very wide consultation to get the best system'.

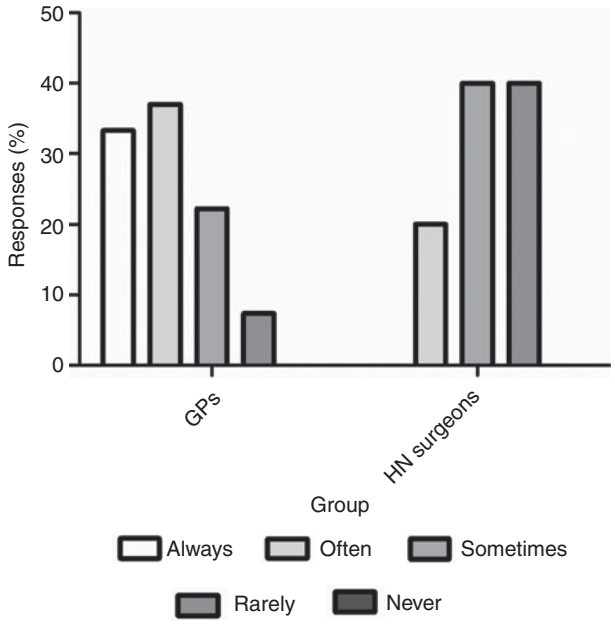

FIG. 2

Frequency of which a patient is made aware, or it is deemed they have been made aware, of the significance behind their two-week wait referral for suspected head and neck cancer. Expressed as percentage of total responses for each group. GPs = general practitioners; HN = head and neck

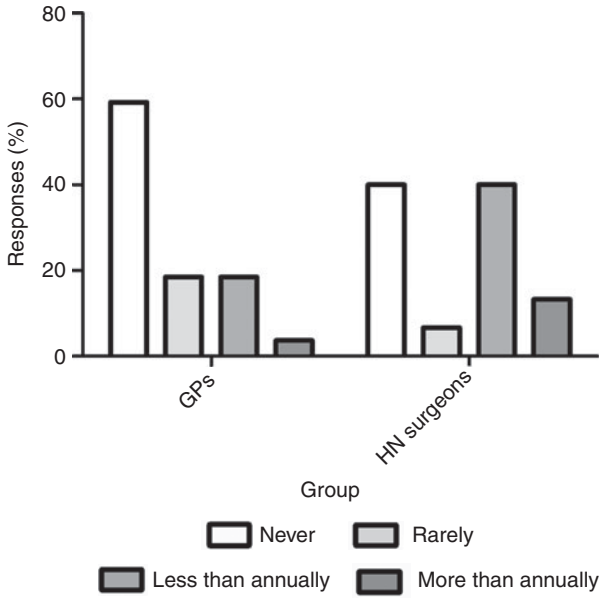

FIG. 3

Frequency of general practitioners who receive training from head and neck surgeons or of head and neck surgeons who give training to general practitioners on the topic of two-week wait referrals for suspected head and neck cancer. Expressed as percentage of total responses for each group. GPs = general practitioners; HN = head and neck

Discussion

The two-week wait system was introduced to speed up the investigation and subsequent diagnosis of patients with symptoms of suspected cancer. However, since its introduction, there has been little refinement of the system or the assessment criteria for determining

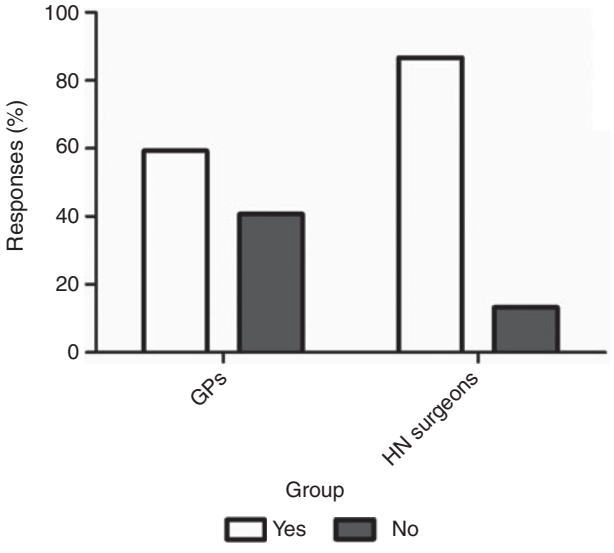

FIG. 4

Overall opinion on whether improvements can be made to the two-week wait referral system for suspected head and neck cancers. Expressed as percentage of total responses for each group. GPs = general practitioners; HN = head and neck

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which patients are appropriate for two-week wait referrals. In many cases, the criteria do not represent 'a strong suspicion of cancer'. In addition, our study suggests that there is often a mismatch between what consultants are expecting patients to be told about their referral and what general practitioners feel is appropriate to say to their patients. Both parties agree that allowing general practitioners to add more free text clinical information would benefit the quality of referrals. However, it has to be questioned what purpose this would have, as once a referral is received it is NHS policy that it cannot be downgraded. Equally, it would be administratively and medico-legally challenging for a consultant to decide on the basis of information provided in a letter or form that a patient does not need to be seen within two weeks.

The need for improved communication between primary and secondary care is a mantra that is often repeated in many areas of the NHS, and with regards to two-week wait referrals this could clearly lead to significant improvements in effectiveness and efficiency. An idea that was expressed by the respondents in this study is the concept of a set and agreed communication channel for general practitioners to use in order to communicate with a consultant when there is uncertainty as to whether a two-week wait referral is appropriate. One comment suggested that e-mail would be a suitable medium for this, which does have the advantage of not requiring the consultant head and neck surgeon to respond immediately, allowing them to continue their normal clinical activities without interruption. Such pre-referral dialogue would also allow for any further investigations to be organised in primary care, as recommended by the specialist, prior to the patient being seen in their clinic, which should also speed up the subsequent diagnosis and management of the patient.

Improved pre-referral dialogue may also address how best to communicate to a patient the meaning of their two-week wait referral, as in this study there was a clear mismatch between what the general practitioners reported that they told their patients and the head and neck surgeons' reporting of the patients' understanding of the nature of their referral. In addition, a clearer definition of the philosophy behind the two-week wait system that is accepted by both sides of the primary and secondary care divide would also be helpful here, as there is often a marked difference between the 'strong suspicion of cancer' statement and the likelihood of a diagnosis of cancer from the specified two-week wait referral criteria.

The issue of ongoing professional development and education for general practitioners specifically to improve the appropriateness of two-week wait referrals is a contentious one. Some studies looking at skin cancer referrals have reported increased diagnostic accuracy following educational measures of lectures and slideshow presentations.[12] However, with increasing pressures on primary care, it is unlikely that general practitioners will find time to attend face-to-face educational sessions for each of the specialties that they encounter, particularly those that are less common, as is the case with head and neck cancer. In addition, a previous study which tried to circumvent this problem by using indirect educational methods had no effect on the number, or diagnostic accuracy, of suspected skin cancer two-week wait referrals.[13] Furthermore, a systematic review looking at interventions to reduce primary care delays in cancer referral did not find any intervention that achieved this.[12]

- **The two-week wait referral system was introduced nationally in the UK to improve cancer-related mortality**
- **Around one million referrals take place annually using this system**
- **The study results indicate that pre-referral communication between primary and secondary care would reduce inappropriate referrals and enhance professional relationships**

The results of this study confirm the need for reform of the two-week wait referral system, and indicate that communication and education should be the cornerstones of any such changes. A scheme of compulsory pre-referral e-mail communication between general practitioners and head and neck surgeons for all two-week wait referrals would fulfil both criteria, and would be both simple and inexpensive to pilot. Clear guidance on required response time would ensure there was no significant delay in patients being seen, and consultant advice on appropriate investigations prior to clinic appointments would partly mitigate this. Workload implications for consultants would be balanced by reduced demand for two-week wait appointments and improved pre-referral investigation of patients. Finally, the dialogue would help to enhance professional relationships, whilst also providing clinical guidance and education for general practitioners' professional development.

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