Cancer care in the UK: updating the professional culture

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The past decade has shown a notable change in the way cancer services are provided within UK hospitals. It was necessary that something was done. The EUROCare studies of cancer survival going back to the start of that period confirmed that for many common epithelial cancers survival is inferior to comparable European countries. Ten years ago I wrote an article which showed how these observations could be connected with the culture of cancer management that had developed within the National Health Service (NHS) over the preceding half-century.1

SURVIVAL IN THE UK
Some questions have been raised as to how accurately the EUROCare data reflect true differences in cancer survival between different countries.2 3 Much effort is devoted to assuring the quality of the data.4 In an exercise to assess the effect of under-registration in the UK, adjustment for the maximum possible error failed to overturn the survival advantage of Finland over the Thames region except for some lung and oesophageal cancer cases where the methodology used is implausible.5 It has to be emphasised that these data compared results from populations. Cancer survival is not just a matter of how excellent the top academic institutions are, but how effectively patients have access to competent services. Other studies show that poor survival is associated with advanced stage at presentation—for example, a EUROCare study in colorectal cancer6 and a hospital based study in lung cancer.7 Furthermore, there is a clear mechanism in its reliance on primary care gate keeping to minimise demand on specialist services which explains why the UK might be so poor. Another western European nation which relies on this is Denmark which also languishes near the bottom of the EUROCare league.8

SERVICE DEVELOPMENT IN THE PAST DECADE
Strong positive developments have occurred in how patients are processed through the system once cancer has been identified. These existed as ideas in 2000 and have been developed into current practices. Once the possibility of cancer has arisen the passage of a patient through the system is governed by timed pathways, so that the first definitive treatment must be given within 62 days of a patient being referred for a suspected cancer or for other patients within 31 days of the diagnosis being made. This has been associated with investment in more staff to undertake diagnostic management including investment in acute general hospitals (AGHs) and above all in the establishment of multidisciplinary teams. The previous concern that patients with cancer often did not have access to an oncologist is countered by ensuring that all patients are discussed at a meeting of a group of which relevant oncologists are members—this nearly, but not quite, resolves the issue. The culture persists that holds that medical and clinical oncology are tertiary referral disciplines that are aloof from the hurly-burly of general hospital life, only requiring to be involved with a very select group of patients.

CENTRALISATION
Further developments aimed at enhancing the quality of the service have included the centralisation of surgery for less common procedures for which detailed surgical expertise is thought to be beneficial—upper gastrointestinal tract, urinary tract, and gynaecological cancers being the main examples. Surgery for lung cancer was centralised in the 1960s rationalisation of the NHS. This policy cannot be considered a success in a health service that aims at universal provision because access to operations for lung cancer is affected by the distance of the thoracic surgical centre from the patient’s residence. This phenomenon is strongly true for the socioeconomically deprived sector of the community.9 Radiotherapy was centralised in the 1960s and distance decay and reduced access for deprived people can similarly be identified, even after 7 years of a cancer plan being enacted.10 11

DEPRIVATION
Analysis of hospital episode statistics covering the period affected by the implementation of that plan shows that there is a strong socioeconomic relationship in the proportion of first admissions to hospital for cancer which are via the emergency route.12 13 In this study a relationship with age was demonstrated which improved over time, whereas the socioeconomic status effect did not. Differing routes of admission can be interpreted as showing the timeliness of access to services for cancer; elective admissions predominantly include the optimal scenario of presentation to a diagnostic service where an operable cancer is identified and the patient is admitted for surgery with curative intent. Emergency admissions include patients presenting late in the disease with previously unrecognised cancer and patients whose tumours are inoperable at diagnosis and who are admitted with complications of advanced disease or its treatment.

The culture of cancer management in the UK at the end of the first decade of the 21st century can therefore be summarised as one where the role of experts in the teaching hospitals has been emphasised, but where the question of equity of access remains open. There are impediments both between primary and secondary care and between secondary and tertiary services.

TWO MAJOR IMPROVEMENTS
Two developments offer real promise for addressing the major problems. The first is the National Awareness and Early Diagnosis Initiative which is described in a special issue of the British Journal of Cancer.14 15 I believe that if this was enacted, it would be the single most valuable step in bringing UK cancer survival into line with the rest of the developed world. Symptoms of early cancer are notoriously vague and valid screening systems are available for only a few tumour sites. The role of the general practitioner (GP) as diagnostician rather than that of gate keeper needs to be developed; this requires a cultural change in primary care. The person who happens to have cancer is ill served if the policy is to reassure patients on the first presentation, reserving investigation for those whose symptoms are unduly persistent. The inescapable truth is that this requires more tests to be done.
CANCER MEDICINE COMES OF AGE

When UK medical oncologists formed their specialist society in the mid 1980s it was agreed that its name should avoid the implication that its members were concerned solely with a particular modality of treatment; all aspects of care of the patient with cancer are their remit.

So the Association of Cancer Physicians was founded. It is therefore surprising that only now has NCAG introduced the concept of an acute oncology service for hospitals with emergency departments. This applies to hospitals, where patients go in reality, not to Trusts which might believe they know to which of their premises patients ought to go. It means that a consultant oncologist, with or without radiotherapeutic expertise, is scheduled to be present in the AGH throughout the working week to provide advice and to engage closely with the functioning of that institution. NCAG does not envisage that such doctors would admit patients under their own name.

This is flawed because when oncological issues dominate the patient’s stay there can be issues about who is leading the patient’s care—the oncologist or the clinician nominally responsible. In my experience this leads to lack of clarity among members of staff and can defeat the object of conducting inpatient stays as efficiently as possible. This factor apart, the introduction of specialist cancer medicine services into the day to day life of the AGH will mark the coming of age of non-surgical oncology in the UK.

These developments augur well for the development of the culture of cancer management in the UK in the next few years. A major cause of anxiety over their implementation must be the financial gloom which covers the country. Depression is a persistent underlying issue, and the widening socioeconomic gap in premature mortality in the UK means that it must be insisted that the promise of ring-fenced funding for the NHS is translated into the implementation of developments such as these.

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REFERENCES