Management of cancers of the head and neck in the United Kingdom: questionnaire survey of consultants

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Cancers of the upper aerodigestive tract—that is, of the head and neck and excluding lymphomas—present a number of challenges in implementing the changes recommended by the Expert Advisory Group on Cancer Services.¹ As head and neck cancers are heterogeneous and occur at several sites they are managed by several disciplines. Treatment for these cancers may form a small part of the caseload of each of these disciplines, making it difficult for specialists to develop expertise in this area.²

We report on the current provision of services for the treatment of head and neck cancers in the United Kingdom.

Subjects, methods, and results

From April to June 1996 a questionnaire was sent to consultant members of specialist associations. These associations included otolaryngologists, maxillofacial and plastic surgeons, and medical and clinical oncologists. The questionnaire requested information on the management, facilities, and types and numbers of cases of head and neck cancers seen by each consultant.

One thousand and forty one (74%) consultants responded; 122 (12%) did not treat head and neck cancers and were excluded from further analysis. Of the 919 respondents who did treat head and neck cancers, 515 (56%) said that they routinely assessed patients in joint clinics, 193 (21%) within their specialties in liaison with another specialty, and 211 (23%) within their specialty alone. Only 37 (4%) consultants used any standardised method of collecting patient information and 129 (14%) said that they did not routinely record the clinical stage of tumours in the patient's notes. Three hundred and eighty one and 322 consultants reported no access to nurse specialists or counselling services (40% and 35% respectively).

The caseload of each consultant was recorded for each anatomical site—for example, lip, mouth, and larynx. The 919 consultants treat the 6500 new cases of cancer per year in the United Kingdom; less than 10 cases per consultant, even allowing for joint management. Less than half of the consultants treated more than 10 cases a year at any anatomical site (table). The consultants who treated more cases at any one site were also more likely to record the clinical stage of the tumour and to receive most of their referrals from hospital colleagues ($P < 0.0001$).

Comment

Although there are inherent problems with self reporting questionnaires this study provides scarce information on the management of head and neck cancers in the United Kingdom. The treatment of these cancers is widely spread between individual consultants, disciplines, and provider units. A reduction in the number of consultants dealing with head and neck cancers would have implications for training and staff-

Caseload of consultants based on maximum number of cases at any one site

No of consultants	Maximum No of cases treated at any one site per consultant				
	0-4	5-9	10-19	20-29	30+
	170	385	220	70	80

ing. Only five to six new surgical consultants in oncology are estimated to be needed each year, but 57 surgeons are currently being accredited in the United Kingdom, all of whom will be able to deal with cancers of the head and neck.³

A team approach to the management of head and neck cancers has long been recommended⁴ but is practised by only half of consultants. The proportion of consultants not recording the clinical stage of the tumour makes any systematic audit of outcomes impossible. Given the psychosocial impact of cancer and its treatment,⁵ access to specialist nursing and counselling services would need to be ensured when changes are made to oncology services.

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- 1 Expert Advisory Group on Cancer Services. A policy framework for commissioning cancer services. *Report of an expert advisory group on cancer to the chief medical officers of England and Wales* 1995. London: HMSO.
- 2 Lore JM. Dabbling in head and neck oncology: a plea for added qualifications. *J Otolaryngol Head Neck Surg* 1987;113:1165-8.
- 3 Birchall M. *Head and neck cancer services in Avon and the South west: profile and proposals for development. Report to the regional health authority*. Bristol: 1995.
- 4 Rapidis AD, Angelopoulos AP, Langdon JD. The team approach in the management of oral cancer. *Ann R Coll Surg Engl* 1980;62:116-9.
- 5 Edwards D. *Face to face: head and neck cancer services*. London: King's Fund, 1997.

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Endpiece

Moral closure

Ethics likes to ask questions, whereas medicine needs answers. This is one of the tensions in any form of applied ethics; at some stage, consideration of different options and arguments will have to stop, and a decision be taken about what should be done. Just as one of the insights of communication skills is that open questions may get more answers, or a greater depth of answer, and closed questions are best used sparingly and only when required, so a better moral outcome might be anticipated if moral closure is prevented until the appropriate moment.

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See editorial by Tobias

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