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The role of general practice in cancer care

Background
The incidence of cancer is rising, so the workload of managing cancer is increasing rapidly. Among the advances in cancer care are advances in coordination of care, with team care being a preferred method.

Objective
This article examines the role of the general practitioner, by looking at each step in the patient's cancer journey. The current role of the GP and practice staff is examined, as well as potential roles that can be undertaken to maximise the role of general practice in an integrated cancer service.

Discussion
A complete rethink of how cancer is managed, in particular defining the roles that must be performed by specialists and those that can be performed in primary care, needs to take place in order to deal with the rising cancer incidence in Australia. General practice must prepare to modify how it works to meet this challenge, in a similar way to confronting the rising tide of other chronic illnesses.

Determining the current and potential roles of the general practitioner in cancer care must occur in the context of a rapidly changing landscape in cancer management. Two parts of that landscape are particularly relevant.

Rising cancer incidence

Australia's population is aging; 12.5% of people were over 65 years of age in 2001 and this is estimated to rise to 25% by 2052.[1] This is reflected in a rapidly rising incidence of cancer (*Figure 1*), which will place great strain on existing resources. A complete rethink of how cancer is managed, in particular defining the roles that must be performed by specialists and those that can be performed in primary care, will ensue. General practice must prepare to modify how it works to meet this challenge, in a similar way to confronting the rising tide of other chronic illnesses.

Cancer care through multidisciplinary teams

There is considerable attention being paid to models of care delivery in cancer care. Much of cancer care is successfully delivered through a cancer specialist who refers to other specialist colleagues in a hub-and-spoke model (*Figure 2*). There is a push to formalise cancer care planning by having a patient's treatment planned by a multidisciplinary team (MDT), or a network between a local centre and a central MDT. This approach may confer several benefits to patients, including:

- improved confidence and reduced concerns that their treatment is based on the knowledge of just one individual
- patient satisfaction and patient psychological wellbeing
- continuity of good quality care that improves the quality of life
- cost effectiveness to the patient and third party payers.[2]

Multidisciplinary teams comprise professionals from different disciplines, including general practice, who bring their expertise to bear simultaneously on individual cases. This process often takes place informally at present, but there is a current move to formalise

the process into teams that physically meet. Multidisciplinary teams can be established around tumour streams (eg. head and neck), or can address different cancer types, depending on the resources in a geographic area. Some regional areas have a link to central MDTs, either through a visiting specialist or the use of communications technology. In some cancers, survival may improve as a result of MDT involvement.[3,4] In particular, survival in low incidence cancers might be impacted by the experience of the clinical team, so every effort should be made to refer to specialists or teams who have experience in a particular cancer.

At present, GPs may not be aware of the location or existence of disease specific MDTs, or they may not be aware of which specialists may have expertise in particular cancers. It is often assumed that a specialist referral, or referral to the local hospital, will lead to the patient being offered best practice care through secondary referral.

General practice and the cancer journey

So, what is the role of the GP once a patient has cancer? *Figure 3* illustrates both the patient and their carer's cancer journey. Discussed below are tasks for the GP, and potential tasks that might occur in the future, for each state of the journey.

Diagnosis

A major role of GPs in the care of cancer patients is in diagnosis. For some cancers – such as breast, cervical, and colorectal – general practice has a critical role to play in early detection to maximise the chance of cure.[5–7]

In other cases, a presumptive cancer diagnosis relies on the patient presenting with symptoms that arouse suspicion. While a cancer diagnosis can be straightforward, Murtagh's diagnostic strategy[8] fails if the diagnosis is not considered a possibility. Problems occur where the GP's index of suspicion is reduced, such as symptoms in a patient of the wrong age, wrong gender, or with no cancer risk factors. Here safety netting, the strategy of having the patient return if the symptom does not resolve, becomes critical. The timing and reason for the return visit needs to be set out, and clearly understood.

Once a presumptive diagnosis of cancer is made, the GP must explain the diagnosis, probable investigations required and probable treatment to the patient. The patient will be completely distracted by the diagnosis, and will need follow up visits to allow digestion of the diagnosis, reiteration of the information they need, and a chance to generate questions and have them answered.[9] The patient should be encouraged to have a confidant present for these consultations. There is also a role for patient peer support at this time;[9] several organisations can provide this support (*Table 1*).

The second critical step is to decide to whom the patient should be referred. General practitioners will frequently refer to specialists in the discipline for definitive diagnosis and treatment (*Figure 2*). The GP will usually assume that if the specialist is not regularly dealing with that cancer type, the specialist will make a secondary referral to another specialist or specialist team that has expertise in that cancer type. Team decision making may confer benefits over hub-and-spoke management (where patient care is coordinated by the first person referred to) (*Figure 2*). The GP should seriously consider how their usual specialists make such decisions. Cancer Australia, through the CanNET program,[10] is responsible for facilitating the development of cancer teams in each state and territory. They are also examining ways of getting information to GPs about where appropriate specialist teams are located, and how to arrange a referral (*Table 2*).

Figure 1. New cancer cases in Australia 1995–2011 (projected)

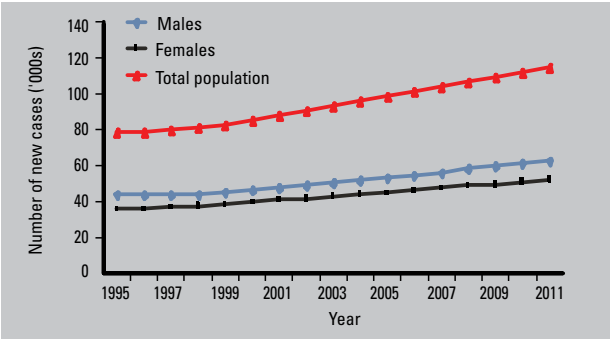
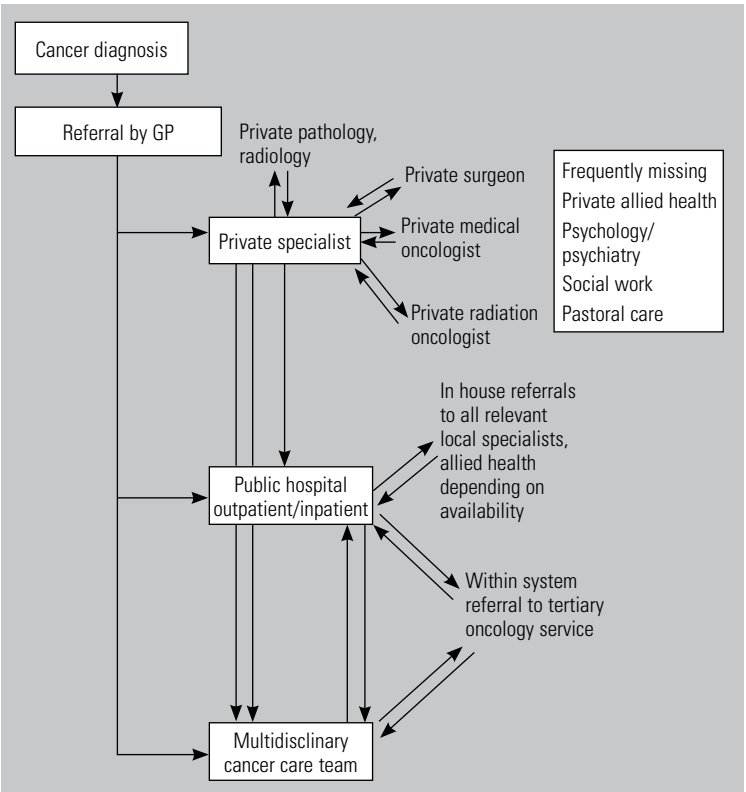


Figure 2. Referral pathways after a diagnosis of cancer



During treatment planning

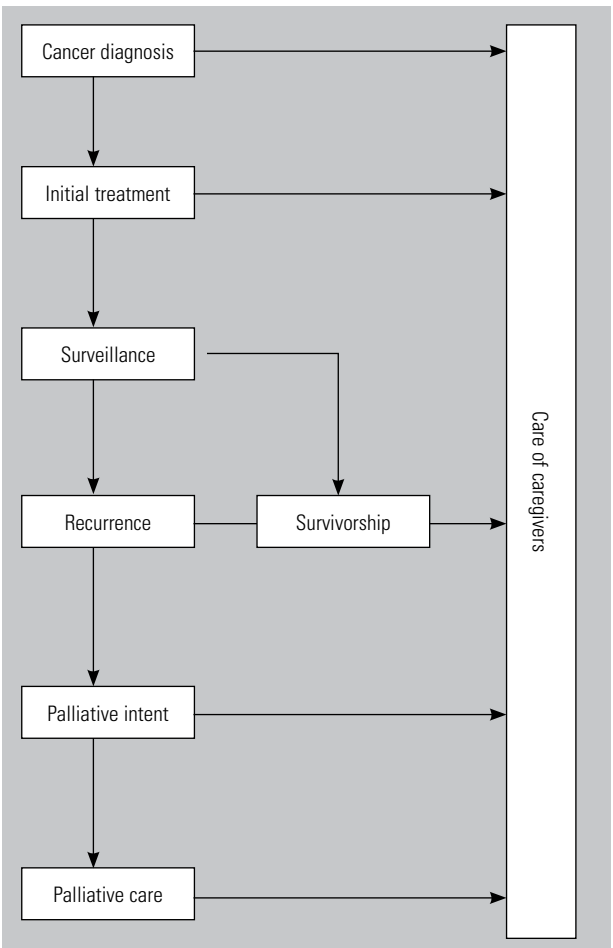
Much of the workup required for staging of a cancer can be arranged ahead of referral to the specialist or MDT. This will make the

workup process much more efficient. Having access to material that informs GPs what workup is required would make the process more streamlined. If the GP participates in the MDT, they should be able to provide a history of the illness. More importantly, the GP should be able to provide information on the patient's personal and social history, which could be important in ensuring adequate and appropriate social support is in place. Additionally the GP may be able to negotiate a role in treatment.

Treatment

The role of the GP at this point of the cancer journey depends on the type of treatment required. Many cancers require repeated cycles of chemotherapy. It may be possible for the GP to arrange pre-chemotherapy checks of the patient's haematological and biochemical status. If the GP has access to protocols to deal with common chemotherapy side effects, eg. the CI-SCaT pages of the New South Wales Cancer Institute (www.cancerinstitute.org.au), it should be possible to provide surveillance and treatment of at least some of the possible side effects without having to go to hospital. Practice based cancer care should involve the development of a GP management plan and team care arrangements where appropriate.

Figure 3. The cancer journey



There may be the potential to develop new roles for practice nurses. Some GPs (eg. in rural areas) are able to conduct chemotherapy under the guidance of the treating specialist.

Surveillance

Here is where the GP can either play a major part, or no part at all. The follow up process generates anxiety for the patient and their caregiver: there is no active treatment, and often patients will not rest unless they know unequivocally that there is no recurrence. If the GP is aware of the surveillance visits, they will have a support

Table 1. Organisations offering information, peer support and counselling for cancer patients and their families

Cancer Council Australia

Cancer Council Australia provides answers to a wide range of cancer questions, written for lay people. It also provides an array of information for clinicians. See 'Common questions about cancer'

www.cancer.org.au

Cancer Voices Australia

Cancer Voices Australia is an organisation of people affected by cancer, who aim to advocate on behalf of cancer sufferers

www.cancervoices.org.au

Carers Australia

Carers Australia provides support, written advice and counselling for carers of people suffering from any long term condition, including cancer and palliative care

www.carersaustralia.com.au

Caresearch

Caresearch is the information hub for palliative care in Australia. It has a section with information for patients, carers, family and friends. It is also a repository for research based tools for clinicians and a library of grey literature around palliative care

www.caresearch.com.au

DIPEx

DIPEx is a registered UK charity with an ongoing program of collecting personal experiences of health and illness. Researchers have identified patients and their carers through primary care and specialist services and have undertaken in depth interviews, which are audiotaped and video recorded. The website covers cancers, heart disease, mental health, neurological conditions, screening programs, chronic illness and teenage health and pregnancy. The patient, carer or health professional can watch or read the interviews and find reliable information on treatment choices and where to find support. For those with life threatening illnesses, there are detailed accounts of receiving bad news, finding information, treatment decisions and symptoms, facing death, religion, faith and philosophy

www.dipex.org

role to play. A mental health plan and psychology assessment and treatment should be considered to manage the anxiety proactively.

The GP could perform surveillance in conjunction with the specialist team. This can be done effectively.[11] Protocols that identify what tests are to be done, what symptoms to look for, and what to do if problems arise should allow the GP to provide appropriate follow up. In addition, the GP should be better placed to provide psychological and practical support to both patient and caregiver. The result of this type of process could be reassurance delivered at reduced costs in transport and time.

Table 2. Cancer Australia and general practice[10]

Cancer Australia is developing a number of specific initiatives to better engage and support GPs in the delivery of cancer care, including:

- the CanNET program
- continuing professional development modules
- development of information and resources including web based cancer treatment protocols to support GPs in caring for patients during and after cancer treatment
- Diploma of Clinical Oncology for medical practitioners

CanNET is a national program that aims to improve the delivery of cancer services through a number of demonstration projects. It incorporates key interventions shown to improve cancer care and outcomes for people with cancer including:

- commitment to consumer involvement in all aspects of service planning and delivery
- supporting GPs in prompt diagnosis and early referral to a multidisciplinary team
- multidisciplinary care
- a systematised approach to quality improvement
- evidence based protocols

Each state and territory has a funded program aimed at improving cancer care delivery in the local context

Transition to survivorship or palliative care

Cancer death rates in Australia were 12% lower in 2003 than in 1993.[12] Survivorship is gaining considerable attention now that the ability to cure cancer has improved markedly. The impact of cancer may persist during prolonged survival. Themes reported by cancer survivors include: the struggle between independence and dependence, balance, a sense of wholeness, life purpose, reclaiming life, dealing with multiple losses, having control, the altered meaning of health, and surviving cancer from a family perspective.[9,13] Moreover, there are long term complications from chemotherapy, radiotherapy and surgery, and new problems are coming to light (*Table 3*).[14] Long term follow up and awareness of the issues can be achieved by the GP. Transfer of care from the oncology team to the GP can be a fraught process for patients who have learnt to rely on the oncology team, and work to smooth this transition needs to occur.

Should a recurrence herald progression to death, the GP also has a major role to play in the care of the patient.[15] Care of a person with a life limiting disease is complex, but entails all the elements of general practice: competence in assessment and symptom control, awareness of the whole person, awareness of the needs of the family, and the context in which the person lives their life.[16,17] Hopefully, there has been an ongoing link between the patient and the GP during the treatment and surveillance phases. The GP can play an important role in referral to palliative care services and in ongoing shared care arrangements.

Table 3. Long term and late effects of cancer treatments[14]

Treatment	Long term side effects	Late onset side effects
Chemotherapy	• Fatigue • Menopausal symptoms • Neuropathy • Disrupted memory and thinking • Heart failure • Kidney failure • Infertility • Liver problems	• Cataracts • Infertility • Osteoporosis • Reduced lung capacity (eg. from pulmonary infiltrates) • Second primary cancers
Radiotherapy	• Fatigue • Skin sensitivity	• Cataracts • Cavities and tooth decay • Heart problems • Hypothyroidism • Infertility • Lung problems (eg. pulmonary artery stenosis, gas transfer impairment) • Intestinal problems • Memory problems • Second primary cancers
Surgery	• Scars • Chronic pain	• Lymphoedema

Caregiver care

During this time, the caregiver is an active participant in the patient's cancer journey (*Figure 3*). Caregivers are in a curious position; they are intimately involved in the care, they attend consultations with the patient, and they will often have to guide or even make decisions that a well patient would routinely make. At the same time, the person with cancer is the centre of therapeutic attention; the carer usually taking a back seat. Carers have physical, social and emotional needs that should be recognised. General practitioners are well placed to care for the caregiver. It is important to allow the caregiver consultation time in their own right. How the GP can better contribute to caregiver care is the subject of current research.

GP cancer management in the future

Cancer Australia, through the CanNET program and other initiatives, is supporting developments in the interface between specialists and general practice. There will be a surge in activity in this area in the near future (*Table 2*).[10]

Closer cooperation between primary care and specialist care relies on the definition and enactment of roles for each, underpinned by information sharing. This should be achievable with current web based technology.

Models exist where there is a close working relationship between GPs and patients in cancer care. One of the best examples is the UPCON program in Winnipeg, Canada.[18] Here the availability of a shared electronic record has led to the development of a network of cancer care oriented general practices. Lead physicians in these practices were provided with supported continuing medical education for 3 years, and actively engage with the city's cancer services. The result is close cooperation between cancer services and the primary care team.

Finally, the government chronic disease management strategy gives general practice an opportunity to arrange itself to deliver more complex care. Cancer care can easily fit into that paradigm.

Summary

Cancer impacts profoundly on patients and their caregivers. The cancer journey has evolved to a specialist domain, but there is increasing realisation that multidisciplinary care involving GPs is important. The role for the GP in cancer care will expand in the years to come.

Conflict of interest: none declared.

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