

GENERAL PRACTITIONER-BASED MODELS OF POST-TREATMENT FOLLOW-UP

Meagan Brennan^{1,2} and Michael Jefford^{3,4}

1. The Patricia Ritchie Centre for Cancer Care and Research, The Mater Hospital, North Sydney, NSW.

2. Northern Clinical School, University of Sydney, NSW.

3. Division of Haematology and Medical Oncology, Peter MacCallum Cancer Centre, Melbourne, Victoria.

4. Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, Victoria.

Email: m.brennan@usyd.edu.au

Abstract

In Australia, most survivorship care is currently provided by specialist oncologists. However, the increasing numbers of cancer survivors, together with workforce issues in oncology, make the development of alternative models of care essential. Following completion of cancer treatments many survivors have significant unmet needs. As providers of comprehensive, long-term care with an intimate knowledge of the patient's health and social context, general practitioners are ideally placed to provide survivorship care. Several models involving general practitioner care have been evaluated and other potential models are yet to be fully developed and assessed. These include exclusive general practitioner care following discharge from specialist care, general practitioner led interventions and shared care programs, generally supported by the use of survivorship care plans. These will be explored and benefits and potential challenges will be discussed.

In Australia, survivorship care following cancer treatment is largely specialist based. As in the US, increasing numbers of long-term survivors combined with workforce issues, make sustainability of this model of care a challenge.¹ Additionally, specialist based follow-up is not cost-effective. As providers of comprehensive continuous care in the primary health care setting, GPs are ideally placed to incorporate survivorship issues into long-term care.^{2,3,4} GPs can be integrated into oncology treatment teams to provide survivorship care in a variety of models, including exclusively providing follow-up care after discharge from specialist care, specialist and GP 'shared care' models and the development of special interest GPs with additional training in oncology and survivorship issues.

Aims of survivorship care

The concept of survivorship care continues to evolve and the definition and aims of survivorship care are the subject of considerable debate. In 2006, the Institute of Medicine (IOM) in the US released a landmark report titled '*From cancer patient to cancer survivor – lost in transition*'.⁵ This report described survivorship as a distinct phase of the cancer journey. It provided recommendations for long-term care after treatment for cancer with the aim of encouraging a comprehensive, coordinated approach to care that meets the many long-term needs of survivors. The four essential elements of survivorship care are prevention, surveillance, intervention and coordination.⁵

GP involvement in survivorship care

A recent US study comparing the expectations of patients, oncologists and primary care physicians regarding survivorship care reported discordant views between

patients and doctors regarding the oncologist's role in long-term care.⁶ Primary care physicians expected a high level of involvement in follow-up care and patients anticipated more involvement from the oncologist. Primary care physicians also expected to take on a high level of responsibility in domains of survivorship care such as cancer surveillance, cancer screening and preventive health care, whereas oncologists believed these areas were their responsibility.⁶ A recently reported Canadian study found that GPs were very willing to assume exclusive responsibility for the follow-up of survivors.⁷ Nissen and colleagues reported that many GPs lacked necessary information to enable them to feel confident regarding survivorship care.⁸ Our own work indicates that oncologists and nurses generally believe that GPs can and should have a major role in post-treatment follow-up.⁹ GPs were keen to participate in survivorship care. Together, these findings suggest there is general support for GP involvement in survivorship care, providing GPs receive the necessary information and training. However, there is some confusion about who might be responsible for various aspects of care. Patients also need to feel confident that their GP can provide complete survivorship care.

Trials of GP follow-up care

Models of follow-up care involving the GP have been most comprehensively assessed in breast cancer. In 1995, Grunfeld et al reported a trial conducted in the United Kingdom involving 296 women who were randomised to receive follow-up with their general practitioner or through a district hospital clinic, according to a set protocol.^{10,11} One hundred and fifteen general practitioners were involved in the study. During the 18 months of the study, 26 (8.8%) women presented with a recurrence of breast cancer,

with no statistically significant difference in recurrence rates between groups. Quality of life, including anxiety, was also assessed and showed no difference between the two groups.^{10,11} A subsequent economic analysis favoured the GP group.¹² Costs to patients and to the health service were lower in the GP group.¹² A subsequent randomised trial (involving 968 patients) was conducted by the same investigators in the Canadian health setting.¹³ Similar results were seen, with no significant difference in recurrence related serious events or health related quality of life.¹³ General practitioner protocol based follow-up care, therefore, appears to represent a safe, reasonable alternative to hospital clinic care for women with early breast cancer.

GP follow-up has also been evaluated for people with colon cancer. In an Australian trial, 203 patients were randomised to follow-up by their surgeon or general practitioner.¹⁴ There were similar rates of recurrence, time to detection of recurrence and death rates between the groups. GPs tended to order more faecal occult blood tests than surgeons, whereas surgeons ordered more colonoscopies and ultrasounds. The study concluded that while patterns of investigation were different, there was no significant difference in outcomes, including quality of life.¹⁴

Shared care models

'Shared care' in the setting of cancer survivorship usually refers to a specialist oncologist sharing follow-up care with the patient's usual GP.¹⁵ It has also been used to describe models of sharing care between an oncologist and a cancer nurse. Several models of shared care between oncologists and GPs have been proposed, most frequently consisting of a program of visits alternating between the two practitioners over a number of years.¹⁵ This style of care is often used for sharing care between specialists from different disciplines, for example sharing of follow-up between a surgeon, medical oncologist and radiation oncologist for women with early stage breast cancer.

In a three-year pilot study of 133 patients in the Netherlands, adult survivors of childhood cancer were followed in a shared care program between a family physician at the cancer centre and their own GP. High levels of patient and GP satisfaction were reported, and there was adequate monitoring for late effects.¹⁶

In Australia, Jefford et al conducted a randomised trial of an intervention in which tailored information about an individual patient's prescribed chemotherapy regimen was faxed to the GP.¹⁷ There was a statistically significant improvement in confidence and satisfaction with both information received and with perceptions of shared care for GPs who received this information, compared to those receiving standard correspondence.¹⁷ This simple strategy of providing GPs with timely, tailored information and advice may be a useful strategy in post-treatment follow-up.

Holtedahl et al in Norway conducted a randomised trial of a counselling intervention by GPs shortly after the end of cancer treatment.¹⁸ Relatives' satisfaction with

care increased over six months in the intervention group, however there were no other significant differences between the intervention and control groups regarding quality of life or satisfaction with care. This nevertheless remains a potential strategy for survivors.

Survivorship care plans

Survivorship care plans are formal, written documents that provide details of a person's cancer diagnosis and treatment, potential late and long-term effects arising from the cancer and its treatment, recommended follow-up, and strategies to remain well.^{5,19} The IOM report has strongly supported the routine use of care plans.⁵ Use of care plans may facilitate shared care with GPs or exclusive care by GPs. Australian surveys in bowel and breast cancer show support by consumers and health professionals for the development and use of survivorship care plans.^{9,20} There are no published trials specifically assessing the impact of survivorship care plans, however trials are underway in Australia and elsewhere.

Potential benefits of GP involvement in survivorship care

As primary care providers, GPs develop long-term relationships with their patients and have an intimate knowledge of the context of a cancer diagnosis in the patient's life and overall health. The GP is well placed to integrate cancer related health care into the long-term care already being offered.² Cancer survivors frequently report unmet needs regarding psychosocial care.^{21,22} GPs are trained to recognise and respond to psychosocial concerns and may have more time to deal with concerns. GPs also have a greater focus on health promotion and health surveillance.

The GP is often the first point of contact for healthcare and advice, even for patients also under the care of specialists. In the Grunfeld UK study, when breast cancer recurrence developed during the study period, 72% of recurrences presented with symptoms between routine visits. All of the women with recurrences in the GP group presented to the GP with their symptoms and 58% in the hospital clinic group presented to the GP with symptoms.¹¹ All specialist oncology care is essentially 'shared care', even if it is not specifically designed to be. This relationship can be used to enhance patient care. Strategies to improve communication, teamwork and confidence between medical practitioners (for example using survivorship care plans, developing formal shared care programs and faxing chemotherapy information) should be developed.

Accessibility of GPs is another potential advantage of follow-up in primary care. GP follow-up may be far more convenient for patients in rural and remote areas. Cost may also be an advantage.

Potential challenges and barriers for GP involvement in survivorship care

Possibly the greatest challenge for developing models that include GPs in survivorship care is the diversity of cancer, clinicians, patients and health services. This means

that a model that may suit one cancer type, one health system, one geographical area, one group of patients and particular clinical teams, may be less suitable in another setting. Models of care need to be relevant and applicable to local circumstances. A range of models of follow-up will need to be developed.

General practitioner care may not be preferred or be appropriate for some patients. Some people may not have a good relationship with their GP or have confidence in the GP's ability to provide oncology-related care. Likewise, some GPs may feel they do not have the skills, time or interest to provide such care. In the Grunfeld UK trial, 33% of women declined to participate. Of the two GPs who declined participation, lack of resources and time for the required paperwork were the reasons cited. During the trial, 3% of patients in the GP group and 3% in the hospital clinic group requested change to the other group.¹⁰ In the equivalent trial in Canada, there was only 55% uptake of study by patients and 83% of GPs agreed to participate.¹³ While there may be specific reasons for not wanting to participate in the study separate to the issue of who provides the care, it is likely that a proportion of patients preferred to remain under the care of the cancer centre than be followed up by their GP.

In Australia, the preferences of bowel and breast cancer survivors and health care professionals regarding follow-up care have been evaluated. Baravelli et al found patient support for shared care programs using GPs and nurses in bowel cancer follow-up, but a desire to remain under the care of a specialist for at least some visits.⁹ Brennan et al also found support for the concept of GP and nurse care, shared with specialist oncologists in the breast cancer setting. However, there was some concern by patients that GPs might not be able to provide the high level of specialised care that women felt they required (unpublished data).

If the GP is to become more involved in survivorship care, education of patients and GPs and provision of information and advice to GPs is essential. Direct, efficient referral pathways must also be established so GPs can refer as necessary.

Shared care programs have the added challenge of ensuring that communication between the clinicians caring for the patients is smooth and that it is clear to the patient and clinicians who has responsibility for the various aspects of care, so that care does not become fragmented and poorly coordinated. There are a number of ways that this can be optimised, such as the use of written follow-up protocols, prompt correspondence between clinicians, use of patient-held records and survivorship care plans.⁵

Another alternative - 'GP specialists'

An alternative to GP or hospital specialist follow-up of breast cancer survivors in Australasia is follow-up with a breast physician. These practitioners, most with a background in general practice, undertake specialised training in breast medicine, particularly in the diagnostic phase of care. Traditionally based in private diagnostic breast clinics and BreastScreen services, breast physicians are becoming more involved in breast cancer treatment

and follow-up care.²³ Breast physicians bring a specialist level of knowledge to survivorship care with many of the benefits of a GP approach, including experience in the management of menopausal symptoms, bone health and general health issues. In a survey of health professionals, breast physicians expressed a high level of interest in being more involved in follow-up care.²⁰

The breast physician model could be used to develop other GP oncology related special interest areas. Prostate cancer, colorectal cancer and childhood cancers are all examples where specialised GPs can offer invaluable support to patients and oncologists. This is already evolving in some clinical settings.

Conclusion

As providers of health care throughout a person's life, GPs are already involved in follow-up care after cancer. There are several ways in which their role may be formalised. This includes discharging patients from specialist to GP care after treatment (with or without a period of specialist observation), shared care programs involving GPs and the development of specialised GPs, such as breast physicians. While some of these models have been assessed internationally, there is a need for more research into models of care that include GPs in Australia's unique health care system.

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