

The role of family physicians in cancer care: perspectives of primary and specialty care providers

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ABSTRACT

Background Currently, the specific role of family physicians (FPs) in the care of people with cancer is not well defined. Our goal was to explore physician perspectives and contextual factors related to the coordination of cancer care and the role of FPs.

Methods Using a constructivist grounded theory approach, we conducted telephone interviews with 58 primary and cancer specialist health care providers from across Canada.

Results The participants—21 FPs, 15 surgeons, 12 medical oncologists, 6 radiation oncologists, and 4 general practitioners in oncology—were asked to describe both the role that FPs currently play and the role that, in their opinion, FPs should play in the future care of cancer patients across the cancer continuum. Participants identified 3 key roles: coordinating cancer care, managing comorbidities, and providing psychosocial care to patients and their families. However, FPs and specialists discussed many challenges that prevent FPs from fully performing those roles:

- The FPs described communication problems resulting from not being kept “in the loop” because they weren’t copied on patient reports and also the lack of clearly defined roles for all the various health care providers involved in providing care to cancer patients.
- The specialists expressed concerns about a lack of patient access to FP care, leaving specialists to fill the care gaps.

The FPs and specialists both recommended additional training and education for FPs in survivorship care, cancer screening, genetic testing, and new cancer treatments.

Conclusions Better communication, more collaboration, and further education are needed to enhance the role of FPs in the care of cancer patients.

Key Words Family physicians, cancer specialists, communication, qualitative studies

Curr Oncol. 2017 Apr;24(2):75-80

www.current-oncology.com

INTRODUCTION

In Canada, an estimated 196,900 people received a new diagnosis of cancer in 2015, with colorectal cancer accounting for 13% of diagnoses for both men and women, and breast cancer accounting for 26% of all new cancers diagnosed in women¹. Because of improvements in early detection and treatment, increasing numbers of people are now living with and beyond cancer². Care for that growing number

of cancer patients is often shared between primary and secondary care providers. Cancer specialists are primarily responsible for the active treatment and management of cancer patients after diagnosis; however, the specific role of family physicians (FPs) is still not well defined and is constantly evolving²⁻⁵.

With limited and diminishing health care resources to address the growing need for cancer care, understanding the role of FPs throughout the cancer care continuum

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becomes increasingly more important³. Lack of clarity concerning the role for FPs in cancer care is often a result of large variations in regional health care delivery, of geographic area, of FP relationships with patients and specialty care providers, and of the personal preferences of health care providers (HCPS) and patients^{2,4,5}.

Family physicians are well-positioned to provide comprehensive care to cancer patients because of their accessibility in the community and their relationships with patients, particularly their knowledge of the personal history, social circumstances, and comorbidities of those patients^{2,6,7}. Because many cancer patients are elderly, health care for comorbidities and follow-up cancer care become closely intertwined for this population. In addition, colorectal and breast cancer are not rare, and so many FPs will have several patients in their practice who have been or are being treated for those diseases⁸. Furthermore, studies have shown that FPs are capable of providing quality cancer care, particularly during the diagnosis, follow-up, and palliative care phases^{9,10}. Two multicentre randomized controlled trials of breast cancer patients found that follow-up care provided by the patient's FP was a safe and acceptable alternative to specialist follow-up care^{9,11}. However, studies show that a number of barriers limit the role that FPs are able to play in cancer care—for example, communication problems, lack of role clarity between health care providers, lack of adequate training, and system issues^{4,12,13}.

The Canadian Team to Improve Community-Based Cancer Care Along the Continuum (CANIMPACT) is a pan-Canadian team of researchers, health professionals, and knowledge users committed to improving the care for cancer patients. The present work is based on data from the qualitative component of CANIMPACT's mixed-methods program of research focusing on the role of FPs in cancer care. To improve coordination and continuity of care for cancer patients, the first step is to better understand the ways that both FPs and cancer specialists view the role of FPs and the factors that influence the ability of FPs to carry out that role in cancer care.

METHODS

Using a constructivist grounded theory approach, we conducted semi-structured telephone interviews with 58 HCPS. Grounded theory is a qualitative methodology focusing on the generation of a theory or framework grounded in the data collected¹⁴. A constructivist grounded theory approach encourages researchers to be actively involved in the data collection process as they interact with participants by asking questions and inviting clarifications or elaborations about various aspects of the phenomenon under study¹⁵.

Before participant recruitment and data collection, ethics approval was obtained from all relevant research ethics boards. Using a purposive sampling technique, we sent letters of invitation to a random selection of FPs and cancer specialists across Canada, having already obtained postal contact information from online directories of provincial medical regulatory authorities. To ensure a diverse sample of participants and experiences, we then theoretically sampled to help refine emerging categories

and mailed invitation letters to HCPS selected according to medical specialty, sex, province, and geographic location type (urban or rural). A reply card was included with the invitation letter, and interested physicians could contact the research coordinator by fax, e-mail, or toll-free telephone number to schedule an interview. All information was sent in both French and English, and potential participants were given the option to select their preferred language for the interview.

Oral consent was obtained from all participants before their interview commenced. During the interviews, participants were asked about the roles currently played by FPs and the roles that participants believed FPs should play in the future care of cancer patients across the cancer continuum. All interviews were digitally recorded, transcribed verbatim, and then checked for accuracy. During a 2-day meeting, three co-investigators (BM, MAO, JC) and the research coordinator (JE) independently read the same set of 3 transcripts and developed a coding scheme. To ensure consistency, the remaining transcripts were then coded line-by-line by the research coordinator (JE) who used the constant comparison method, and coding was refined during continued discussions between the team members. Recruitment was terminated when saturation of themes occurred. The coding process was facilitated by the NVivo 10 qualitative data analysis software application (QSR International, Doncaster, Australia). At the completion of data analysis, participants received a summary of study findings and were invited to review and comment as a form of member checking.

FINDINGS

Table 1 presents the characteristics of the 58 HCPS—21 FPs, 15 surgeons, 12 medical oncologists, 6 radiation oncologists, and 4 general practitioners in oncology—who participated in a telephone interview.

When participants were asked about the role that FPs *should* play in providing care for cancer patients, FPs and cancer specialists both said that the key roles for FPs should be to coordinate cancer care, manage comorbidities, and provide information and psychosocial support to patients and their families. Even though participants weren't specifically asked to choose a word to describe the main role of FPs in cancer care, many summarized the ideal role using one or two key descriptors. The word cloud in Figure 1 is a visual depiction of the words that many HCPS chose to describe the ideal role of FPs in cancer care (larger words represent a higher number of uses of that word in the interview transcripts). The word most frequently used to describe the ideal role of FPs was "quarterback," referencing the key position in North American football occupied by a player who acts as the team leader and calls the plays for the game. Other words such as "linchpin," "conductor," "manager," "coordinator," and "hub" also speak to a similar perception of the FP being the key person in helping to manage and coordinate cancer care for the patient.

However, despite those common themes about the role that FPs *should* play in the provision of cancer care, the *actual* role of FPs as discussed in the interviews did not always match that ideal. The participation of FPs in

TABLE 1 Profile of the study participants

Variable	Value [n (%)]
All participants	58
Practice type	
Family physician	21 (36)
Surgeon (general, surgical oncologist)	15 (26)
Medical oncologist	12 (21)
Radiation oncologist	6 (10)
General practitioner in oncology	4 (7)
Location type	
Urban	45 (78)
Rural	13 (22)
Sex	
Women	30 (52)
Men	28 (48)
Geographic area	
Western Canada ^a	16 (28)
Central Canada ^b	13 (22)
Eastern Canada ^c	23 (40)
Territories ^d	6 (10)

^a British Columbia, Alberta, Saskatchewan, Manitoba.
^b Ontario, Quebec.
^c New Brunswick, Prince Edward Island, Nova Scotia, Newfoundland and Labrador.
^d Northwest Territories, Nunavut, Yukon Territory.

the provision of cancer care to the patient throughout the cancer continuum varied greatly based on a multitude of personal and system factors. In some cases, FPs were involved only in the pre-diagnostic and diagnostic phases of the continuum; in other cases, FPs were actively involved in providing care to the cancer patient from diagnosis straight through to end-of-life care. The FPs and cancer specialists both described some of the challenges that often prevent or inhibit those roles for FPs from becoming standard practice in cancer care.

Challenges Inhibiting FP Involvement in Cancer Care—FP Perspective

One of the challenges most commonly cited by FPs as inhibiting their involvement in cancer care was poor communication with cancer specialists—and particularly not being copied on all medical reports for their patients. Many FPs said that they were often not “kept in the loop” about their patients once those patients had entered the cancer system. As a result, it was challenging for them to follow the patient. As one FP put it,

I feel like I’m the quarterback for my patients, but that’s not really accurate, you know, because sometimes I’m not even in the game.
 — Interview 39

Many FPs described a feeling of often being bypassed once patients had entered the cancer system. Those participants used phrases such as “swallowed up by the cancer system,” “the black hole of the cancer clinic,” and “lost my



FIGURE 1 Word cloud for the ideal role of family physicians in cancer care, as expressed in participant interviews.

patient to cancer services” when describing entry of their patients into the cancer system in their area. As one FP said,

When the patient is on treatment, they are completely lost into the cancer system, and then they kind of come out at the end having had a whole adventure, and the family doctor doesn’t know anything about it.
 — Interview 44

Another FP described how that feeling of not being included and informed about the care of their patients in the cancer system had an effect when the patient did finally return for FP care:

Patients kind of disappear from me [during cancer treatment] and come back only when they need me. And it’s sometimes at a time that you don’t know what to do because you’ve not been involved the whole time.
 — Interview 7

Also related to communication challenges was the lack of clearly defined and broadly communicated roles of the various physicians involved in the care of cancer patients, particularly during follow-up. For example, many surgeons said that they would see patients for follow-up after a cancer surgery, but that it was often unclear whether they should be providing other follow-up care (that is, medical tests or exams) for those patients, or whether such care would be covered by the oncologist or FP. Often that lack of clarity about roles led to confusion and duplication of tests and care. As one FP summarized the situation:

Communication, that’s what it comes down to. If everyone knows what’s going on, there shouldn’t be a problem.
 — Interview 31

Another challenge described by FPs was a lack of knowledge and opportunities to learn more about caring for cancer patients, particularly in relation to cancer screening, genetic testing, new cancer treatments, and cancer survivorship issues. A need and desire for more education and information was expressed. As one FP indicated,

We need some more educational materials, depending on, you know, adjuvant endocrine therapy, what the surveillance guidelines are, how long they continue for. Lymphedema ... [we need to know] how to diagnose them and who to refer to.... We need to know some sort of resources, not only at the cancer centre, but in the community for some of these other things.

— Interview 55

Challenges Inhibiting FP Involvement in Cancer Care—Specialist Perspective

Although most physicians agreed that FPs have the potential to play a very important role in coordinating and managing the care of cancer patients, many specialists indicated that they often end up having to play that role and be the “quarterback” because of several personal and system issues. On a personal level, trust was often mentioned, both in terms of the specialist’s trust in the FP to provide adequate cancer follow-up care and concern about the patient’s trust in the FP, especially after a delayed diagnosis. As one surgeon put it,

Some people like their family doctors. A lot of them up through here don’t even know who their family doctor is because they’ve never seen them ... or there are some of them that absolutely don’t like the family doctor at all.... It’s usually the people that either don’t like their family doctor or don’t trust their family doctor, that come back to follow-up with me.

— Interview 58

Also on a personal level, a few specialists described how their cancer patients often sought care from them for comorbid conditions other than cancer (for example, diabetes) because they experienced appointment fatigue and preferred to only see one physician for all health concerns, including their follow-up.

On a system level, many specialists echoed the concerns of FPs in the present study about the lack of communication and the need for clearly defined roles:

I do feel ... kind of lost about who exactly is following up with the patient.... I feel sometimes there is duplication of care. You know, for patients post-care, they are very compliant with coming back ... but I’m not sure I’m doing much more for them than with the oncologist. So maybe they’re seeing me unnecessarily or seeing the oncologist unnecessarily.

— Interview 52

In some cases, specialists even recognized their own role contributing to the communication breakdown, particularly in terms of keeping FPs in the loop and copying them on every report. Although attempts were usually made to keep the FPs informed, many specialists said that they could do a lot better to ensure that communication becomes a standard practice and a priority so that the FP is involved throughout the care of their patients.

The shortage of FPs was another system-level issue that played a role in determining who provided care. Several specialists, particularly surgeons, discussed how they often have to take on general care for cancer patients who don’t have a FP or who have difficulty accessing their FP. As one general surgeon said,

We are short on family doctors.... A lot of people don’t even have family doctors, [and] so when their family doctor leaves, there is no one to—they can go on 2 years without a family doctor, [and] so I’m left dealing. It’s not only some of their oncology problems, but also their medical problems, which is not ideal.

— Interview 17

DISCUSSION

The role of the FP in caring for a patient with cancer is important in Canada; however, there seems to be a discrepancy between the role that FPs feel they *should* play and their current day-to-day reality. Family physicians must deal with patient-based, system, and professional barriers to executing the preferred activities that would best serve their cancer patients. Those barriers also make it challenging for FPs to assume the desired role as “quarterback.” Some patients want to remain under the care of the specialist for various reasons, such as appointment fatigue and personal attachment to the specialist throughout treatment. The latter finding is consistent with patient-expressed preferences previously reported in the literature^{5,16}. However, many patients are content to have their FP more involved in cancer follow-up care^{9,17}.

One major issue hindering the desired role of the FP as expressed by our study participants is both a system and a professional barrier: the lack of clear communication lines and methods between specialists and FPs, which is also a recurring theme in the literature^{13,18,19}. Improving communication might seem to be the obvious solution; however, prior research indicates that the task is not a simple one^{20,21}. Further complicating the issue is the lack of trust between FPs and specialists (mostly specialists toward FPs in providing follow-up cancer care), which can have a negative impact on effective communication. Prior research has demonstrated that FPs are skilled clinicians and capable of providing competent cancer follow-up care to their patients^{4,9,11}; however, as Mitchell and colleagues⁴ say,

While it may appear that [FPs] lack competency and training for cancer care, sound generic clinical skills augmented by information about the special requirements of cancer care may be all that is needed to make [FP]-based cancer care feasible and practical. Access to shared records is a system problem, not a competency problem that requires a system-based solution.

Based on the results of the present qualitative research, we recommend that specialists and FPs make an effort to enhance mutual communication at a local level.

Another study looking at FPs providing cancer survivorship care also identified the need for improved communication with specialists and emphasized the importance of good rapport between colleagues²². Face-to-face relationships between specialists and FPs should not be underestimated as a powerful tool to enhance patient care. If such relationships do not exist, they can be created if deemed important to improving patient care. For example, joint education sessions might be a first step to enhance knowledge for FPs about new cancer treatment protocols and could potentially enhance personal relationships between specialists and FPs by breaking down silos and simply allowing them to get to know one another. Alternatively, electronic solutions that allow for direct asynchronous communication between HCPs might be a more practical alternative to face-to-face meetings²³.

LIMITATIONS

As is common in qualitative research, the results reported here might not be generalizable to all physicians in every clinical situation, but could be transferred to physician populations in circumstances similar to those of our participants.

CONCLUSIONS

Better communication, more collaboration, and further education are needed to enhance the role of FPs in the care of cancer patients throughout the continuum of cancer care. Specialists and FPs can create educational opportunities at a local level and, in the process, might also enhance communication and collaboration.

ACKNOWLEDGMENTS

This study was supported by the Canadian Institutes of Health Research (grant 128272).

CONFLICT OF INTEREST DISCLOSURES

We have read and understood *Current Oncology's* policy on disclosing conflicts of interest, and we declare that we have none.

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