Australian Cancer Council Essay Competition

Cancer in General Practice – Accompanying Patients Along the Journey

By

Amanda Tillmann (UNSW III)
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Cancer in General Practice – Accompanying Patients Along the Journey

Introduction

In the context of Australia’s increasing cancer survivorship rates and ageing population it is inevitable that cancer will make its mark on the careers of general practitioners. This is confirmed in reports stating that average general practitioners will annually encounter around four new patients with diagnoses of potentially fatal cancers and that they have roughly sixteen patients diagnosed with cancer under their care at any point in time (Cancer Council Victoria, 2012). General practitioners’ multidimensional involvement in their patients’ health combined with the trusting and long-standing relationships they often share with patients places them in a unique position to make significant contributions to patients’ wellbeing throughout the cancer care journey.

This essay will delve into the wide and varied contributions made by general practitioners throughout the spectrum of their patients’ cancer experiences including their roles in cancer prevention, screening, diagnosis, treatment, survivorship and palliative care. The challenges currently facing the general practitioner community will also be explored as well as the possible future initiatives to ameliorate such obstacles. The essay will ultimately conclude with a consideration of the ways the skills learnt in medical education translate into future general practice and prepare students to deliver appropriate and quality care.

Role of the General Practitioner at Different Stages of Cancer Management

Prevention

The alarming statistics that one in three Australian cancer cases are preventable and that more than 13,000 cancer deaths could be avoided annually if lifestyle factors such as smoking, diet, alcohol intake, physical activity, weight and sun exposure were properly managed give an indication of the potential of preventative initiatives in reducing the burden of cancer (Cancer Council Australia, 2012). Cancer prevention and lifestyle factor modification have traditionally been associated with general practice and comprise a major part of primary practice’s involvement in cancer care. On average Australians visit a general practitioner five times annually often with the expectation of
being informed about and receiving assistance with preventative health problems. This context places primary care practitioners in an ideal position to act as agents promoting healthy lifestyle alterations and easily allows them to monitor and assess these changes (Harris, 2008).

The government’s Lifescripts initiative involves a variety of evidence-based brief-interventional means by which general practitioners can discuss, advise and educate patients about lifestyle factors overall aiding in cancer and other chronic disease prevention (Australian Government, 2011). Key components of this program and complementing practices recommended by the Royal Australian College of General Practitioners (RACGP) include utilisation of the 5As assessment and management framework; behavioural counselling approaches incorporating motivational interviewing; and regular physical and history health checks (RACGP, 2012) (Australian Government, 2010). The latter for example has been shown in Australian studies to improve patients’ willingness to implement diet and exercise changes resulting in a consequent increase in fruit and vegetable consumption and exercise participation (Harris, 2008). Another essential element of lifestyle modification mediated cancer prevention in general practice is the use of referrals to counselling, follow-up and supportive services such as Quitline for smoking. The action of such referrals has been shown in Cochrane reviews to double the efficacy of advice offered in primary care (Australian Government, 2010).

**Screening, Detection and Referral**

Cancer screening, detection and referral represent other aspects of the cancer management spectrum in which general practice has a long-established role. Screening of breast, colorectal and cervical cancers forms a vital part of general practice and is believed to significantly contribute to better outcomes in the screened cancers, for example Australia’s having the lowest mortality rate of cervical cancer globally (RACGP, 2012).

General practitioners hold a ‘gatekeeper’ position referring to their role of mediating the transition of suspected malignancy cases from primary to secondary care through referral to appropriate specialists. Ensuring this is done efficiently and not unnecessarily requires general practitioners to engage in thorough history-taking, examination and diagnostic work-ups in a timely fashion (Olesen, 2009). British audits have revealed that general practitioners refer more than 75% of patients who receive a confirmed diagnosis of cancer from secondary specialists after only one or two consultations, an indicator of the important role played by general practitioners in initial assessment (Mayor, 2013).
Care During Active Disease

As cancer management shifts from a more segregated approach with clearly defined borders between primary and secondary health to a multidisciplinary model increasingly characterised by integration and collaboration, the general practitioner’s role in the care of patients undergoing treatment is becoming more prominent (Weller & Harris, 2008). The degree of involvement is highly dependent on the treatment modality as well as accessibility of specialist care. An example of general practitioners participation in the treatment stage is their involvement in chemotherapy which can take a variety of forms including pre-treatment haematological and biochemistry checks, managing of side effects and administration of treatment (Mitchell, 2008). Psychological support is also another crucial responsibility often held by general practitioners during treatment when patients’ health-related quality of life can suffer (Roorda, et al., 2012).

Survivorship and Palliative Care

As curative cancer treatments improve cancer-related mortality descends, having great implications for general practitioners by placing demand on their survivorship care services (Mitchell, 2008). The general practitioner’s holistic, multidimensional and personalised approach to health is of utmost importance at this stage of the cancer care journey which involves balancing a variety of tasks such as monitoring for signs of recurrence; treating side effects from treatment; health promotion; assistance with organising additional support services or involvement in support groups; addressing psychosocial effects; and care of family or caregivers related to the patient (Mao, et al., 2009). In cases where a palliative management strategy is indicated general practitioners can contribute to care through symptom control, carer bereavement support and care coordination overall creating a sensitive and considerate environment for the end of life (Mitchell, et al., 2004).

Challenges and Future Directions of Cancer Management in General Practice

Diagnostic Issues

Delayed diagnosis represents a great hurdle to optimal cancer management in general practice. A British audit study involving more than 13,000 diagnosed cancer patients revealed that whilst early diagnosis and referral occurred in the majority of cases, roughly 20% of patients were not referred until three or more consultations had taken place and between thirty-four and ninety-seven days had elapsed since their initial presentation. These deferred diagnoses often occurred in cases with non-specific symptoms associated with multiple myeloma, lung and stomach cancers (Lyratzopoulos, et
al., 2013). Cancer symptoms presenting in patients with atypical age and gender as well as lack of relevant risk factors are other elements that can confound general practitioners and hinder early diagnosis (Mitchell, 2008).

This tardiness of diagnosis is especially significant in determining the outcome of cancers such as lung cancer in which early detection and treatment can significantly increase life expectancy (Mayo Clinic, 2013). Recent projections assert that between 5,000 and 10,000 deaths within five years of diagnosis could potentially be prevented annually in England if early primary diagnosis and surgical treatment were improved (Rubin, 2011).

Strategies by which a more timely diagnosis can be achieved in future practice include the development and encouraged use of systematic and accessible clinical decision support tools aimed at enhancing efficiency of investigation and referral pathways. Efforts to accomplish this in Australia have involved the Cancer Council General Practice Committee’s development of the *Primary Care Resources Directory*; Cancer Australia’s *Clinical Best Practice* guidance material for general practitioners; and the Cancer Institute of NSW’s development of a flipchart of *Referral Pathways for Suspected Cancer* (Cancer Council Australia, 2013) (Cancer Australia, 2013) (Cancer Institute NSW, 2009). These resources aim to provide standardised information to the primary practice sector on the distinguishing of cancer symptoms and implementing of appropriate investigations hence producing more efficient and informed diagnoses and referral decisions. Ultimately the clinical improvements in general practice potentially produced by such guidelines could better the overall cancer outcome for many patients in the future.

**Communication Issues in Multidisciplinary Care**

The multidisciplinary model that underpins the current desired approach to cancer care management is heavily reliant upon effective communication between stakeholders. Rowlands et al. (2012) have recently illuminated the flaws in the communication relations between secondary care providers and general practitioners when patients are discharged from specialist care including poor timing and exchange of incomplete information. This lack of punctuality and information regarding patient treatment and details is well documented in the literature as interfering with general practitioners’ ability to confidently manage their cancer patients. The study revealed that belated receiving of important patient information placed general practitioners in the awkward position of being unable to answer patients’ queries and having to at times depend upon the unreliable accounts of events relayed by the patients themselves. Communication with general practitioners was shown to be primarily managed by medical officers and hence often had a clinical focus that did not meet
primary care workers’ need for social and allied healthcare information which is required for holistic patient management.

In light of these findings suggestions to mitigate communication barriers included utilisation of shared electronic health records enabling access to health information instantaneously; implementation of standardised multidisciplinary discharge summaries; and encouraged involvement of general practitioners in multidisciplinary team meetings (Rowlands, et al., 2008). The potential exists for these initiatives to substantially strengthen future post-treatment management of cancer patients in general practice as well as the multidisciplinary model of cancer.

Problems with Rural Cancer Care

One third of Australian cancer patients live in regional, rural and remote areas and are typically attributed with poorer outcomes (National Rural Health Alliance, 2012). Reduced access to predominantly urban-based specialist and tertiary hospital services and workforce shortages place rural general practitioners under mounting pressure to manage cancer cases in difficult conditions such as shorter consultations and resource-poor environments relative to their urban colleagues (Beilby & Furler, 2004).

Australian studies have confirmed that higher and more specialised levels of skill are often demanded of rural practitioners during the cancer management of patients. Select examples of this include the ability to engage in a greater amount of procedures including chemotherapy administration; management of emergencies such as neutropenia; and the capacity to distinguish between the urgency of cases for referral through refined skills detecting the nuances of clinical presentations (Hanks, et al., 2008). Many of these activities require special training and safety, management and support strategies which are inaccessible for most rural practitioners hence resulting in less preparedness and confidence during management (McCarthy, et al., 2003).

Initiatives that hope to address these matters and direct future rural general practice cancer care towards a better supported and more multidisciplinary state include programs such as Telehealth; the government’s establishment of specialised regional cancer centres; networking services between rural and urban professionals such as CanNET; and other state strategies (Cancer Institute NSW, 2009). Education represents another component of the plan to improve future rural general practice deliverance of cancer care. Cancer Australia’s Cancer Learning online hub provides rural general practitioner’s with easily accessible educational activities and resources to facilitate the tailoring of their knowledge to the particular demands of rural cancer management (Australian Government, 2012). Workshops and mentoring programs are other means by which rural general
practitioner’s cancer knowledge can be expanded. A prime example of this approach is Country Health SA’s Rural Chemotherapy Mentoring Program which significantly enhances primary practitioners’ understanding of chemotherapy principles following collaborative learning with urban oncology specialists (Hoon et al., 2009).

**Problems with Indigenous Cancer Care**

Cancer represents the second greatest cause of mortality among indigenous Australians despite attracting a disproportionately low amount of attention and often being considered a lower priority aspect of Indigenous health (Cancer Council Australia, 2013) (Saunders, et al., 2002). Within healthcare settings, not excluding general practice, impedance of optimal management of Indigenous cases largely revolves around a lack of cultural understanding and culturally-appropriate techniques which can give rise to problems such as ineffective communication (Australian Indigenous HealthInfoNet, 2009). This cultural competency deficit can perpetuate problems related to poor cancer outcomes such as the prevalence of negative preventative lifestyle factors like smoking, lower screening rates and later diagnosis trends. This highlights the considerable importance of general practitioners being attuned to the Indigenous perspective, seeing as they are often a central component of medical services in Indigenous communities. (Condon, et al., 2006).

One of the most recently launched initiatives aiming to improve future Indigenous cancer prospects through education about cancer from an Indigenous perspective and offering of cultural-sensitivity guidance for medical professionals is the National Indigenous Cancer Network (NICaN). Following in the wake of other health-oriented ‘Close the Gap’ initiatives, NICaN aspires to provide members access to evidence-based informative resources as well as the opportunity to attend Indigenous Cancer Roundtable network meetings and take part in Yarning Place discussion forums (NICaN, 2013). It is expected that through participation in such organisations as well as Indigenous culture training programs offered by bodies like the RACGP general practitioners will gain greater skill in handling Indigenous patients and consequently provide effective cancer care in the future to this patient sub-group.
Importance of University Medical Education in Preparation for Cancer Management in General Practice

The need to begin developing skills during university medical studies that will later serve as solid foundations in general practice cancer management is well recognised. Recommendations in Cancer Council Australia’s (2007) *Ideal Oncology Curriculum* as well as the RACGP’s (2011) oncology syllabus stress the importance of gaining a firm and comprehensive understanding of cancer management and its epidemiological and social context in Australia in order to form a strong base from which finer skills can be built. This broad and varied bedrock of knowledge formed in medical school is particularly important and relevant for future general practitioners whose involvement throughout the cancer journey necessitates a good understanding of the medical science and cultural principles underlying care as well as the ability to effectively communicate and engage in positive teamwork dynamics.

Conclusion

Increasing survivorship rates and ageing population statistics have not only changed the cancer landscape of Australia but have also brought about changes in general practitioners’ involvement with cancer management. Departure from the traditional role that was more limited to prevention, screening, referral and post-treatment care has led to general practitioners having the opportunity to actively see patients through the entire expanse of the cancer journey by engaging in multidisciplinary and multidimensional care.

However, accompanying this general practitioner role revision is the revival of old and creation of new challenges to cancer care delivery such as issues with diagnosis, communication and service to rural and Indigenous communities. Through the implementation of initiatives targeting these problematic areas as well as continued medical school oncology skills education it is hoped that general practice cancer care will be well equipped to assume an important and vital role in meeting the future needs of Australians affected by cancer.
References


