

Cancer care: what role for the general practitioner?

David P Weller and Mark F Harris

General practice is still somewhat adrift in the complex world of cancer services

General practice has not traditionally had a central role in cancer care. Typically, general practitioners have had the task of identifying and referring patients to specialists in a timely manner, but have stayed on the periphery of cancer care until patients reach the palliative stage. But the climate is changing — driven partly by the growing burden of cancer and the need to expand and diversify the workforce. The prevalence of cancer has increased substantially in Western countries,^{1,2} largely due to the ageing of the population: in Australia, by the age of 75 years, the risk of cancer is 1 in 3 in men and 1 in 4 in women.¹

There is now an explicit recognition that GPs should be involved in all stages of the cancer journey, from first presentation to palliative care, and that service reforms must incorporate more significant roles for primary care.³ This has found its way into policy and practice in the United Kingdom and Australia, where service guidance emphasises integration of services and urges all those involved in delivering cancer services to better connect the various stages of the cancer journey and to provide care that is accessible and convenient — all predicated upon significant primary care input.^{4,5}

Management of cancer is complex. It requires specialised skills and knowledge, access to sophisticated diagnostic and treatment facilities, and often long-term management of symptoms and recurrences. Despite this complexity, when cancer patients are asked about how their care could be improved, their requests are often simple: they want to know who is in charge of their overall care, they want ready access to care that is convenient and non-threatening, and they want reassurance that they will have access to specialised services if needed.⁶ A diagnosis of cancer has a profound psychosocial impact, and those who care for cancer patients need to address a range of complex and often rapidly changing needs.

Ideally, cancer care should be provided by teams, supported by a network of services. The concepts of multidisciplinary teams and managed clinical cancer networks have been widely advocated,⁷ but the place of primary care within these teams has remained poorly defined and highly variable.⁸ This variability is demonstrated by urban–rural differences: in Australia, rural GPs tend to play a more active role in treating cancer patients than their urban counterparts.

General practice is still somewhat adrift in the complex world of cancer services. In this issue of the Journal, Jiwa and colleagues (page 78) describe the many challenges faced by general practice in providing cancer care that is truly integrated with other parts of the health care sector.⁹ They emphasise that integrated care is required at *all stages* of the cancer journey. Just as cancer screening should link public health and clinical perspectives, post-diagnosis treatment needs a range of health care providers, including GPs, to be part of the team effort. Effective communication between specialist and primary care services is an essential component of this integration.

There is growing emphasis on the concept of survivorship in cancer patients — rightly so, as cancer has taken on the character-

istics of other chronic illnesses such as diabetes and coronary heart disease. Increasing numbers of patients have very prolonged periods of survival after cancer diagnosis, and die *with* their illness rather than *of* it. Survivorship is a very positive concept, and general practice, with its capacity for multidimensional care, is well placed to play a leading role in improving services for people living with cancer, providing follow-up that addresses patient priorities, and developing more personalised care for cancer survivors.¹⁰ This typically involves “survivorship care plans”, which include a range of tools for health care providers and users. It features heavily in the UK’s Cancer Reform Strategy.⁵ A challenge for primary care is to recognise its unrealised potential for promoting survivorship and to develop new models of care that allow it to do so.¹¹

Primary care must be able to respond to rapidly changing health care needs of cancer patients in an appropriate and flexible manner. If we are to develop and test new models with enhanced roles for primary care, we need to better define and understand current patterns of care. Do GPs and primary care teams provide the kinds of services that cancer patients need? How well do they detect and manage recurrence of disease and toxicity from treatments? Do they provide the kinds of psychosocial support cancer patients need, and do they help or hinder truly integrated care? How well do they address issues of patient choice, and how good are they at providing education and support?

The experiences and needs of cancer patients and their carers vary tremendously. We have perhaps been slow, in general practice, to respond to the needs expressed by our cancer patients. But if we take time to listen to our patients, from the time of diagnosis to death and bereavement, many ideas emerge about how the services we provide could be improved. Cancer patients have a range of illness and social trajectories, their patterns of wellbeing fluctuate, and they often perceive a lack of integration in the services they receive.¹² GPs also need to maximise their contribution to primary prevention of cancer, especially in relation to smoking cessation and lifestyle risk factor management — despite the challenges of time constraints, practice systems and patients’ reluctance to change.^{13–15}

To meet the challenges of the future and to adapt to changing health service environments, general practice must be prepared to evolve.¹⁶ A better understanding of the role of primary care in cancer management is vital if we are to improve outcomes and quality of life in our cancer patients.^{3,17} We need to know how primary care can contribute to new models of care. At present, there is little evidence on which to base service design and innovation. We need to develop new, genuinely integrated models of care that address important priorities for cancer patients, such as the availability of care close to home, timely management of symptoms, early detection of recurrences, and comprehensive psychosocial support. Until we have done so, GPs will remain at the periphery of cancer management, and there will be ongoing confusion over how we can make our most effective contribution.

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