Oncologists and family physicians

Using a standardized letter to improve communication

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ABSTRACT

PROBLEM BEING ADDRESSED Communication between oncologists at a regional cancer centre and family physicians caring for palliative cancer patients in the community was ineffective.

OBJECTIVE OF PROGRAM To improve communication between oncologists and family physicians by routine use of a template for dictated letters concerning follow-up care.

PROGRAM DESCRIPTION A consultation letter template was constructed and tested at a single clinic. The template was designed to guide oncologists dictating letters to family physicians for patients' follow-up visits. Effectiveness of the standardized letter was evaluated with a before-after survey.

CONCLUSION Using the template letter improved communication with respect to the relevance, timeliness, format, and amount of information. As care for patients at the end of life increasingly shifts to the community, ongoing efforts are required to improve communication between cancer centres and primary care physicians.

RÉSUMÉ

PROBLÈME À L'ÉTUDE Défaut de communication entre les oncologues d'un centre régional de cancer et les médecins de famille responsables des soins palliatifs aux patients cancéreux dans la communauté.

OBJECTIF DU PROGRAMME Améliorer la communication entre les oncologues et les médecins de famille par l'utilisation routinière d'un modèle de lettre dictée pour le suivi des patients.

DESCRIPTION DU PROGRAMME Un modèle de rapport de consultation a été élaboré et testé dans un seul centre médical. Il avait pour but d'aider les oncologues à fournir au médecin de famille les renseignements nécessaires au suivi des patients. L'efficacité de cette lettre standard a été évaluée par une enquête avant-après.

CONCLUSION L'utilisation de la lettre standard a amélioré la communication en termes de pertinence, d'à-propos, de format et de quantité d'information. Vu que les soins aux patients en fin de vie sont de plus en plus dispensés au sein même de la communauté, il devient essentiel d'améliorer la communication entre les centres de cancer et le médecin de première ligne.

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In Canada, regional cancer centres typically provide specialty-level multidisciplinary cancer treatment and, when necessary, team-based oncologic follow up. Patients treated at cancer centres are referred back to their primary care physicians in the community where they live for ongoing primary care and cancer follow up. Cancer centre specialty care and family physician primary care complement each other.

In times of transition, the focus of care can shift toward cancer centre care (as with initiation of intensive cancer treatment) or toward primary care (as with a change from active cancer treatment to palliative care). When the shift is toward primary care, a smooth transition is more likely when family physicians receive sufficient information from cancer centres.

The Tom Baker Cancer Centre (TBCC) in Calgary, a large regional centre, serves as the sole tertiary referral centre for approximately 1.5 million residents in southern Alberta. After each patient visit, TBCC oncologists have sent letters to patients' primary care providers in about the same way for the past several decades without evidence that the information contained in these letters was actually useful to these primary care physicians.

We found several instances where family physicians indicated information from TBCC was insufficient for them to assume care of their now terminally ill patients. The literature shows that written communications from oncologists to primary care providers sometimes lack information critical to ongoing care of patients in the community.[1,2] How to improve this physician-to-physician communication is unclear. A standardized format for communication is preferable to a narrative summary.[3] The objective of this program was to improve the quality of dictated consultation letters from TBCC to community family physicians through use of a standardized letter.

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Program

The main components of the program were developing and implementing a standardized letter template for a defined cancer patient population, establishing a way of fast-tracking transcription of the letters, and developing an evaluation process.

A project team, consisting of an oncologist, a community family physician, a palliative care physician, and a palliative home-care nurse, was established to develop the standardized letter template. The template was constructed based on clinical input from members of the project team that reflected their perception of what information physicians would need for community-based palliative care for cancer patients and on published information on the topic.[1-6]

The template was subsequently reviewed by 10 community family physicians who were known to be experienced clinicians and respected as local opinion leaders. They were advised of the nature of the program and were encouraged to help identify the information they would find most useful in a consultation letter from a cancer centre. Minor changes were made to the original template based on their feedback. The final version of the standardized template is shown in **Figure 1**.

To simplify implementation and evaluation, the template was tried in a single clinic. The TBCC Lung Clinic was chosen because many of its patients require palliative care. The oncologists there agreed to use the template for communication about patients who were thought to need palliative care (those who had advanced cancer and no chance of cure).

To ensure timely communication of information to family physicians, template letters were fast-tracked by the transcription service at TBCC. The plan was to mail or fax them from the TBCC within 72 hours of being dictated.

Program evaluation

Evaluation was done with a before-after survey. Before implementation (baseline), surveys were sent to all community family physicians who cared for patients seen at the TBCC Lung Clinic during a 4-month period (December 1, 1998, to March 31, 1999). Family physicians were identified from the charts of these patients. Data were collected during April and May 1999.

The new template was implemented June 1, 1999. After use of the template was well established at TBCC, postimplementation data were collected during April and May 2000. To improve the response rate and complete the project within the time constraints

Figure 1. Template for letters regarding palliative patient care: Guidelines for dictation.

The following headings (1-10) are to be described in point form (ie, kept to one line in length where possible)

1. **Diagnosis:**
2. **Stage:**
3. **Current problem(s):** (eg, presenting symptoms such as hemoptysis)
4. **Treatment objective:** (eg, symptom relief, curative)
5. **Treatment plan:** (eg, palliative radiotherapy, new medication, patient to decide about palliative radiation)
6. **Potential problem(s) anticipated:** (eg, side effects of treatment, problems caused by cancer)
7. **Prognosis:** (eg, extremely poor, life expectancy_____)
8. **Discussion with patient and family:** (describe information discussed)
9. **Follow-up arrangements:** indicate, if possible, if oncologist or family physician will provide primary care. Next TBCC appointment is in __ months.
10. **Home-care involvement:** Home-care referral made or currently receiving home care

Following the above point-form summary will be the body of dictation in narrative format.

If you require further information regarding this patient, please contact Dr_____ at 670-_____.

of our research grant, we changed the methodology so that postimplementation surveys were appended to the consultation letters sent to physicians.

Survey questions asked about family physicians' satisfaction with the relevance, timeliness, consistency, format, and amount of information and overall satisfaction with consultation letters received from TBCC. The survey used a Likert scale with the categories very dissatisfied, dissatisfied, neutral, satisfied, and very satisfied. We did not specifically evaluate whether family physicians had easier access to oncologists because a direct telephone number was shown on each clinic letter. Informal feedback on having the telephone number was positive.

Analysis included descriptive statistics that focused on the proportion of family physicians giving a rating in each of the categories on the Likert scale. Level of significance for the difference between the percentage of physicians who chose "very satisfied" at baseline and after implementation was also determined. The study was reviewed by the Conjoint Health Research Ethics Board at the University of Calgary.

Responses

To collect baseline data, 138 surveys were mailed to family physicians. Seventy-six were returned (55% response rate). After implementation, 56 surveys were mailed to family physicians and 27 were returned (48% response rate).

Baseline data (**Table 1**) collected before implementation of the template revealed that family physicians were generally satisfied with the letters they received. Most family physicians (86%) indicated they were satisfied or very satisfied with the relevance of information, but less satisfied with its timeliness (70%), consistency (74%), format (81%), and amount (77%). Most (85%) were satisfied or very satisfied overall with the letters.

Given the relatively high satisfaction rate before implementation, evaluation analyses focused on the difference in the percentage of family physicians who were very satisfied with nonstandardized letters and, after implementation, very satisfied with the standardized consultation letters. In each category measured, the percentage of family physicians who were very satisfied increased significantly (**Table 2**).

Limitations

There are several potential limitations to this program evaluation. Response rates for both the baseline and postimplementation surveys were about 50% and are, therefore, at risk of sampling bias. Also, there was a change in the method used to collect the data: baseline surveys were not attached to specific consultation notes, while postimplementation surveys were actually attached to consultation notes. This change in methodology risks introducing positive bias in results. We speculate, however, that this change might have caused us to underestimate the difference in satisfaction between the groups. Those who received just the survey might not truly remember the details of consultation letters they had received and, therefore, might have been less critical of the timeliness and content. Those who received standardized letters

Table 1. Level of satisfaction with consultation letters before implementation of standardized template (baseline)

CATEGORIES OF SATISFACTION	VERY DISSATISFIED (%)	DISSATISFIED (%)	NEUTRAL (%)	SATISFIED (%)	VERY SATISFIED (%)
Relevance (n=48)	2	2	10	69	17
Timeliness (n=48)	2	4	23	60	10
Consistency (n=47)	2	4	19	68	6
Format (n=48)	2	2	15	71	10
Amount (n=48)	2	6	15	67	10
General satisfaction (n=48)	2	2	10	75	10

Table 2. Percentage of family physicians "very satisfied" with clinic notes before and after implementation of template: *P <.001 for all categories.*

CATEGORY OF SATISFACTION	BASELINE (%)	AFTER IMPLEMENTATION (%)
Relevance	17	60
Timeliness	10	44
Format	10	63
Amount	10	56
General satisfaction	10	56

and the survey as a package might have been more critical.

The baseline survey revealed that only 10% of family physicians were generally "very satisfied" with the TBCC's communications about their patients. After the template was in use, this percentage increased to close to 60%.

Discussion

Cancer care in many countries is delivered by various partner organizations, often with complementary functions. Providers' failure to communicate effectively can threaten cancer patients' care. Often, patients do not maintain relationships with their community physicians while they are receiving active treatment at a tertiary cancer centre, so it can be challenging for family physicians to quickly assume all care for such patients after cancer treatment is completed.

In many places, there has been a dramatic shift of care at the end of life from hospitals to the community. In Calgary, the proportion of cancer patients dying in hospital dropped from 73% in 1994 to 39% in 2000, and deaths in the community (home and hospice) increased from 19% to 53%.[7] This shift has resulted in an increasing need for community-based family physicians to care for cancer patients at the end of life.

Family physicians believe that fragmentation of care is not good for patients.[4,8] Palliative patients view cooperation and timely communication between family physicians and cancer specialists as important to their care.[5] A model of care where family physicians have active relationships with patients has been shown to be desirable by family physicians[2] and oncologists.[6]

We reasoned that the processes of communication between TBCC and primary physicians would be an appropriate target for quality-improvement initiatives. We were able to document improvement in several areas following institution of the standardized consultation letter. As cancer care continues to shift to the community and away from hospitals, it will become even more important that all health care providers involved in care of cancer patients have sufficient information to fulfil their unique roles.

Integration of care is an important element of cancer care delivery today and has been profiled in Canada's Strategy for Cancer Control[9] and in the Canadian Council of Health Services Accreditation national standards for cancer program accreditation.[10] If achieved, better communication could not only improve patient care, but might also increase provider satisfaction, promote appropriate use of resources, and improve efficiency within the health care system.

We are considering other steps at TBCC to enhance communication between oncologists and family physicians: using the template letter in all clinics at the centre; routinely copying correspondence to patients' home-care nurses; embedding links to educational material on TBCC's website in clinic letters; and including direct telephone numbers of treating oncologists so family physicians can have rapid access to them if telephone consultation is desired. Such initiatives could mean primary care providers have more timely and relevant information about their cancer patients. A similar initiative has been instituted at a recently established tertiary palliative care unit where TBCC patients are admitted. Discharge summaries are hand-delivered to patients when they are

discharged from hospital so they can give them to their community physicians.

Conclusion

Development and implementation of a template for a standardized letter was shown to improve family physicians' satisfaction with the relevance, timeliness, format, and amount of information they received from oncologists. The increasing number of patients being cared for in the community at the end of life will require ongoing efforts to improve communication between regional cancer centres and community-based health care providers.

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Contributors

All four authors substantially contributed to conception and design of the project; to interpretation of results; and to editing, revision, and final approval of the paper. **Dr Smith** *and* **Ms Summers** *contributed to data collection;* **Dr Braun** *and* **Ms Summers** *contributed to data analysis.* **Dr Hagan** *and* **Ms Summers** *wrote the initial draft of the paper;* **Dr Braun** *revised it.*

Competing interests

None declared

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Editor's key points

- Communication between oncologists and family physicians has not been good in the past, frustrating both patients and their family physicians.
- In response to this concern, the Tom Baker Cancer Centre in Calgary introduced a new structured discharge letter that incorporated suggestions from community physicians.
- The letter included diagnosis, stage of disease, current problem(s), treatment plan, potential problems, prognosis, discussion with family, follow up, and home-care arrangements. Satisfaction with the relevance, timeliness, format, and amount of information was much improved.
- Other strategies for the future could include copying letters to patients' home-care nurses, using the centre's website for specific clinical problems, and having direct telephone links with treating oncologists.

Points de repère du rédacteur

- Dans le passé, une communication inadéquate entre oncologues et médecins de famille était une source de frustration pour le patient comme pour le médecin de famille.
- Devant ce problème, le Tom Baker Cancer Centre de Calgary a élaboré une nouvelle lettre de congé incorporant des suggestions à l'intention du médecin de famille.
- Cette lettre précise le diagnostic, le stade de la maladie, le ou les problèmes courants, le plan de traitement, les problèmes potentiels, le pronostic, les discussions avec la famille, le suivi et les ententes sur les soins à domicile. Une importante amélioration de la satisfaction à propos de la pertinence, de l'à-propos, du format et de la quantité d'information a été observée.
- Comme autres stratégies futures, mentionnons l'envoi d'une copie de la lettre aux infirmières visiteuses des patients, l'utilisation des sites web des centres pour des problèmes cliniques spécifiques et l'instauration d'un lien téléphonique direct avec les oncologues traitants.