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Family Physicians' Perspective of Patient Care at the London Regional Cancer Clinic

SUMMARY

This article describes a survey of the opinions of family physicians practising in the London, Ontario, area concerning the management of doctor/patient relationships and patient treatment in cases referred by family physicians to the London Regional Cancer Clinic. Findings clearly identified a need for better communication between Clinic staff and referring family physicians, greater continuity of care for patients at the clinic, continuing family physician support of patients during periods of hospitalization at the Clinic, and some administrative adjustments in Clinic routines that would reduce patient stress and discomfort and improve morale. (*Can Fam Physician* 1987; 33:71–74.)

SOMMAIRE

Cet article analyse les opinions des médecins de famille en pratique dans la région de London, Ontario, concernant la relation patient/médecin et le traitement des cas référés par les médecins de famille au London Regional Cancer Clinic. L'analyse a clairement identifié la nécessité d'une meilleure communication entre les médecins de cette clinique et les médecins de famille référants, d'une meilleure continuité des soins auprès des patients pendant qu'ils sont traités à la clinique, d'un support continu par le médecin de famille pendant les périodes d'hospitalisation et de certains ajustements administratifs dans les procédures de la clinique, lesquels contribueraient à diminuer le stress et l'inconfort du patient et rehausseraient son moral.

Key words: cancer clinics, referrals, professional relationships

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WHEN A DIAGNOSIS of cancer is made, the patient is often referred to a regional cancer centre for assessment and establishment of a treatment plan. The patients referred sometimes seem to become lost to the care of their family physicians during this process. Such fragmentation of care is potentially of concern to many family physicians, patients, their families, and oncologists.

In April 1986, the annual Cancer Clinic Symposium was held in London, Ontario. The organizers of the program had asked the principal author to provide them with feedback on patient-care issues from the family physician's perspective. As a result of this request and of the need to try to provide a representative statement of family physicians' views, a survey was conducted so that a truly collective opinion could be put forward. The results of this survey were presented at the Symposium. Although the general issues raised were specific to the London Regional Cancer Clinic, they may apply, as well, to other regions of Ontario and Canada. For this reason, information about the survey and its findings is offered here.

Methods

A 13-item pre-tested questionnaire was mailed to all family physicians in Middlesex County, Ontario, who were registered with the London and District Academy of Medicine. A single reminder letter was sent to those physicians who did not return the initial questionnaire within three weeks of mailing. All replies received by March 21, 1986 were included in the statistical analysis.

Results

A total of 220 questionnaires were mailed, of which 164 were returned,

representing an overall response rate of 75.6%. Practice experience roughly divided itself into equal parts: those in practice 10 years or fewer (38%); those in practice 10 to 20 years (27%); and those in practice more than 20 years (35%). Approximately half of the respondents had had at least 16 patients treated at the Cancer Clinic during the preceding five years.

Three-quarters of the respondents declared that they rarely or never had problems communicating with consultants at the Cancer Clinic, indicating that in general, community physicians were satisfied with the care of their patients. However, as more specific questions were asked, it became clear that more physicians were identifying more issues of concern than had been expected. The physicians who responded that they had concerns about communication with the Clinic identified the most common problem as difficulty in contacting the consultant responsible for the care of their patient. Some indicated that they were not always notified of significant changes in their patients' treatment program or condition. In relation to this area of concern, the physicians cited delay in receiving consultation notes and deficiencies in the content of such notes, particularly with respect to the expected side-effects of treatment protocols and the management of such side-effects. Cross-referrals to other specialists without prior notification of the family physician were another problem identified.

Another concern identified was the perception that the family physician was not allowed to write orders on patients hospitalized during their illness when those patients were under the care of Cancer Clinic physicians.

When the family physicians were asked to suggest procedures that would improve communication with the Cancer Clinic, approximately half of them suggested that a phone call informing the family physician of major changes in a patient's treatment would be appreciated. Many of the respondents stated that they considered the family physicians responsible for initiating contact if they had concerns. Many believed that the Cancer Clinic consultants should encourage patients to maintain contact with their family physician during treatment. Other respondents noted the need for the Cancer Clinic to address the issue of continuity of care for patients being treated at the Clinic, as many of these patients were seen by a number of consultants during their treatment program. Some stated that there should be more liaison between consultants and family physicians, but made few suggestions as to how liaison could be strengthened. Others commented that the addition of family physicians to the Cancer Clinic staff would probably improve communication.

Over 94% of the respondents indicated that they continued to see their patients during their time of treatment at the Cancer Clinic. This figure supported the view of the majority of family physicians who believed that follow-up care of cancer patients should be the joint responsibility of both the consultant and themselves.

Two-thirds of the respondents considered that their patients had a positive experience at the Clinic. Another third were rather neutral in their responses about the experience of their patients, while only 4% believed that their patients had had a negative experience. Typical comments made by patients to physicians were: "Every time I went to the clinic, I saw a different doctor"; "I waited and waited and waited . . ."; "There was never any time to discuss my concerns"; "My care was very impersonal"; "The Clinic is so crowded"; and "I didn't know whom to call if there were a problem." Other respondents indicated that their patients had expressed positive feelings about their treatment, mentioning, in particular, the many resources available to them, such as drugs, special equipment, palliative care and support services. Other patients had commented on the co-operative nature of the staff and the compassionate and supportive care provided by the Clinic's health professionals.

The majority (80%) of respondents believed that they themselves should see all or most of their patients to provide supportive care while the patients were receiving active treatment at the Clinic. One-third considered that it was the patient's responsibility to arrange for family-physician contact, while over half considered that it was their responsibility to initiate contact. Some physicians were of the opinion that the consultant at the Clinic should be responsible for actively recommending that the patient contact the family doctor for supportive care.

PANADOL*
acetaminophen

Indications: As a nonsalicylate analgesic-antipyretic for the relief of pain in a wide variety of arthritic and rheumatic conditions involving musculoskeletal pain, as well as in other painful disorders such as headache, dysmenorrhea, myalgias, neuralgias. Acetaminophen is also indicated for the symptomatic reduction of fever due to the common cold and other bacterial or viral infections.
Contraindications: Hypersensitivity to acetaminophen.
Adverse Effects: When used as directed, acetaminophen is virtually free of severe toxicity or side effects. It is unlikely to cause gastrointestinal upset. If a severe sensitivity reaction occurs the drug should be discontinued. Hypersensitivity to acetaminophen is usually manifested by rash or urticaria, or, rarely, by asthmatic attacks.
Regular use of acetaminophen has been shown to produce a slight increase in prothrombin time in patients receiving oral anticoagulants but the clinical significance of this effect is not clear.
Precautions and Treatment of Overdose: The majority of patients who have ingested an overdose large enough to cause hepatic toxicity have early symptoms. However, since there are exceptions, in cases of suspected acetaminophen overdose begin specific antidotal therapy as soon as possible. Maintain supportive treatment throughout management of overdose as indicated by the results of acetaminophen plasma levels, liver and renal function tests, and other clinical laboratory tests.
Prompt antidotal therapy with N-acetylcysteine decreases the risk of acetaminophen induced hepatic injury. N-acetylcysteine is available in Canada as an antidote in oral and parenteral dosage forms.
Dosage: Adults: 650 to 1,000 mg every 4 to 6 hours, not to exceed 4,000 mg/24 hours. May be administered with or without food. The recommended maximum single dose of 1 to 2 tablets or capsules every 4 hours up to 8 daily if 500 mg or, up to 12 daily if 325 mg.
Children: 10 to 15 mg/kg every 5 to 6 hours, not to exceed 65 mg/kg/24 hours.
Supplied: Tablets 325 mg: Each round, white tablet, with "325" on one side and PANADOL engraved on the other side. Contains: 325 mg acetaminophen, no sodium and 0.09 cal/tablet. Plastic bottles of 24 and 100.
Tablets 500 mg: Each round, white tablet, engraved PANADOL on one side and "500" on the other side. Contains: 500 mg acetaminophen, no sodium and 0.14 cal/tablet. Plastic bottles of 24 and 100.
Capsules 325 mg: Each dark blue and pale blue capsule, marked PANADOL 325 mg on each half of the capsule contains 325 mg acetaminophen, no sodium and 0.38 cal/capsule. Plastic bottles of 24 and 50 capsules.
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April, 1986 *Reg. Trade Mark

Family-physician respondents to a question about the most suitable timing of this intervention were split between the active treatment phase and the time period immediately following the initial course of treatment. Two-thirds of the respondents believed that additional supportive care should be provided by other professionals in care-related fields, such as clergy, social workers, nurses, the palliative care team, home-care providers and volunteers in various services, depending on the needs of the patients and their family.

One-half of the respondents considered that changes were required at the London Cancer Clinic in order to improve patient care. The suggested changes could be grouped into three areas: communication, organization and attitude.

Concerning communication, the family physicians believed that improved methods of notification of admission of their patients to hospital or of any significant change in the clinical course of treatment would be helpful. They thought that more telephone communication between family physicians and consultants would be helpful, and that the family physician should assume at least equal responsibility with the consultant for initiating this contact. Some family physicians suggested that more information should be given to patients about their treatment options and the side-effects to be expected from the treatment.

Concerning organization, the respondents suggested that improved treatment facilities would be helpful. In particular, they identified a need for more space and more staff. They also believed that the consultant staff should offer more continuity of care for patients at the clinic, and that prolonged waiting times should be avoided, where possible, by improved scheduling. They considered, too, that an increased rate of transcription of consultation notes would be helpful.

Concerning attitude, the family physicians identified the need for a more personal, empathetic and caring approach to patients at the Cancer Clinic. They also emphasized a need for the consultants actively to encourage more involvement by the family physician in the patient's overall treatment program.

Overall, the following areas were identified as needing attention. Family physicians should assume more responsibility for involvement in their patient's care. A significant proportion of the long-term follow-up care given by the Cancer Clinic could be transferred to the family physician, thus decreasing the load on the consultants. There is need for a service directory outlining the support services available to patients from the Cancer Society and other community support services.

Finally, the respondents believed that the "dumping" of patients to the family doctor at the time of palliative crisis should be avoided in the interest of good patient care. A clear transfer of care at the time when all active treatment was completed would go a long way to avoiding this uncomfortable gap in patient care.

Conclusions

The authors hope that the willingness expressed by family physicians to become more involved in the care of their cancer patients and to share with the clinic consultants the responsibility for providing this care will be heard and acted upon by all concerned. It appears that the respondents to this survey were making a strong plea for the sharing of the work load, and for a common respect for the capability of all health professionals involved in caring for cancer patients, in order to strive for the goal of meeting those patients' care needs. That task is too big for any individual to shoulder; it requires a well co-ordinated team effort to achieve the goal of optimum patient care.

It is our hope that all the members of the health team can take up the challenge of improving our care to the patient with cancer by each doing our share a little better, giving a little more thought to details, and offering a little more care and understanding both for the other professional care providers involved and for the patients concerned. ◉

Acknowledgements

The authors would like to thank all the family physicians in Middlesex County who chose to respond thoughtfully to our questionnaire. We also wish to thank the staff of the London Regional Cancer Clinic who encouraged us to provide them with constructive feedback on patient-care issues.

Lectopam® (bromazepam)

Prescribing Information

Indications:
Short-term, symptomatic relief of excessive anxiety in patients with anxiety neurosis.

Contraindications:
Known hypersensitivity to benzodiazepines or myasthenia gravis.

Warnings:
Not recommended in depressive disorders, psychosis or for patients younger than 18 years. Advise patients against concurrent use of alcohol and other CNS depressants. Warn patients against driving, operating dangerous machinery, or engaging in other hazardous activities requiring mental alertness and physical coordination. Should not be used during pregnancy or given to nursing mothers. Warn women of child-bearing potential to consult physician if they intend to become or suspect they are pregnant.

Precautions:
In elderly and debilitated, initiate medication with very low doses and increment gradually to avoid over-sedation or neurological impairment. Should not be administered to patients prone to drug abuse; caution in patients with potential for psychological dependence. Withdraw gradually if used in prolonged high doses, or if the individual is suspected of being dependent. Should not be used in ambulatory psychotic patients because of possible paradoxical reactions. In the presence of impaired hepatic or renal function, initiate therapy at very low doses and increase dosage appropriately to residual organ function. Monitor patient closely, with periodic laboratory assessments. Periodic blood counts and liver function tests are advisable during chronic therapy.

Adverse reactions:
Most frequent are drowsiness, ataxia and dizziness. Paradoxical effects can occur with benzodiazepines. Less frequent side effects include visual disturbances, headache, seizures, slurred speech, mental confusion, elevated or depressed mood, nervousness, sleep disorders, lethargy, stupor, dry mouth, nausea, vomiting, non-specific gastrointestinal disturbances, muscle spasm or weakness, hypotension, tachycardia, pruritis, rash, incontinence, change in libido, variations in hematologic parameters and liver function tests.

Dosage and administration:
Individualize and titrate dosage to avoid excessive CNS depression. Initial treatment course should be no longer than one week without reassessment of need for limited extension. If necessary, adjust drug dosage after one week.

Usual adult dosage:
Initially, 6 to 18 mg daily in equally divided doses, depending on severity of symptoms and response. Treatment should be initiated at lower doses and adjusted as necessary. Optimal dosage range 6 to 30 mg daily in divided doses. Up to 60 mg daily may be used in exceptional cases.

Elderly and debilitated:
Initial dose should not exceed 3 mg daily in divided doses. Adjust dosage carefully, depending on tolerance and response.

Supply:
Pink, cylindrical biplane scored tablet, containing 3 mg bromazepam.
Green, cylindrical biplane scored tablet, containing 6 mg bromazepam.
Bottles of 100 and 500.

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