Urban family physicians and the care of cancer patients

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SUMMARY
Members in the Department of Family Medicine of a university teaching hospital were surveyed to find out their involvement in caring for cancer patients. Respondents indicated that many cancer patients were followed, but few cancer support services in the hospital and the community were used. The desire to take on new cancer patients was lacking, yet an interest in continuing medical education existed. Feedback from the department will help guide our Education Committee to develop continuing medical education programs for family physicians caring for cancer patients.

RÉSUMÉ
On a procédé à une enquête auprès des membres du département de médecine familiale d'un centre hospitalier universitaire d'enseignement afin de préciser leur implication dans les soins auprès des cancéreux. Les répondants ont indiqué qu'ils suivaient de nombreux cancéreux mais qu'ils faisaient un usage restreint des services de soutien aux cancéreux disponibles à l'hôpital et dans la communauté. Ils ont exprimé leur peu d'enthousiasme à prendre en charge de nouveaux cancéreux mais ils ont manifesté un intérêt en formation médicale continue. Les commentaires du département guideront notre comité d'éducation à développer des programmes d'éducation médicale continue destinés aux médecins de famille impliqués dans les soins aux cancéreux.

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FAMILY PHYSICIANS HAVE THE potential to play a key role in the care of cancer patients. The rich, long-term relationship with the patient that continuous, comprehensive care might foster can reduce the threat and anxiety that the diagnosis of cancer often brings.[1,2]

Family physicians are not, however, fulfilling this role at present. Apart from the early detection, casefinding, and screening for cancer, family physicians in urban areas play a decreasing role in the medical care of oncologic patients, including the palliative care phase. This process of abandonment is complex and is influenced by the perceptions of patients, family physicians, and members of specialist oncology teams.[1-3]

A descriptive study done in London, Ont, found that about 30% of cancer patients die at home, mostly under the care of family physicians.[4] This study identified a need for better communication between oncology staff and the referring family physician.[4] Another study[1] found that only 60% of cancer patients thought their family doctors were aware of their current problems. Similar observations have been reported from the United States and Great Britain.[2,3,5]

But what are the perceptions of urban family physicians? Are family physicians willing to take on the task of continuous care of cancer patients? Do they feel knowledgeable enough to meet the challenge? How do they want to prepare themselves to do so? Information of this kind would be important in planning oncologic and palliative care services and continuing medical education (CME).

The purpose of this pilot study was to assess interest on the part of urban, community-based physicians in our Department of Family Medicine in caring for cancer patients, as well as their use of community resources and their perceived needs for CME.

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METHODS

Population

At the time of the questionnaire, the Department of Family Medicine comprised 106 physicians based in the community and at the Herzl Family Practice Centre of the Sir Mortimer B. Davis Jewish General Hospital (SMBD-JGH), a McGill University teaching hospital.

Table 1. **Number of cancer and palliative care patients seen in the past month:** *Not all respondents answered all questions.*

NO. OF PATIENTS FOLLOWED	DISTRIBUTION OF FAMILY PHYSICIANS %	TOTAL
CANCER PATIENTS		
None	27.9	19
1	14.7	10
2	16.2	11
3	17.6	12
4-5	7.4	5
6-10	10.3	7
>10	5.8	4
TOTAL	100.0	68
PALLIATIVE CARE PATIENTS		
None	56.0	28
1	26.0	13
2	8.0	4
3-5	10.0	5
TOTAL	100.0	50

Questionnaire

An anonymous questionnaire was mailed to all 106 physicians. Using Dillman's methodology, we sent three reminders.[6] The questionnaire consisted of seven questions. Family physicians were asked about the number of cancer and palliative care patients seen in their practices during the previous month, their use of community cancer resources, their interest in proposed topics for CME, and their preferred methods for CME. They were also asked whether they were interested in accepting new cancer patients. A six-point Likert scale was used to measure use of community oncologic resources and interest in CME topics. (Zero represented no use at all of services or no interest at all in CME topics and 5 represented a great use of services or an extreme interest in a CME topic.)

Analysis

The use of community resources (use score) and the interest in CME topics (interest score) were derived by calculating the means and standard deviations of all the respondents' responses. The Epi Info statistics calculation package, Version 5.00, was used.

RESULTS

The response rate to the mailed questionnaire was 68.8%. Data were available to compare the respondents (73 doctors) to the nonrespondents (33 doctors). There were no significant differences between the two groups in sex, age, university, or year of graduation or certification.

Table 1 shows the number of cancer patients the respondents report having seen in the month preceding the study. The family physicians followed a mean of 3.2 such patients (SD 4.4; range = 0 to 20); of these, a mean of 0.8 (SD 1.3) needed palliative care. Almost half (48.5%) of the respondents followed one to three cancer patients; 27.9% followed none.

Table 2 shows the use of oncologic resources by family physicians taking care of cancer patients. No association was found between the number of patients followed and the resource use score.

Table 3 shows physicians' interest in CME on five suggested cancer-related topics, and *Table 4* shows their preferred teaching methods. No association was found between the number of patients a family physician followed and the topics of interest.

Only 13.4% of respondents (nine) were interested in referrals of more cancer patients; 65.7% (44) were unwilling to receive any new referrals. No correlation was found between number of patients followed and interest in more referrals.

DISCUSSION

The therapeutic oncology team is composed of nurses, a medical and a surgical oncologist, radiotherapists, and other surgical subspecialists, whose focus on cancer treatment does not necessarily include interaction with primary care physicians. In fact, the intensity of the oncology team's involvement seems to lead to the exclusion of family physicians. Conversely, primary care physicians might feel intimidated by the high-tech investigations. They might believe they have too little knowledge of new advances in the treatment of cancer and might fear the emotional fall out of a life-threatening illness and possibly death of the patient. These factors, along with the time and energy requirements of busy office practice, could preclude active involvement.[7-11]

In a study done by McWhinney and colleagues[1] on 493 cancer patients who said that they had a family doctor, the family doctor had, according to the patients, been involved in the diagnosis of 282 (57.2%), the treatment of 132 (26.8%), and the follow up of 214 (43.4%). Our respondents reported variable involvement.

A survey of family physicians at the London Regional Cancer Clinic in Ontario found that two thirds of respondents felt a need for additional supportive care from other health professionals.[4] Our urban family physician group did not use either hospital or community oncology support services much – possibly because they were unaware of or dissatisfied with such services or found them unavailable, or possibly because their training did not emphasize the multidisciplinary approach.

It is often difficult for family physicians to become reinvolved after a long separation. The patient and family who perceive that their family physician has abandoned them have often developed an emotional bond to the cancer centre and might have also lost confidence in their doctor's ability to help.[7,8,10,11] Yet the family physicians in our study showed interest in improving relevant knowledge, attitudes, and skills, especially in symptom control and pain management: areas in which family physicians can play an important assessment and therapeutic role.[2,12] The most attractive form of CME was case presentations, followed by lectures and seminars. The challenge for medical educators is to develop a case-centred CME program that focuses on the educational needs identified by family physicians.[13]

Although most of our respondents were following a small number of cancer patients, very few were interested in new referrals. (Four mentioned retirement plans as a reason.) However, reluctance to accept new referrals does not necessarily mean that family physicians would not be

Table 2. **Resources used by family physicians in caring for cancer patients:** *Not all respondents answered all questions.*

TYPE OF RESOURCE	MEAN USE (±SD)*	TOTAL
Hope and Cope volunteer services†	2.0 (±1.6)	54
CLSC Home Care‡	1.8 (±1.7)	51
Oncology nurses§	1.7 (±1.9)	50
Social services	1.6 (±1.6)	48
Palliative care	1.2 (±1.5)	47
Supportive Care Team‖	1.0 (±1.5)	45
Chaplain services	0.6 (± 1.2)	46

**Likert scale: 0 – no use at all; 5 – very frequent use.*
† Volunteer support service.
‡ Québec Community Health Centre.
§ Oncology ambulatory clinic staff.
‖ Multidisciplinary hospital-based consultation team.

Table 3. **Physicians' interest in CME topics:** *Not all respondents answered all questions.*

CONTINUING MEDICAL EDUCATION TOPIC	MEAN INTEREST (±SD)*	TOTAL
Symptom control	3.5 (±1.5)	67
Rehabilitation	3.1 (±1.6)	64
Chemotherapy/radiotherapy	2.8 (±1.5)	64
Family consultation	3.2 (±1.6)	64
Grief counseling	2.9 (±1.7)	54

**Likert scale: 0 – no interest at all; 5 – extreme interest.*

willing to follow up their own patients should they develop cancer.

The care of the patient with cancer provides an example of the gap that often occurs between primary care providers, secondary care providers, and patients: a gap all three groups have helped to create.

Table 4. **Preferred CME methods**

TEACHING METHOD	PROPORTION INTERESTED (%)	TOTAL*
Case presentations	70.5	61
Lectures	60.0	60
Seminars	57.9	57
Small group discussions	48.2	54

**Number of respondents who answered the question*

This separation has several possible harmful consequences. Dying patients who prefer to be at home might have no physician to attend them. Cancer clinics might be overloaded with patients who could be treated by family physicians, especially in the palliative phase. Patients and families might incur needless cost and inconvenience traveling to clinics when home care would be more appropriate.[14] Finally, patients and families might miss the continuing support of a family physician when they have to make informed medical and ethical decisions on difficult questions of investigation and treatment.[15,16]

Perhaps family physicians will become more interested and involved in oncologic care if they can gain more knowledge and skills, better links with community resources, and enhanced communication with the oncologic teams.

This study might not be representative of family physicians' perceptions in urban centres in other parts of North America. Thus, the generalizability of the results might be limited.[6] However, as a pilot study, it could offer some insights into the role of urban family physicians in the care of cancer patients. Further research on the role of family physicians in all stages of oncologic care is important both to patients and to the discipline of family medicine. ■

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