

It takes a team

CanIMPACT: Canadian Team to Improve Community-Based Cancer Care along the Continuum

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In the 1990s pioneers in family medicine research in Canada such as Ian McWhinney and Martin Bass^{1,2} lamented, in the pages of *Canadian Family Physician (CFP)*, the separation between FPs and their cancer patients. The prevailing metaphor at that time was that after a cancer diagnosis patients went into the “black box” of the cancer centre. Those FP researchers, however, challenged that metaphor and through chart reviews³ and surveys^{4,5} showed that FPs were not only willing to play a greater role, they were in fact already playing an active role in the follow-up care of their patients with breast cancer, and likely other cancers as well. Despite this early work, however, the metaphor of the black box persists and, despite the many changes in primary care systems, cancer care systems, and communication systems, I still hear it often: *plus ça change, plus c'est la même chose*.

Advances in care

The early 1990s also saw landmark parliamentary hearings that highlighted the need for greater consistency in breast cancer services and delivery, identifying communication problems, variations, and fragmentation of care.⁶ It will not be lost on the readers of *CFP* that most of the studies I cite here are about breast cancer. In many ways this is a direct result of the parliamentary hearings and ensuing report⁷ that drew attention and resources to breast cancer. Indeed, over the past 20 years there have been tremendous advances in breast cancer diagnosis and treatment: identification of *BRCA1* and *BRCA2* mutations and introduction of screening programs for high-risk patients; better imaging techniques for early diagnosis; advances in adjuvant radiotherapy; advances in adjuvant systemic therapy both in terms of hormonal therapy and targeted therapies; and recognition of the benefits of exercise both for quality of life and improved outcomes.

It was during that time that I completed my FP residency and was working at a cancer centre. Those articles and reports made a big impression on me and were consistent with my own clinical experience. The number of breast cancer patients seen for well follow-up at the cancer centre was large, and I often asked those patients about the ongoing involvement

of their own FPs. I also questioned whether continued long-term follow-up at the cancer centre was necessary, as the clinical skills and knowledge required are well within the purview of family practice. Surely, I hypothesized, it would be better for patients and for the use of resources if long-term follow-up was centred in primary care. This observation and hypothesis set the direction of my career. While many things have changed since the 1990s, the lament about the black box and the fragmentation of care persists: *plus ça change, plus c'est la même chose*.

What has changed

What *has* changed, however, is that, based on evidence from randomized controlled trials,⁸⁻¹¹ it is now widely accepted that well follow-up centred in primary care is a safe and acceptable alternative to cancer centre follow-up. Clinical practice guidelines endorse^{12,13} and cancer programs encourage¹⁴ transfer to primary care for routine follow-up. Moreover, we now have rigorous population-based studies that show frequent ongoing active involvement of FPs,^{15,16} even during chemotherapy,¹⁷ confirming the earlier studies. Many studies, commentaries, conferences, and continuing professional development events now focus on the role of FPs in the care of cancer patients.

What has also changed is that we no longer focus solely on cancer-specific issues. The discourse has widened to consider the holistic needs of those who are living beyond a cancer diagnosis. This holistic perspective is captured in the concept of survivorship.¹⁸ The impetus for this change is improvements in cancer survival whereby now, for the high-prevalence adult cancers (breast, colorectal, and prostate), most patients will be long-term survivors.¹⁹ Optimum care goes well beyond cancer treatment and cancer management to include management of cancer treatment's late and long-term effects. Moreover, as most cancer patients are elderly and have multiple chronic conditions, the management of those comorbid conditions and psychosocial sequelae, as well as general medical and preventive care, are equally important.¹⁸ The recent breast cancer survivorship guidelines specifically designed for primary care reflect this holistic approach.²⁰ This is truly a paradigm shift. However, serious problems of fragmentation persist²¹: *plus ça change, plus c'est la même chose*.

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Fragmentation of care

The latest Canadian cancer statistics project a 40% increase in cancer incidence by 2030.¹⁹ The implications of this increase will reverberate throughout the cancer system and the broader health care system. It will be crucial that primary care plays a pivotal role from diagnosis through to end-of-life care. In recognition of this, *Lancet Oncology* commissioned a comprehensive report to examine the role of primary care along the cancer control continuum.²² Part 7 of the report focuses on integration of care between primary care and cancer specialist care, and an accompanying editorial identifies integration as one of the key challenges.²³

To better understand the issues underlying this fragmentation of care, a multidisciplinary pan-Canadian group of primary care physicians, nurses, oncology specialist physicians, researchers, knowledge users, and patients coalesced to form a team: the Canadian Team to Improve Community-Based Cancer Care along the Continuum (CanIMPACT).²⁴ The vision of CanIMPACT is “improving cancer care together.” The overarching objective is to enhance the capacity of primary care to provide care to cancer patients and improve integration between primary care and cancer specialist care along the cancer care continuum. CanIMPACT has taken a multimethod approach, and the activities of the team are divided into 2 phases. Phase 1 represents the foundational research using population-based administrative health databases; qualitative methods involving primary care practitioners, cancer specialists, and patients; an environmental scan and systematic review of existing initiatives to improve integration of care; and—a unique element—the exploration of issues related to personalized medicine. Phase 1 culminated in a consultative workshop with key stakeholders from across Canada and abroad.

Through a deliberative process, ideas were generated and prioritized that give direction to CanIMPACT for its second phase. Phase 2 will test an intervention developed in phase 1 to improve the integration of cancer care.

In this issue of *CFP*, findings from the first phase of CanIMPACT are presented,²⁵⁻³⁰ along with some practical reviews for FPs on care of patients with and at risk of breast cancer.^{31,32} The importance of primary care and the ongoing commitment of FPs to their cancer patients has not changed: *c'est la même chose*. However, the problems of communication, coordination, and integration of care persist. *Plus ça change, plus c'est la même chose?* Let's put that tired truism to rest!

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Competing interests

None declared

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