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The two solitudes of primary care and cancer specialist care: is there a bridge?

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The Two Solitudes

In *Canadian Cancer Statistics*, the Canadian Cancer Society recently reported a projected increase in cancer incidence of 40% by 2030[1]. It does not take much effort to imagine the effect such an increase will have on the health care system: more patients will present with symptoms suggestive of cancer, requiring correct work-up; more and timely diagnostic processes will be needed; more patients will be undergoing treatments that are continually increasing in complexity; more people will survive their cancer, and more will require end-of-life care—and the ideal of patient-centred care will underpin all those services[2].

And yet, even as the country becomes alert to this impending situation, a fundamental structural problem in our cancer care system is allowed to persist. In Canada, since at least the early 1990s, we have described, worried about, and lamented the fact that family physicians (FPs) and cancer specialists function as two solitudes[3]: the providers and services that constitute primary care, and the providers and services that constitute cancer specialist care.

Internationally, similar concerns about the lack of coordination and integration between the primary care and cancer care systems have been expressed[4]. Importantly, *Lancet Oncology* recently published a comprehensive report on the expanding role of primary care in cancer control[5], emphasizing that integration between primary care and oncology care is key[6].

Examining the Two Solitudes in Canada

This issue of *Current Oncology* brings together a collection of papers that describe and seek to understand the nature of the two solitudes within the Canadian context and also initiatives that attempt to bridge the two solitudes. The papers stem from a program of research called CanIMPACT (Canadian Team to Improve Community-Based Cancer Care Along the Continuum, http://canimpact.utoronto.ca). The multidisciplinary pan-Canadian CanIMPACT program is studying how to improve cancer care to patients in the primary care setting. It is funded by the Canadian Institutes of Health Research for 5 years (2013–2018, Canadian Institutes of Health Research grant no. 128272; Grunfeld E, principal investigator).

Each paper in this issue presents findings from studies that were designed to meet the specific objectives of the CanIMPACT program. Each study brings a different lens and insight to the problem of the two solitudes. Breast cancer is used as the exemplar disease, but the findings are likely transferrable to other adult cancers.

- The paper by Grunfeld and Petrovic[7] contains a detailed description of the CanIMPACT research program. It presents the framework of the program, describing the objectives, methodologic approaches, and multidisciplinary team members.
- The paper by Tomasone and colleagues[8] lays the groundwork by reporting on a pan-Canadian environmental scan undertaken to determine the current state of cancer care coordination in Canada. Based on the scan, they compiled a casebook of existing collaborative models of care in Canada (downloadable from http://canimpact.utoronto.ca/streams-and-themes/knowledge-translation/). The casebook profiles 23 initiatives from across Canada designed to improve coordination between primary care and cancer care. The number of initiatives indicates that the need to improve coordination of care is widely recognized, and cancer systems across Canada are making an effort to address it. In their paper, Tomasone and colleagues summarize the challenges and insights gleaned during the casebook process, providing recommendations for elements that should be in place to improve the success of such initiatives.
- Easley and colleagues[9] used qualitative methods involving semi-structured interviews with FPs, oncologists, and surgeons from across Canada to ask about the role that FPs currently play, and the role that they should play in the care of cancer patients. The findings are intriguing and concerning. The dominant word used to describe the ideal role for FPs was "quarterback" for their patients. But the barriers and challenges that were also mentioned limit the ability of FPs to fulfil that role, echoing those that we have lamented for almost 30 years[3].
- The papers by Kendell and colleagues[10] and Bastedo and colleagues[11] use population-based quantitative methods to describe, respectively, the utilization of physician services during survivorship and during active chemotherapy. O'Brien and colleagues[12] ask an innovative question about the potential role of FPs in supporting patient decision-making with respect to personalized medicine. Although the received wisdom has always been that FPs are not actively involved during

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those phases of cancer care, the data show otherwise. A recent U.S. study reported similar findings[13].

Taking all of the studies together, what becomes evident is a picture of frequent interaction of patients with their FP throughout the continuum of care—even during chemotherapy treatment. This picture also reveals clear areas of expertise: for example, the oncologist plays the lead role in personalized medicine and managing chemotherapy-related side effects; the FP takes the lead in managing comorbidities and providing psychosocial support. The patient needs and wants both the oncologist and the FP to "quarterback" their cancer care. And yet, persistent problems of communication between the two solitudes are what impede the integration required to achieve better coordination of care.

Building Bridges

In spring 2016, the CanIMPACT team hosted a consultative workshop with stakeholders from across Canada. The goal was to identify a practical, feasible, generalizable, scalable, and sustainable intervention with the potential to improve integration and coordination of care. Through a deliberative process, agreement on an intervention that would potentially help to bridge the two solitudes was reached. The workshop proceedings and outcome of the deliberations are described in the paper by Grunfeld and Petrovic[7].

In addition to using the traditional qualitative and quantitative methods to describe the current situation from many different perspectives, the CanIMPACT team collaborated with members of OCAD University's Strategic Innovation Lab to build a graphic representation of the complexity of the cancer system from the system and patient perspectives. The graphic representation takes the form of a gigamap, described by Jones and colleagues as a "synthesis map to represent research findings as a visual knowledge translation tool"[14]. Readers will be impressed by the complexity of the cancer journey pathway—both for the patient and for the health care provider. It might be speculated that this complexity contributes to the perpetuation of two solitudes as providers struggle to manage their part of the system. The simpler and more evocative patient map shows how valued personal relationships have the greatest direct influence on the patient's journey.

Will the work of CanIMPACT solve all the complex multi-level factors[15] impeding optimal integration of care? No. It is hoped, however, that the research collated in this issue of *Current Oncology,* together with a sister publication in *Canadian Family Physician*[3], serves to better elucidate the true nature of the two solitudes so as to better guide and facilitate the many bridges that need to be built.

CONFLICT OF INTEREST DISCLOSURES

I have read and understood *Current Oncology*'s policy on disclosing conflicts of interest, and I declare that I have none.

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