Role of family physicians in the provision of health services to cancer patients

Rol de los médicos de familia en la provisión de servicios de salud al paciente con cáncer

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Abstract

Introduction: Patients with cancer identify family physicians as a primary resource for informational and emotional support.
Objective: To determine family physicians' attitudes and roles in providing health services to cancer patients.
Methods: A cross-sectional study was carried out.It was conducted using two mail contacts and final telephone contact for non-responders.
Results: 82% of the family physicians (FP) in the newly diagnosed group and 81% in the palliative group reported that they were satisfied with the services provided to their patients.
Conclusions: family physicians facilitate cancer patient care services.

Keywords: cancer, primary care, family physicians, palliative care source: DeCS
DOI Number: 10.14704/nq.2022.20.13.NQ88012 **NeuroQuantology 2022; 20(13): 79-86**

Resumen

Introducción: Los pacientes que viven con cáncer identifican a los médicos de familia como un recurso principal para el apoyo informativo y emocional.
Objetivo: Determinar actitudes y roles de médicos de familia en la provisión de servicios de salud a pacientes con cáncer.
Método:Se realizó un estudio transversal. Se llevó a caboutilizando dos contactos por correo y un contacto telefónico final para los que no respondieron.
Resultados:El 82 % de los MF en el grupo de diagnóstico reciente y 81 % en el grupo de paliativos informaron que estaban satisfechos con los servicios brindados a sus pacientes.
Conclusiones:los médicos familiaresfacilitanlos servicios de atención a pacientes con cáncer.

*e*ISSN1303-5150

Palabras clave: cáncer, atención primaria, médicos familiares, cuidados paliativos fuente :DeCS.

Introduction

Patients living with cancer throughout the disease trajectory identify family physicians (FPs) as a primary resource for informational and emotional support and an access point to other health care providers. However, surprisingly little information exists on the actual role of MFs in directly addressing the supportive care needs of cancer patients[1].Supportive care is services to meet the psychological, social, pain and symptom management, informational, or practical needs resulting from an illness and is considered a necessary adjunct to medical treatment for people with cancer[2]. Cancer supportive care (SAC) services are often community-based and delivered through a wide range of service providers. After diagnosis, the time before transfer to the formal cancer system (i.e., cancer center) can be a period of great need for supportive care. It has been reported in the research literature that up to 40% of cancer patients have unmet supportive care needs[3]. Timely, the issue of unmet needs in SAC has been identified as a priority to reduce the negative impact of the cancer experience[4].

In Ecuador and elsewhere, it has been postulated that FPs should be responsible for managing the SAC needs of their patients after diagnosis. The rationale behind this belief is that MFs have an in-depth knowledge of their patients and their needs, and as mentioned above, FPs are often the preferred contact for cancer patients seeking supportive care. In addition, research has shown that cancer patients treated by oncologists alone received a significantly lower proportion of recommended care than patients who were also treated by an FP[5].

Few studies have directly asked FPs to identify their preferred role in CCS, and, to our knowledge, none have comprehensively examined the actual role assumed by MFs in the specific provision of this type of service. The present study is the first to investigate these issues. We focus on MFs who care for cancer patients at the newly diagnosed and end-of-life ends of the disease trajectory, periods during which SACs are particularly crucial

Method

A cross-sectional study based on a survey was carried out.The survey was conducted in the city of Santo Domingo using a modified version of Dillman's custom design method[6], with two mail contacts and final telephone contact for non-respondents. The survey period was from April to September 2021. This study was approved by the Universidad Regional Autónoma de Los Andes (UNIANDES).

The analysis was descriptive, considering the proportion of FPs in each group (i.e., the newly diagnosed group and the palliative group) who reported: evaluating/providing a specific type of SAC service; a particular role in coordinating supportive care for their cancer patients; and agreement/disagreement with each statement about system performance. The four-item scales were dichotomized for ease of reporting. Open-ended responses were coded and themes were extracted.

All eligible practicing FPs, including palliative care specialists, in the study region were included in the survey. The list of physicians was generated using medical directories and corroborated with listings from professional associations and local hospital registries. To reduce the response burden of MFs responding in terms of newly diagnosed cancer patients and those receiving palliative care, FPs (except palliative care specialists) were randomly selected to receive a questionnaire designated for one stage or the other.

A single questionnaire was developed based on existing instruments, relevant literature, expert opinion, and the judgment of the research team. This questionnaire was piloted with 10 primary care physicians outside the study area for clarity, readability, and relevance. The survey instrument contained three main sections, plus questions to capture physician characteristics.

The first section addressed MF care delivery, identifying key SAC services FPs regularly assess or provide (either through direct provision or referral to other providers). The groups of services specified were: information about cancer and its treatment; information about SAC services; psychosocial support (i.e., counseling services such as support groups, peer groups, and professional counseling); pain and symptom management; medical support and services (i.e., nursing care, homemaker support, nutritional counseling, transportation, rehabilitation services, and home medical equipment/supplies); and palliative care (i.e., hospice care and palliative care specialists; only the palliative group was queried). This comprehensive list of SAC services was derived from the conceptual literature. Response options were dichotomous (yes or no) for all types listed services.

In the second section, MFs were asked to define their current role in coordinating supportive care for their cancer patients. The response options were whether the MF: referred patients to another person or agency who then took responsibility for SAC coordination, was primarily responsible, or saw him/herself as part of a responsible team. Physicians were then asked how satisfied they were with the selected role on a four-point scale ranging from 1 (very satisfied) to 4 (very dissatisfied).

Finally, the FPs were asked about the performance of the regional SAC system in terms of the breadth of services available to patients, the ease of access to these services, and the degree of compatibility between different providers within the system. These three fundamental elements of service delivery must be present for a health system to be coordinated (i.e., function efficiently), according to the evaluative framework of Alter et al. [7].

In responding to each section, FPs were asked to think about cancer patients they had cared for in the past 6 months. Space was provided after most of the scaled response items for the MFs to elaborate or explain their responses.

The database and statistical processing of the data were performed and analyzed in the SPSS 26 statistical program (SPSS Inc., Chicago, IL, USA). Descriptive statistics were used for the results collection, presentation and interpretation. The significance level was set at 0.05 to consider the result significant.

Results

From a sample of 274 MFs, 175 responses were obtained, yielding an overall response rate of 64%. Table 1 reports the distribution and survey response rate for each physician group. Eighty-four MFs reported that they had had a patient with newly diagnosed cancer or receiving palliative care in their practice in the past six months.

Table 1. Surveydistribution and responses

	Mail survey	No response	Ineligible	Type of patient indicated in the practice
MF with palliative care patients	141	50	47	44
MF with newly diagnosed patients	133	49	44	40
Total	274	99	91	94

Source: Ownelaboration

FPs reported practicing in the region for a median of 15 years. Slightly more than half (51%) of the FPs had a solo practice, with the remainder indicating that they shared a practice. The mean FP practice size was 2000, with a median of 33 cancer patients.

A comparison of FPs characteristics (e.g., sex and years in practice) between respondents and non-respondents revealed no significant differences between these groups in the study region.

Overall, the proportions of physician provision for each type of service mirrored those of the assessment. Although it is assumed that if an FPs reported providing a particular SAC service need, some level of patient assessment occurred, this does not necessarily imply that this physician's assessment for that need occurred regularly; therefore, some FPs reported services they had provided but did not regularly assess.

The two groups of FPs varied in their assessment and informed provision (either provided directly or referred to a third party) for patients' SAC needs (Table 2). More FPs in the palliative group who were asked about their patients' SAC provided these services compared with those in the newly diagnosed group. Provision of SAC services associated with the psychosocial and informational domains of care tended to be the least considered. Less than two-thirds of FPs asked about their newly diagnosed cancer patients reported providing information about SAC services.

Table 2. Informed assessment of MFs and provision of SAC services.

	FPs regularly assess the need for				FPs supplying out of necessity			
	Newlydiagnosedpatients (n = 40)		Palliative care patients (n = 44)		Newlydiagnosedpatients (n = 40)		Palliative care patients (n = 44)	
SAC	Nro	%	Nro	%	Nro	%	Nro	%
Information about cancer and treatment.		65,0		84.1		77.5		77.3
InformationaboutSACservices		70.0		81.8		62.5		88.6
Emotionalsupport		77.5	42	95.5		85.0		86.4
Groupcounseling		42.5		56,8		45,0		63.6
Professional advice		45,0	28	63.6		47.5		61.4
NutritionalCounseling		62.5		84.1	28	70.0		81.8
Pain and symptommanagement		87.5		93.2		95.0		93.2
Nursing care		87.5		88.6		87.5	42	95.5
Homemaker or personal care support		92.5		93.2		92.5		93.2
Physicalrehabilitationservices		77.5		81.8		75,0		84.1
Home medical equipment or supplies		72.5		88.6		70.0		90,9
Transportationtoappointments		37.5		61.4		42.5		75,0
Hospice-based care	-	-		74.	-	-		87,

				4				2

Source: surveys and statistical analysis. p ≤0.05

Most FPs reported regularly assessing and providing pain and symptom control, nursing care, and home support in the newly diagnosed and palliative groups. However, assessment and provision were less frequently reported for the remaining types of services not yet mentioned, particularly in the newly diagnosed group.

Nearly 40% of the MFs in the newly diagnosed group reported that they referred these patients to another person or agency who then became responsible for coordinating SAC services. One-third of the MFs reported that they were part of a team responsible for coordinating SAC, and a smaller number of MFs (28%) described themselves as primarily responsible for coordinating patients' SAC.

In contrast, nearly half (46%) of the FPs who were asked about their cancer patients receiving palliative care reported that they were part of a team responsible for coordinating SAC. A quarter of the FPs reported that they referred these patients to another person or agency who then became responsible for coordinating SAC services, and 30% described themselves as primarily responsible. The breakdown of roles reported by palliative care specialists within the palliative group was similar to that reported by the rest. Most FPs (85%) reported being satisfied with their role in SAC coordination.

MostFPs (82% in the newly diagnosed group and 81% in the palliative group) reported that they were satisfied with the SAC services provided to their patients. In addition, half of the physicians felt that the required SAC services were available within the region. Nursing care and psychological and social support were the main services identified as inadequate. Physicians' suggestions for improving the system included the presence of a central coordinating body, increased resources, and more information for physicians about available SAC services.

Discussion

This study represents the first step toward understanding SAC patient-specific needs assessment and access to services through self-reported MF provision or referral for key types of services during the initial palliative and diagnostic phases of care. This study also provides information on important mitigating factors that may influence the level of assessment and access to services in the context of a typical Canadian health care service system from the perspective of FPs.

In our examination of FPs care delivery, we found that most of these physicians reported assessing and meeting their patients' SAC needs in terms of pain and symptom management, emotional support, nursing care, and home services; however, this level of care was not evident for needs such as group or professional counseling, nutritional counseling, and information about SAC services.

The location of patients in their disease trajectory influenced the role of MFs in patient care. Concerning the SAC needs to be examined in this study, a lower proportion of FPs in the newly diagnosed group assessed or provided these SAC services compared with those in the palliative group, with marked differences in emotional and psychosocial support services. Since 50% to 75% of cancer patients require specific ACS, and approximately one-third require expert psychosocial intervention, these care practices may represent a barrier to meeting their needs[8,9].

Research has shown that FPs and oncologists use more instrumental than socioemotional (i.e., psychosocial) communication in cancer consultations[10,11]. For example, in a recent US study in which FPs were interviewed about their involvement in the care of cancer patients, although all FPs played some role in pain management, only one-third reported providing emotional support. Another US study, from the perspective of cancer patients, found that

patients believed their FPwas an excellent source of educational support (with 91% providing educational services) but less for emotional support[12].

Most FPs were satisfied with their reported role in SAC coordination, although the identified role type varied. For example,FPs who were asked about patients receiving palliative care tended to see themselves as part of a coordinating team, whereas MFs who were asked about patients newly diagnosed with cancer were less likely to see themselves as SAC coordinators. This difference could be due to MFs feeling uncertain about how to help their patients navigate the cancer system after initial diagnosis,[13] a possibility that requires further investigation. In addition to the patient's stage of disease and physician preference, the variation in role among MFs has also been explained by the extent to which the specialist (e.g., oncologist) delegates responsibility to the MF[14].

In the study, the highest level of role satisfaction was expressed by physicians who reported being part of a coordinating team, suggesting that models that involve community physicians as team members rather than as sole SAC coordinators are more practical and ultimately more likely to be successful, leading to improvements in supportive care for patients. Enabling MFs to become more active in care coordination and supportive services requires consideration of how current reimbursement practices can be adjusted to reinforce change in MF practices[15,16].

An important observation in this study was that many MFs felt that SAC services for their patients were unavailable, particularly regarding psychosocial support and nursing care. This may have contributed to the reported gaps in these domains' assessment, provision, and referral. In addition, manyFPs were dissatisfied with the oncology system in terms of service delivery, reflecting the fragmentation problem; however, they were generally pleased with the SAC services their patients received. As expected, poor communication between health care providers and sites was another problem that emerged, consistent with the findings of Sargeantet al.[17], who found gaps in information transfer between FPs, community specialists, and oncologists, which interfered with the delivery of timely and compassionate care to patients. As a result, the FPs in the current study recommended a centralized body responsible for SAC planning in the region to improve the coordination of services[18].

A possible limitation of this study in using reported rather than observed practice data is respondent bias, with physicians exaggerating their involvement in providing SAC. However, physicians were quite forthcoming in indicating what they did and did not do, as evidenced by the low percentage of MFs who reported providing many of the types of SAC services and by the open-ended comments attached to the survey, in which physicians had few reservations about explaining their positions. The study did not consider the effects of patient characteristics (e.g., age, sex, education, income, and disease site) on the physician role, an area where other studies have found relationships[19,20]. For this research, it was reasoned that the role indicated by physicians would be the most common role applied to most of their patients.

Conclusions

Understanding how FPs can facilitate access through the assessment, provision, and referral of identified SAC services is essential to develop strategies to improve access to needed services and service providers in the community. FPs play an important role in cancer care; however, many MFs function in isolation from the cancer system. There is an emerging trend among oncologists and FPs to identify shared care as the most appropriate model for addressing the SAC needs of cancer patients. Research is needed to determine how best to integrate FPs into regional cancer programs to ensure optimal management of patients' SAC needs.

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