

# How did we facilitate a change of thoughts in Canada?

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**Canadians  
traveling to  
work**

# **Similarities between health care systems**

- **Universal health care coverage for citizens**
- **Primary care based**
- **Trying to improve access, quality and efficiency of care**
- **Major problem with wait times, especially for cancer patients**

# Objectives of the Presentation

- 1. Why do we consider cancer follow-up care to be important?**
- 2. Evaluation of a primary care based model of follow-up care**
- 3. Why is there reluctance (resistance) to change how we follow cancer patients?**
- 4. Conclusions**

# Objectives of the Presentation

- 1. Why do we consider cancer follow-up care to be important?**

# The Cancer Control Continuum



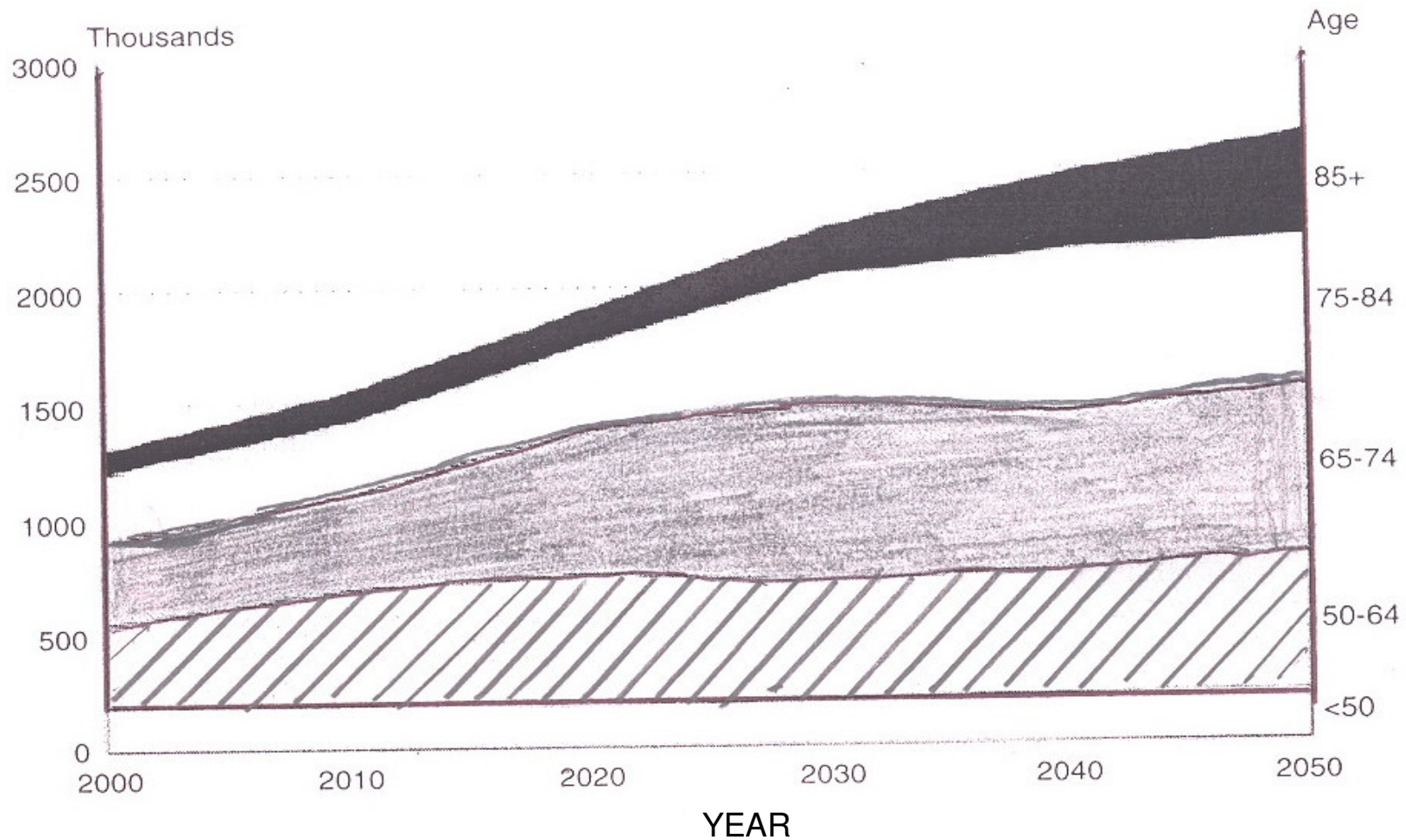
*Adapted from the Canadian Strategy for  
Cancer Control, 2005*

# Definition of Survivorship

**The period following first diagnosis and treatment and prior to the development of a recurrence of cancer or death.**

*From Cancer Patient to Cancer Survivor,  
Institute of Medicine, USA, 2006*

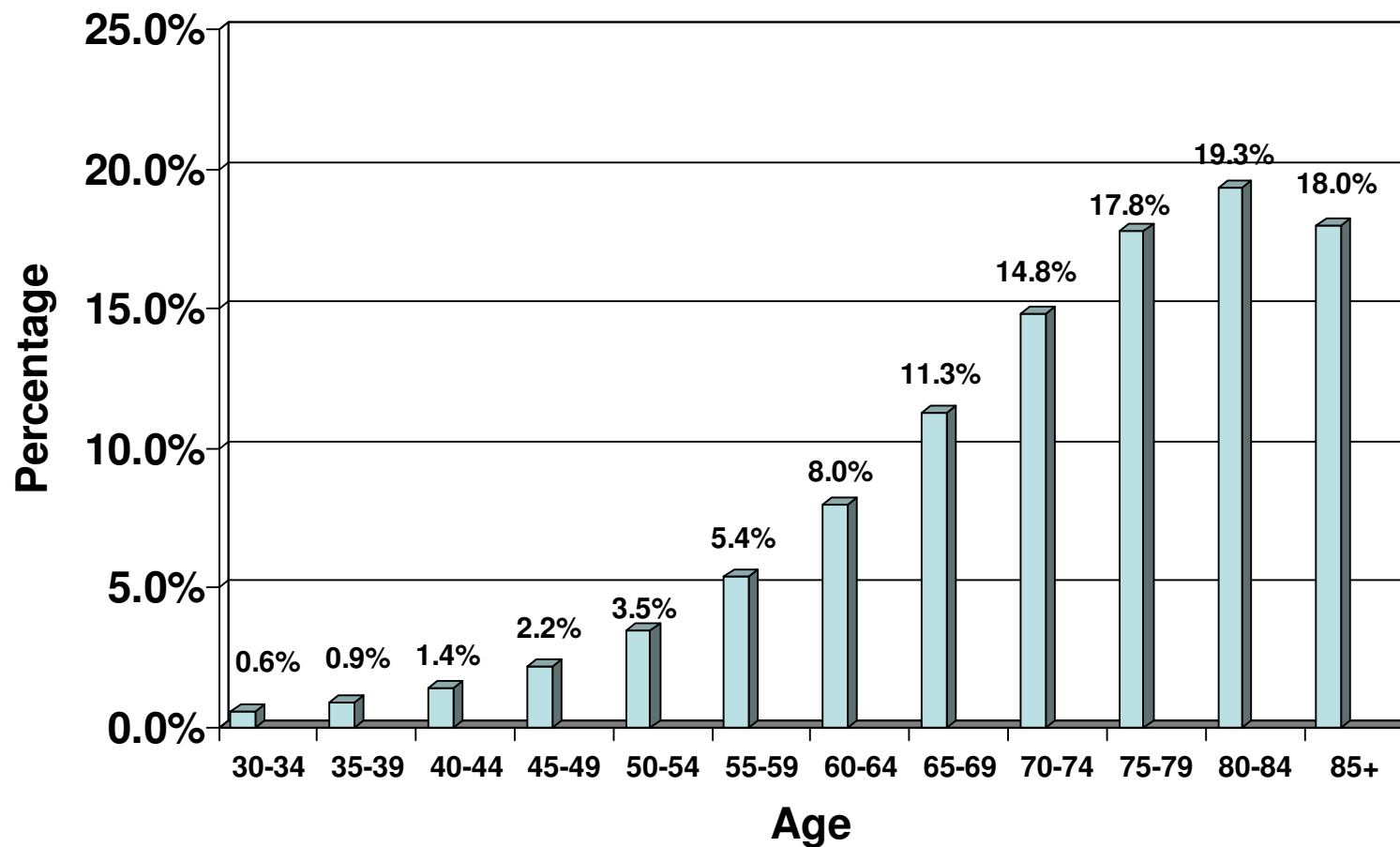
# Projected Number of Cancer Cases for 2000 through 2050



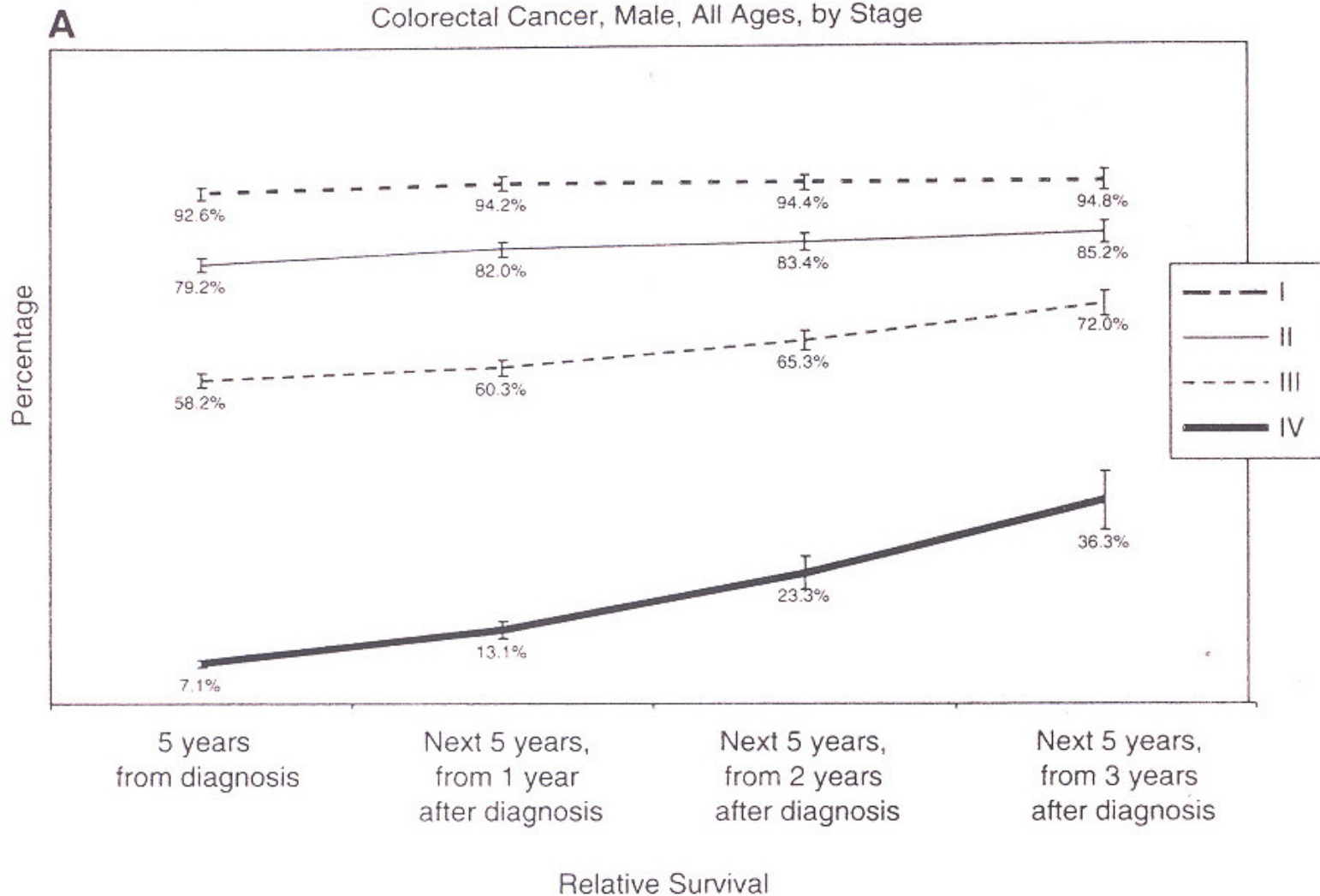
Incidence/year	5-year relative survival
■ Breast - 22,500	>80%
■ Colorectal - 20,800	≈60%
■ Prostate - 22,300	>80%
■ Lung - 23,300	<20%

**\*\* Canadian Cancer Statistics, 2007**

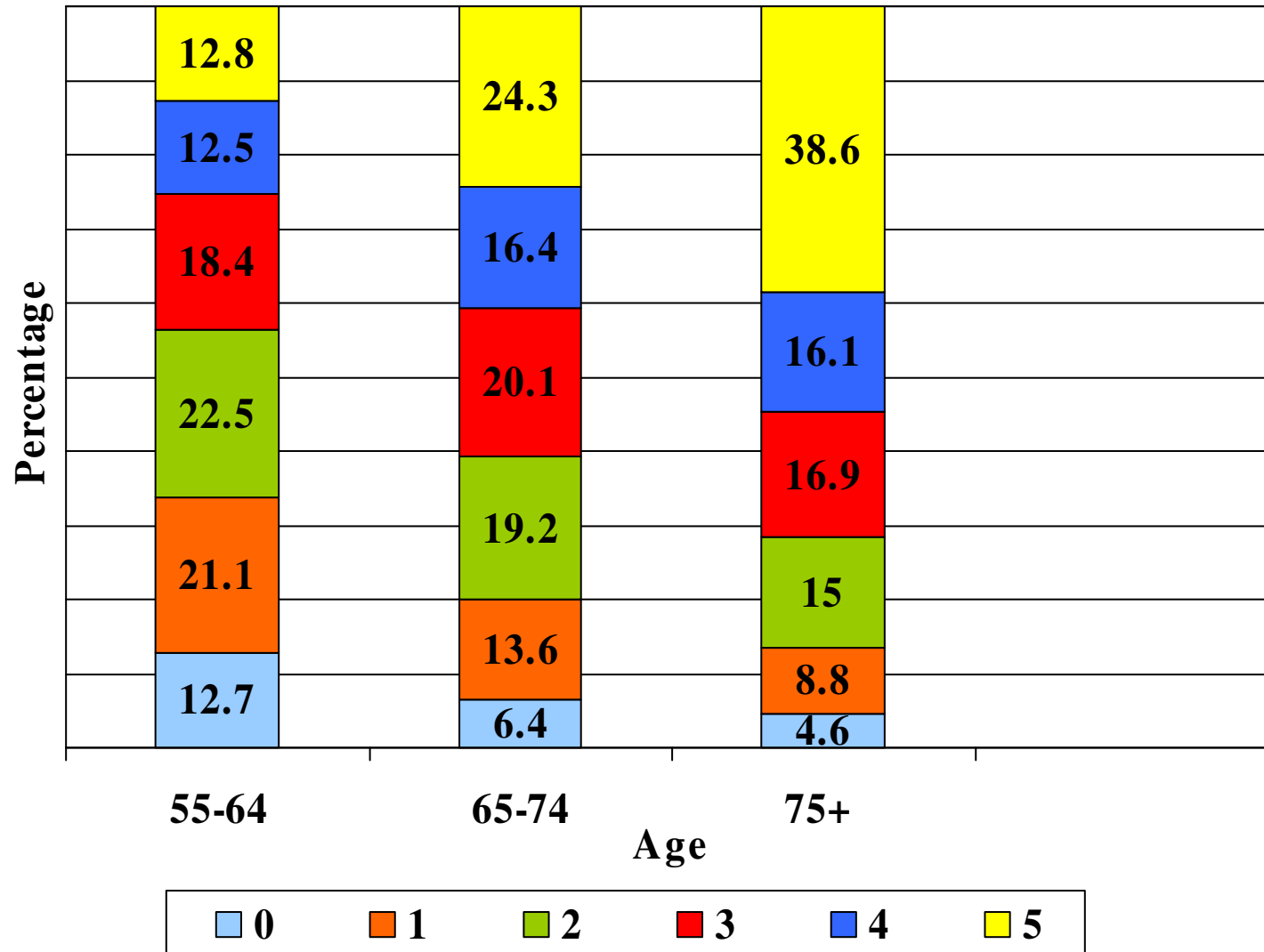
# Cancer prevalence by age



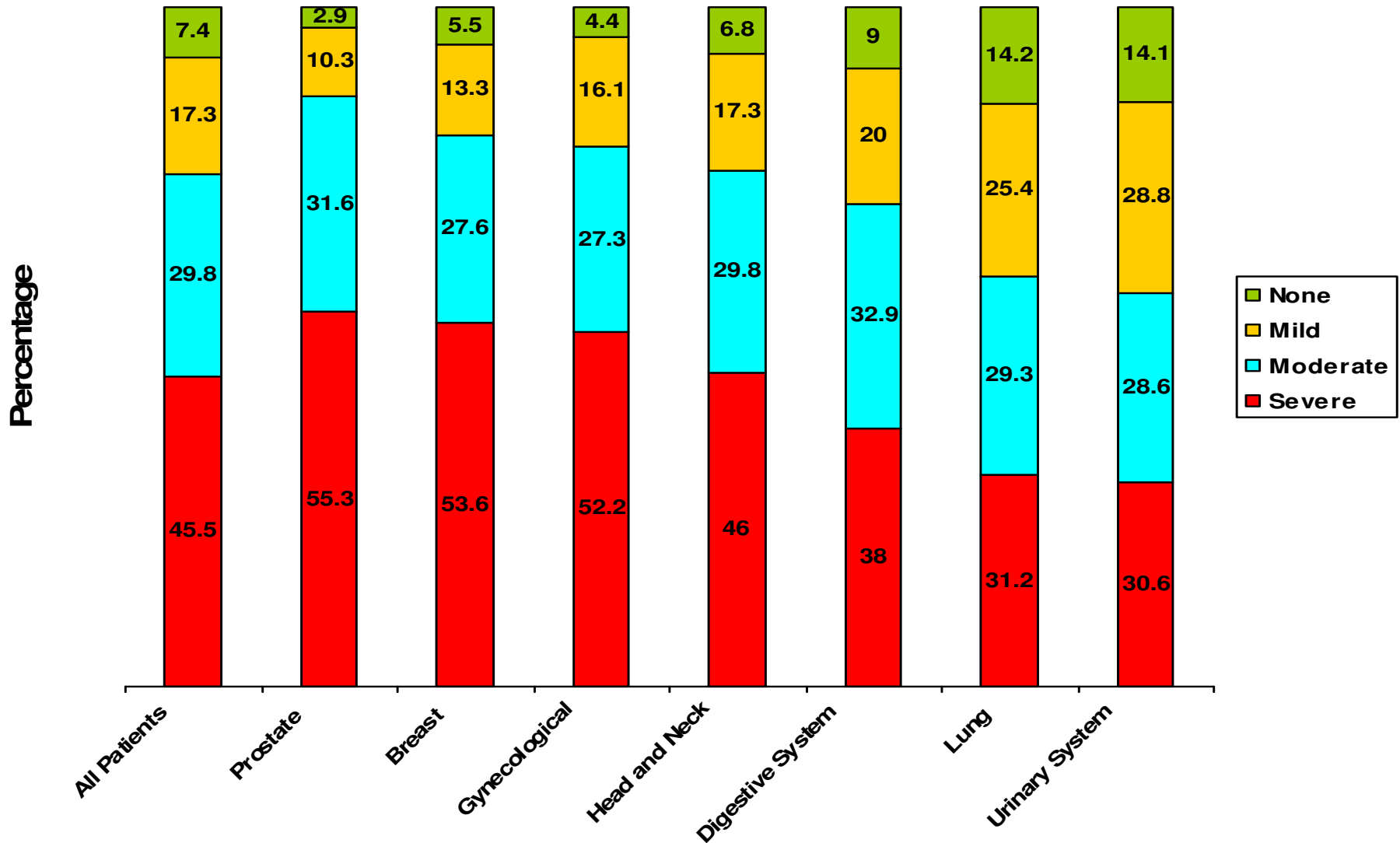
# Colorectal Cancer: Conditional relative survival



# Number of comorbidities by age



# Severity of comorbidity by cancer site



# Survivorship Issues

## **Routine follow-up care**

- **Surveillance for recurrence**
- **Surveillance for late effects of treatment**
- **Surveillance for new primary cancer**
- **Psychosocial issues**
- **Special concerns (social/economic/occupational)**

## **General medical and preventive care**

# Routine Follow-up

- **Frequency of visits**
  - ⇒ clinical examination
  - ⇒ signs and symptoms
- **Frequency of investigations**
- **Types of investigations**
  - ⇒ diagnostic imaging
  - ⇒ laboratory tests
- **Special issues**
  - ⇒ side effects of treatment or late effects

# Breast Cancer: Follow-up Guidelines

- All patients should have regular follow-up with clear allocation of responsibility
- Frequency of visits should be adjusted according to patient's needs
- Mammograms annually
- No other routine investigations
- Encourage patients to report new persistent symptoms
- Psychosocial support

*Clinical Practice Guidelines for Care and Treatment of Breast Cancer,  
Grunfeld et al, CMAJ 2006*

# **General Medical and Preventive Care (example of breast cancer)**

- **Management of comorbid conditions**
  - ⇒ heart disease, diabetes
- **Early diagnosis of new comorbid conditions**
- **Preventive health care**
  - ⇒ **Screening for other primary cancers**
    - new breast primary, colorectal cancer, ovarian cancer
  - ⇒ **Screening for other chronic diseases**
    - osteoporosis, hypertension, hyperlipidemia

# Objectives of the Presentation

**1. Why do we consider cancer follow-up care to be important?**

**2. Evaluation of a primary care based model of follow-up care.**

**3. Why is there reluctance (resistance to change how we follow cancer patients?**

**4. Conclusions**

# Models of Follow-up Care Tested

<u>Model</u>	<u>Design</u>	<u>Comments</u>
<b>Nurse-based</b>		
James 1994	Observational	pilot; no clinical outcomes
<b>Primary-care based</b>		
Grunfeld 1996	RCT	clinical, QL, satisfaction, costs
Grunfeld 2005	RCT	clinical, QL, satisfactions, costs
Grunfeld 2007	RCT	evaluating care plan - ongoing
Wattchow 2006	RCT	QL and patterns of care (CRC)
<b>Specialist based</b>		
GIVIO 1994	RCT	survival, QL
Del Turco	RCT	survival
<b>Patient initiated</b>		
Gulliford 1997	RCT	pilot; no clinical outcomes
Brown 2001	RCT	QL: satisfaction
<b>No follow-up</b>		
Jacob 2001	Markov model	73d ↑ in life expectancy

## Overall objective of the research program

*To determine whether family physician (FP) based routine follow-up of women with breast cancer is an acceptable alternative to the existing system of specialist based follow-up.*

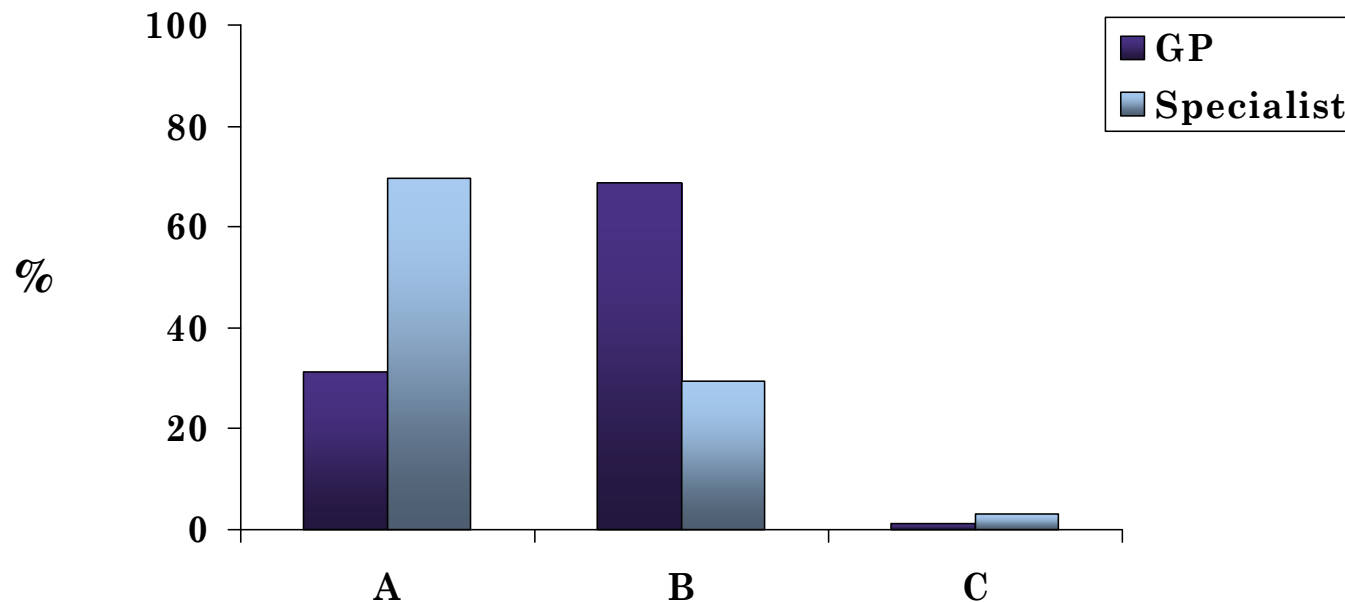
# Testing a Primary Care Model of Breast Cancer Follow-up Care

<b>Study</b>	<b>Years</b>	<b>Methods</b>	<b>Subjects</b>
<b>Phase I</b>	<b>1991-1992</b>	<b>Focus Groups</b>	<b>Patients (England)</b>
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<b>Phase IV</b>	<b>2007 +</b>	<b>RCT (n=400)</b>	<b>Canadian Patients</b>

# Testing a Primary Care Model of Breast Cancer Follow-up Care

STUDY	YEARS	METHODS	SUBJECTS
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# Comparison of PCP and Specialist Responses: The “most preferred” system of follow-up



**A = Routine follow up in oncology clinics, according to usual practice**

**B = Routine follow-up by patient's GP, referral to specialist if problems**

**C = No routine follow-up. Patients' to contact doctor if any problems develop**

# Patient Interview Study

- **109/145 = 78% response rate**
- **Qualitative analysis**
- **Patients in specialists care**
- **3 Themes identified**
  - ⇒ **Continuity of care**
  - ⇒ **Access to specialist care when needed**
  - ⇒ **Quality of the Consultation**

*Adewuyi-Dalton et al, Psycho-Onc 1998*

# Quotes

- *I have more confidence in my own GP that I know than seeing different people all the time.*
- *It is difficult to ask a strange person questions - you need to get to know them first - but they don't give you that time.*
- *I think for the first nine months I was happy with the hospital. I would not have wanted to be followed up by my GP in the initial stages.*
- *They ask are you all right, then by the time you have said yes they turn and have gone.*

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## Phase II: UK RCT of PCP vs Specialist Follow-up

- *Setting:*
  - ⇒ two district general hospitals in England
- *Participants:*
  - ⇒ 296 women with breast cancer on follow-up through specialist clinics
  - ⇒ 18 month study period
- *Randomization:*
  - ⇒ Group 1 – continued specialist follow-up
  - ⇒ Group 2 – follow-up from their own PCP

# Results – Phase II

Randomized Trial (18 months follow-up)	Trial Group		Difference (95%CI)
	GP n = 148	Specialist n = 141	
Time to diagnosis of recurrence (days)	22 days	21 days	1.5 (-13 to 22)
Total time with the patient (min)	35.6	20.7	14.9* (11.3 to 18.4)
Cost per patient (£s)	65	195	- 130 * (-149 to -112)
Time cost to the patient (min)	53	82	- 29 * (-37 to -23)

- No difference in health-related quality of life over time
- No difference in anxiety or depression over time
- PCP patients more satisfied

\*p<0.001

*Grunfeld et al BMJ 1996*

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## Patients

- Early stage breast cancer
- Completed adjuvant therapy (continued Tamoxifen)
- Disease free
- 9-15 months post-diagnosis



## FP Group

- Follow-up by patient's FP
- Guideline (1 page)
- Refer back to CC if recurrence or new cancer

## CC Group

- Follow-up at cancer center
- Usual practice

# Follow-Up Guideline Sent to Family Physicians

## Principal objectives of follow-up:

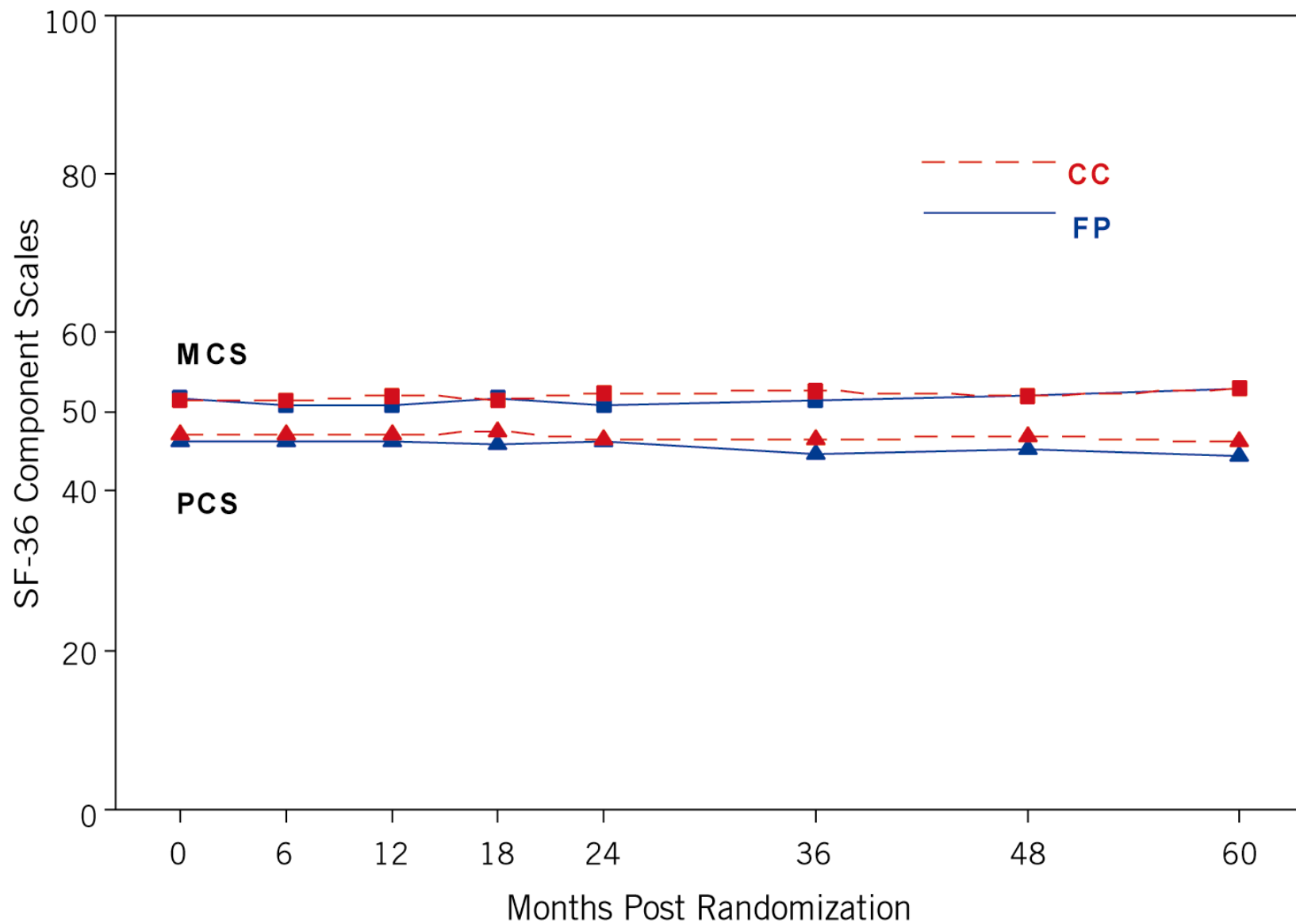
1. To provide support and counseling to the patient and her family
2. To detect local or regional recurrences and initiate treatment promptly
3. To detect metastatic disease and initiate appropriate treatment promptly
4. To detect new primaries in the contralateral breast

## Recommended follow-up plan:

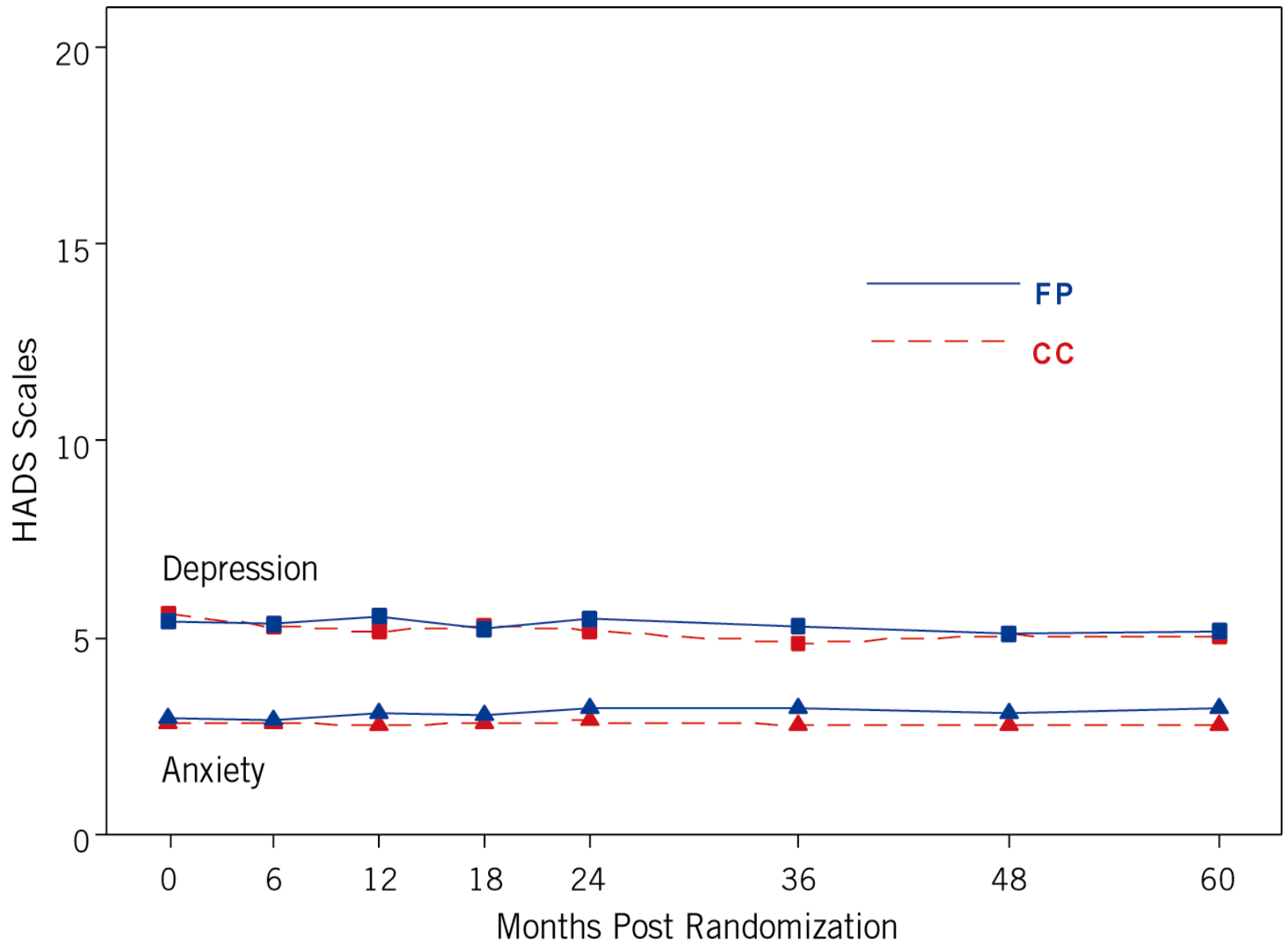
Physical examination and medical history	<ul style="list-style-type: none"><li>• Years 1, 2 and 3 - every 3-6 months</li><li>• Years 4 and 5 - every 6 months</li><li>• Years 6+ (indefinitely) - annually</li></ul>
<ul style="list-style-type: none"><li>➤ The physical examination and medical history should be targeted towards identification of signs or symptoms suggestive of recurrence or contralateral breast cancer.<ul style="list-style-type: none"><li>• locoregional recurrence - examination of ipsilateral breast, axilla and supraclavicular lymph nodes, and chest wall (for women with mastectomy)</li><li>• systemic recurrence<ul style="list-style-type: none"><li>- pulmonary abnormalities (cough or shortness of breath)</li><li>- hepatomegaly, nausea or vomiting, unexplained weight loss</li><li>- bone pain or bone tenderness</li><li>- neurological abnormalities</li></ul></li><li>• contralateral<ul style="list-style-type: none"><li>- examination of contralateral breast and regional lymph nodes</li></ul></li></ul></li><li>➤ All patients should be encouraged to make an earlier appointment if they develop any signs or symptoms suggestive of recurrence between routine follow-up visits.</li><li>➤ The frequency of visits can be tailored to the needs of individual patients. Some patients will require more frequent visits for reassurance and psychosocial support, or if they cannot be relied upon to return early if they develop signs or symptoms of recurrence.</li></ul>	
Mammograms	<ul style="list-style-type: none"><li>• Annually (indefinitely)</li></ul>
<ul style="list-style-type: none"><li>➤ Annual mammography is complementary to physical examination. If a breast abnormality is detected on physical examination it should be investigated further, even in the context of a normal mammogram.</li></ul>	
Routine laboratory and radiological tests	<ul style="list-style-type: none"><li>• As clinically indicated by signs or symptoms</li></ul>
<ul style="list-style-type: none"><li>➤ Routine diagnostic tests (such as LFTs, chest x-rays, liver ultrasound) are not recommended. However, these should be performed as indicated to fully investigate signs or symptoms suspicious of recurrent or new primary disease.</li></ul>	
Pelvic examination	<ul style="list-style-type: none"><li>• Annually</li></ul>
<ul style="list-style-type: none"><li>➤ Women on adjuvant tamoxifen should have an annual pelvic examination and should be asked about vaginal discharge or bleeding because of increased risk of endometrial cancer.</li></ul>	

<b>Characteristic</b>	<b>Family Physician Group (N=483) no.(%)</b>	<b>Cancer Centre Group (N=485) no.(%)</b>
<b>Age at Enrollment (yr):</b>		
< 40	21 (5)	17 (4)
40-49	79 (16)	82 (17)
50-59	136 (28)	113 (23)
60-69	119 (25)	143 (30)
≥ 70	128 (27)	130 (27)
mean (minimum-maximum)	60.9 (25-89)	60.9 (32-92)
<b>Education:</b>		
< secondary	140 (29)	141 (29)
completed secondary	126 (26)	148 (31)
post-secondary	208 (43)	189 (39)
<b>Marital Status:</b>		
single	26 (5)	28 (6)
married/cohabiting	319 (66)	323 (67)
widow	90 (19)	90 (18)
separated/divorced	48 (10)	44 (9)
<b>Tumour Size (cm):</b>		
0-2	349 (72)	340 (70)
>2-5	124 (26)	130 (27)
>5	5 (1)	9 (2)
<b>Nodes positive:</b>		
0	337 (70)	328 (68)
1-3	82 (17)	90 (18)
4 or more	22 (5)	22 (5)
unknown	42 (9)	45 (9)
<b>Tumour grade:</b>		
1	157 (32)	148 (30)
2	178 (37)	199 (41)
3	102 (21)	105 (22)
unknown	46 (10)	33 (7)
<b>ER status:</b>		
positive	345 (71)	339 (70)
borderline	15 (3)	15 (3)
negative	93 (19)	95 (20)
not done	30 (6)	36 (7)
<b>Type of surgery:</b>		
lumpectomy	358 (74)	352 (73)
mastectomy	93 (20)	95 (20)
biopsy only	31 (6)	37 (7)
<b>Treatment:</b>		
radiation	361 (75)	388 (80)
chemotherapy	132 (27)	121 (25)
hormones	240 (50)	275 (57)
none	35 (7)	20 (4)

<b>Outcome Event</b>	<b>Family Physician (FP) Group (n=483)</b>	<b>Cancer Centre (CC) Group (n=485)</b>	<b>Risk Difference CC – FP (95% CI)</b>
<b>Number of Patients (%)</b>			
<b>Recurrence</b>	<b>54 (11.2%)</b>	<b>64 (13.2%)</b>	<b>2.02%</b>
<b>Distant</b>	<b>36</b>	<b>38</b>	<b>(-2.13, 6.16)</b>
<b>Local</b>	<b>10</b>	<b>12</b>	
<b>Contralateral</b>	<b>11</b>	<b>15</b>	
<b>Death (All Causes)</b>	<b>29 (6.0%)</b>	<b>30 (6.2%)</b>	<b>0.18%</b> <b>(-2.90, 3.26)</b>
<b>Serious Clinical Events</b>	<b>17 (3.5%)</b>	<b>18 (3.7%)</b>	<b>0.19%</b> <b>(-2.26, 2.65)</b>
<b>Spinal Cord compression</b>	<b>0</b>	<b>1</b>	
<b>Pathological fracture</b>	<b>3</b>	<b>8</b>	
<b>Uncontrolled local recurrence</b>	<b>2</b>	<b>0</b>	
<b>KPS ≤ 70</b>	<b>14</b>	<b>18</b>	
<b>Brachial plexopathy</b>	<b>0</b>	<b>0</b>	
<b>Hypercalcemia<sup>b</sup></b>	<b>2</b>	<b>2</b>	
<b>35 SCEs over 3,240 patient years</b>			

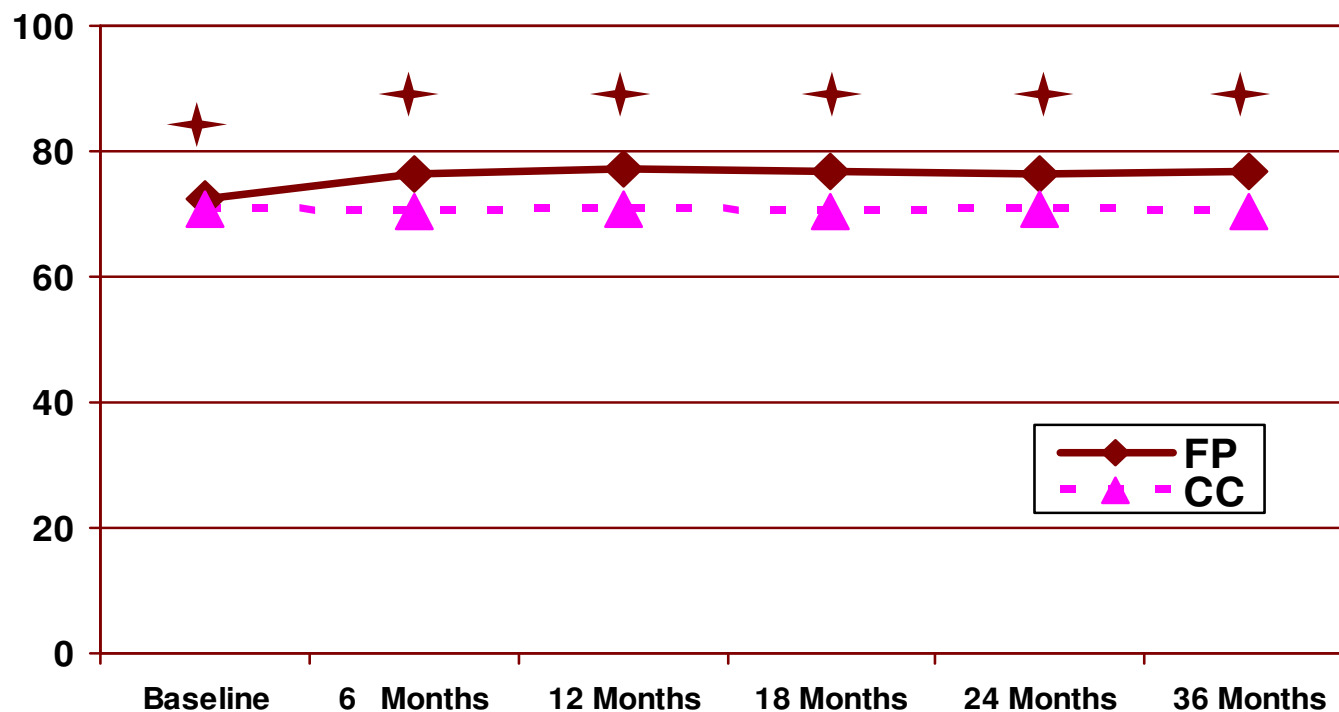


Number of Responses	CC:	468	438	425	394	384	292	187	101
	FP:	467	427	415	390	369	275	184	104



Number of	FP:	472	438	418	394	372	278	189	107
Responses	CC:	478	443	430	405	394	300	193	108

# PSQ Mean Scores from Baseline to 3 years



★ p < 0.0001

Number of Responses	CC	475	439	423	400	389	296
	FP	469	433	411	386	371	277

# Conclusions

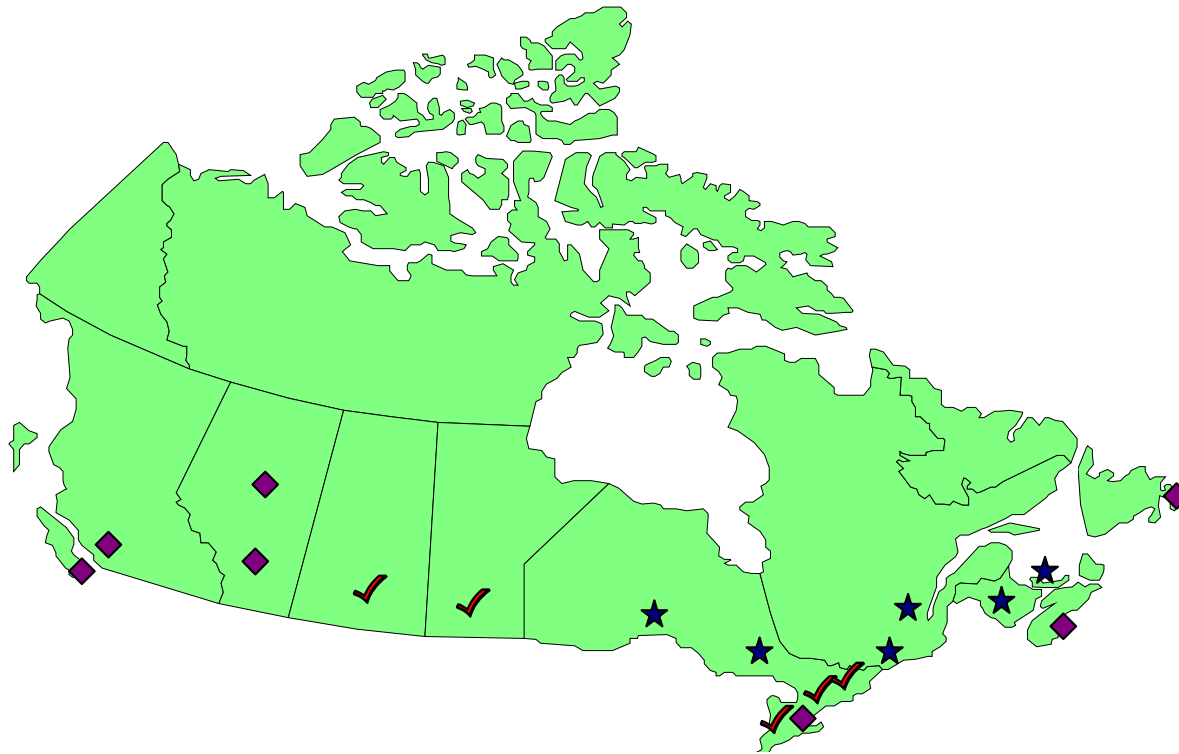
**For woman with early stage breast cancer PCP follow-up is a safe and acceptable alternative to the existing practice of specialist follow-up.**

- **no difference in clinical outcomes**
  - **no difference in QL outcomes**
  - **patient satisfaction is higher**
  - **patient costs are less**
- **These results have now been shown into two RCTs in two different health care settings.**
  - **Patients should make an informed choice about their follow-up arrangements.**

# Testing a Primary Care Model of Breast Cancer Follow-up Care

STUDY	YEARS	METHODS	SUBJECTS
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# Current Follow-Up Practices at Selected Cancer Centres in Canada



- ★ Longterm in cancer centre
- ◆ Transfer of Care to FP
- ✓ Variable

# Phase IV: Implementation Study

- **Overall Objective:**

- ⇒ **To determine if a survivorship care plan for breast cancer survivors who are ready for transition from specialist care to primary care improves patient and health service outcomes**

- **Design:**

- ⇒ **Multicentre RCT**

# What is a Survivorship Care Plan?

- **Identifying information (patient and provider)**
- **Cancer treatment summary**
- **Diagnostic tests completed**
- **Risk of recurrence**
- **Signs and symptoms**
- **Recommended surveillance guidelines**
- **Potential late effects**
- **Preventive care recommendations**

# Phase IV: Implementation Study

- **Patients:**

- ⇒ **200 < 24 months post diagnosis**

- ⇒ **200 ≥ 24 months post diagnosis**

- **Intervention:**

- ⇒ **Guideline for family physician**

- ⇒ **Guideline for patient**

- ⇒ **Educational session for patient (30 minutes)**

- ⇒ **Survivorship care plan for patient (copy sent to the family physician)**

# Study schema

Control Group	Experimental Group
<ul style="list-style-type: none"><li>▪ Follow-up care transferred to the patient's PCP</li> <li>▪ Patients and PCPs instructed to schedule the first follow-up visit in approximately 3 months</li></ul>	<ul style="list-style-type: none"><li>▪ Follow-up transferred to the patient's PCP <i>plus</i> educational session and care plan</li> <li>▪ Educational materials sent to PCP (letter, user friendly guideline, copy of patient's care plan, CMAJ guideline and reminder table)</li> <li>▪ Patients and PCPs instructed to schedule the first follow-up visit in approximately 3 months</li></ul>

# **Patterns of follow-up care in Ontario**

**Objective: To gain a better understanding of the patterns of routine follow-up care provided to cancer survivors. Specifically to:**

- ⇒ describe the frequency of surveillance visits**
- ⇒ describe the frequency of surveillance tests**
- ⇒ describe the frequency of cancer screening**
- ⇒ assess adherence to guidelines**
- ⇒ assess differences by age and income**

# Methods

- **Retrospective longitudinal population based cohort study using linked administrative health databases**
- **Newly diagnosed breast, Hodgkin's lymphoma, endometrial, and colorectal cancers**
- **Follow-up period defined as starting 1 year from the date of diagnosis**

# Objectives of the Presentation

1. Why do we consider cancer follow-up care to be important?
2. Evaluating a primary care based model of follow-up care.
3. Why is there reluctance (resistance) to change how we follow cancer patients?

# Reason # 1

**It is clinically important.**

- ⇒ **improved survival**
- ⇒ **early detection of recurrence**
- ⇒ **early detection of new primary cancers**
- ⇒ **detecting late effects**

# **It is clinically important**

- **Research required to understand the different types of cancer**
- **For breast cancer, only mammograms have been shown to be clinically important**
  - ⇒ **3 RCTs (GIVIO, del Turco, and Grunfeld)**
- **For most cancers studied, recurrences are interval events identified by signs and symptoms**

# Breast Cancer: Diagnosis of Recurrence

		Interval or symptomatic (%)
▪ Tomlin	1987	64
▪ Zwaveling	1987	73
▪ Rutgers	1989	77 (distant)
▪ Ciatto	1985	58
▪ Ormistan	1985	78
▪ Valagussa	1981	78
▪ Stierer	1989	40 (distant)
▪ Pandya	1985	54
▪ Scanton	1980	73
▪ Winchester	1979	91
▪ Grunfeld	1997	69*
▪ Woster	1995	77*
▪ Donnelly	2002	74*
▪ te Boekhorst	2001	63

\* Identified as interval event

*Tomiak Ann Oncol 1993*

## **Reason # 2**

**It is important for research and medical audit (e.g., frequency of recurrence, new primary cancer, late effects).**

- **most cancer clinics do not know their own outcomes**
- **requires rigorous, standardized, comprehensive, and analyzable data**
- **only approximately 5% of cancer patients are actually enrolled in clinical research**

## **Reason # 3**

**A change is unacceptable to patients.**

⇒ **“my patients will not accept an alternative”**

# Patients' views

- **60%** of breast cancer patients state they would contact their PCP if they had problems
- **63%** of patients presented to FP with symptoms
- **56%** of patients participated in the Canadian trial
- **67%** of patients participated in UK trial
- **patient interview study in UK found 3 themes important: continuity of care, access to specialist when needed, and quality of the consultation**
- **several studies found patients prefer status quo because they believe it is clinically important**
- **studies have shown that patients are confused about who is responsible for what during follow-up**

## **Reason # 4**

**A change is unacceptable to primary care physicians (PCPs).**

⇒ **“Family physicians/general practitioners will not agree to accept responsibility for follow-up.”**

# Primary Care Physicians' (PCP) views

- **53% of PCPs have been involved**
- **90% of PCPs would accept responsibility for follow-up**
- **90% agreed to provide exclusive follow-up in the UK trial**
- **84% agreed to provide exclusive follow-up in the Canadian trial**

## Percent Willing to Provide Exclusive Cancer Follow-up: Results from a Canadian National Survey of PCPs<sup>1</sup>

Cancer	≤2yrs	3 to 5 yrs	10 <sup>+</sup> or never
<b>Prostate</b>	<b>55.3</b>	<b>35.4</b>	<b>8.1</b>
<b>Colorectal</b>	<b>49.8</b>	<b>33.4</b>	<b>15.4</b>
<b>Breast</b>	<b>50.0</b>	<b>40.5</b>	<b>7.7</b>
<b>Lymphoma</b>	<b>42.0</b>	<b>41.6</b>	<b>15.4</b>

**1. Current experience providing exclusive follow-up most significant predictor of willingness.**

Del Giudice, Grunfeld, et al, 2009

# Views of Primary Care Physicians (PCP) on Follow-up

	% Agreeing		
	Can <sup>1</sup> PCP	UK <sup>2</sup> PCP	UK <sup>2</sup> Specialist
PCPs are better placed to provide psychological support	79.8	81.7	24.6
PCPs should be involved at an earlier stage in follow-up	63.7	-	-
PCPs have the necessary skills	69.1	68.9	37.6
Patients will not be adequately reassured by PCP follow-up	39.2	18.4	48.4
Patients expect to be followed by cancer specialist	71.7	63.5	85.7

1. Del Giudice, Grunfeld et al, 2009

2. Grunfeld, Mant et al, 1995

## Usefulness of various modalities to help PCPs provide exclusive cancer follow-up

Rank	Modality	%
1	Patient-specific standardized letter with guidelines	95.4
2	Printed guidelines	91.8
3	Expedited rates of re-referral	92.7
4	Expedited access to test for suspected recurrence	91.1
5	Ability to telephone\email specialist for advice	86.1

Del Giudice, Grunfeld, et al, 2009

## **Reason # 4**

**A change is unacceptable to the oncology team.**

- ⇒ **seeing the success of treatment is important for the oncology team**
- ⇒ **seeing only sick or dying patients would overwhelm the oncology team**
- ⇒ **seeing patients who are “successes” is important for the other patients in the clinic**

# Cancer care staff 'burned out'

Study shows doctors, nurses exhausted by soaring workload; consider leaving for other jobs

BY SI

NATIONAL POST, TUESDAY, JULY 25, 2000

Doctors in Ontario's cancer care system are burned out and exhausted, a study says. They are getting out just as fast as they are coming in. Or, with a serious illness, cancer workers

## Burnout overwhelms cancer workers

Ontario study finds they're harder hit than even ER staff

BY BRAD EVENSON

More than a third of Ontario cancer care workers are considering quitting or cutting their work

ments have been developed and screening has become more widespread, particularly in the past five years. As a result, the number of people entering the cancer care system is increasing at about 7% a year.

"People are living longer, and there are more treatments for people when they are in the end stage of their disease," says study co-author Dr. Eva Grunfeld, a

THE GLOBE AND MAIL

## Cancer workers burnt-out, study says

Doctors complain of emotional fatigue

Canadian Press, Toronto

Doctors and health-care workers treating cancer patients in Ontario are experiencing worrisome levels of burnout, a study published yesterday in the Canadian Medical Association Journal warns.

## Cancer centre staff face burnout

Study prompts fear staff may leave Hamilton

By SUZANNE MORRISON  
Medical Research Reporter  
The Hamilton Spectator

Hamilton is in danger of losing highly skilled cancer doctors and health care workers who are coping with job burnout and emotional exhaustion.

edly reflect on the quality of care, because cancer patients expect and need that kind of emotional support."

Slightly fewer than half of the doctors said they have seriously considered cutting back on their hours, taking early retirement, moving to another province or getting out of the field entirely. Thirty-seven per cent of nurses and other health professionals said they have thought of leaving for a job outside of cancer care.

Although the study didn't measure it, doctors and nurses told the researchers they kno

# Acceptability to oncology team

- **82% of surgeons agreed to transfer patients to exclusive PCP follow-up in the Canadian trial**
- **80% of oncologists agreed to transfer patients to exclusive PCP follow-up in the Canadian trial**
- **“It’s not about you”**

# Guideline Statements

## ASCO 2005 update

*Based on two RCTs .. follow-up by a PCP appears to lead to the same health outcomes as specialist follow-up with good patient satisfaction. There is no reason to think that US patients will be any different.*

## Canadian 2005

*“responsibility for follow-up should be formally allocated to a single physician, with the patient participating as much as possible”*

## Comparison between patients, PCPs, and oncologists on respective role in follow-up (%)

<b>Expected role of physician</b>	<b>PCP</b>	<b>Oncologist</b>	<b>Patient<sup>1</sup></b>
<b>Follow-up for cancer recurrence</b>			
<b>Fully\mainly by oncologist</b>	<b>3</b>	<b>98</b>	<b>91</b>
<b>Fully\mainly by PCP</b>	<b>67</b>	<b>0</b>	<b>33</b>
<b>Screening for other cancer</b>			
<b>Fully\mainly by oncologist</b>	<b>2</b>	<b>24</b>	<b>65</b>
<b>Fully\mainly by PCP</b>	<b>96</b>	<b>44</b>	<b>81</b>
<b>General preventive care</b>			
<b>Fully\mainly by oncologist</b>	<b>2</b>	<b>4</b>	<b>16</b>
<b>Fully\mainly by PCP</b>	<b>97</b>	<b>52</b>	<b>93</b>

Cheung et al. 2009

1. Numbers do not sum 100% because of difference in paired samples

# Objectives of the Presentation

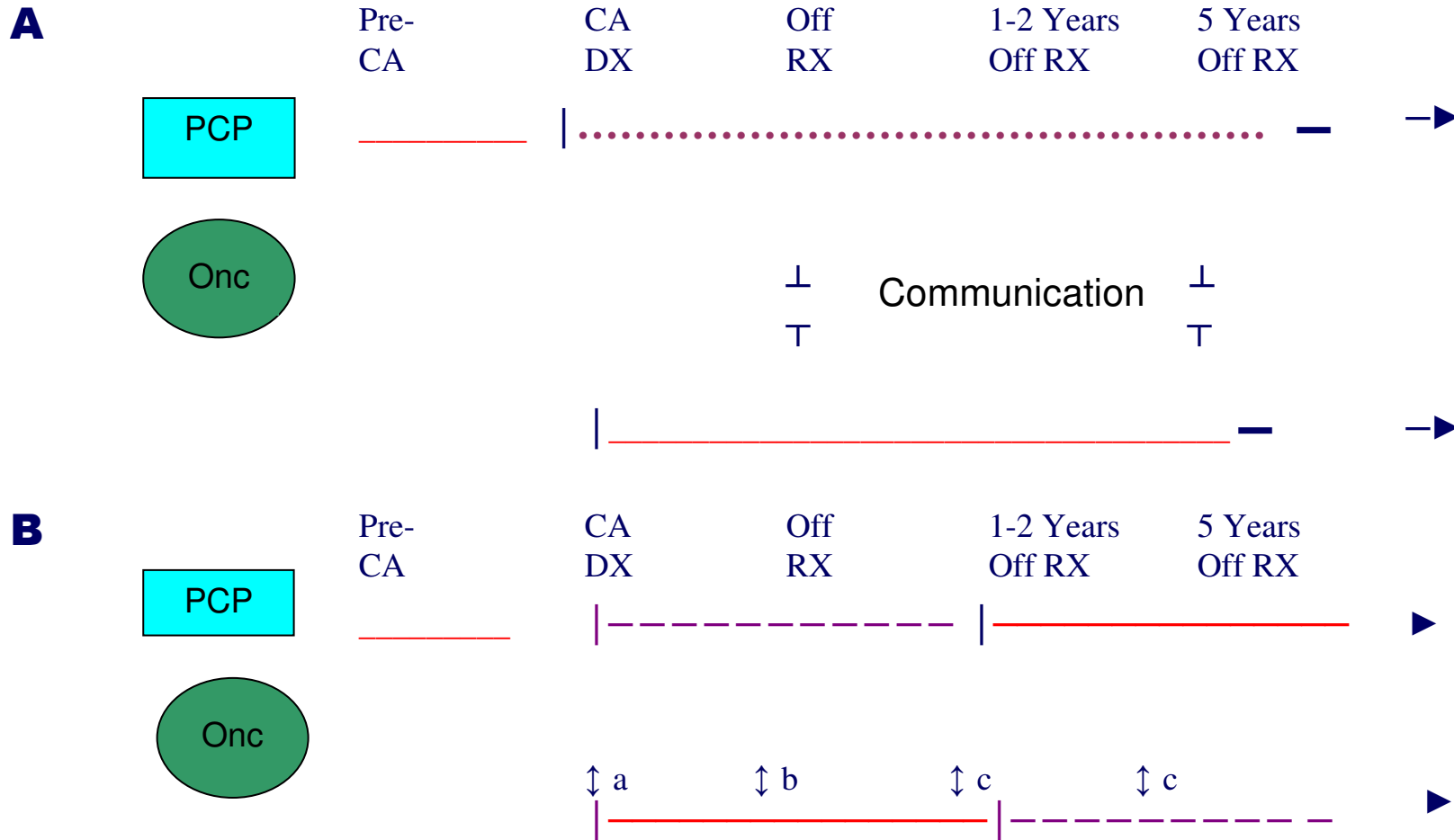
1. Why do we consider cancer follow-up care to be important?
2. Evaluation a primary care based model of follow-up care.
3. Why is there reluctance (resistance) to change how we follow cancer patients?

## 4. Conclusions

# Conclusions

- **Growing prevalence of cancer survivors**
- **Strain on cancer care resources**
- **Change in perspective from acute life threatening disease to chronic disease**
  - ⇒ **greater importance of other general medical and preventive health care**
- **Guidelines on follow-up care needed**
- **Survivorship care plans a valuable tool**
- **Evaluation of models of follow-up care**

# Models for Delivering Survivorship Care



- Cancer diagnosis, stage and/or TNM classification, planned therapeutic approach, brief overview of chemotherapy, radiation therapy, and/or surgery.
- Survivorship Care Plan*: summary of cancer and cancer therapy, a list of potential late effects, up-to-date recommendations for monitoring for recurrence and late effects, contact information
- Continued update with changes in surveillance recommendations and new information regarding potential late effects.