Defining the role of GPOs

Pinch hitters or team players?

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At the Canadian Association of General Practitioners in Oncology (CAGPO) 8th annual meeting in Quebec City this past October, Dr. Jeff Sisler, former chair of CAGPO, presented the results of the National Survey of General Practitioners in Oncology (hereafter referred to as GPOs) conducted in the Spring of 2011. The purpose of the survey, according to Dr. Sisler, was to profile GPOs in order to better understand “who we are, what we do and what we aspire to do.”

Hearing Dr. Sisler’s presentation caused me to reflect upon my own personal experience as a GPO and my present struggle to define my role in my cancer care clinic before this role is defined for me.

SURVEY RESULTS: GPOS REPORT MULTIPLE ROLES IN CANCER CARE

The CAGPO survey results, answered by 100 Canadian GPOs, make it clear that GPOs are providing care for cancer patients in different types of settings across Canada. In some situations, GPOs work independently with telephone support from medical and radiation oncologists in larger centres. These GPOs make it possible for patients to receive their chemotherapy treatments closer to home and increase the greater likelihood of treatment that meets standards of care. In years past, these patients may have decided to forgo chemotherapy as it was logistically too difficult. In other settings, GPOs act as specialized hospitalists providing in-hospital care to cancer patients who have been admitted due to side effects from their treatment or uncontrolled symptoms from their underlying diagnosis. In yet other situations, GPOs assist medical oncologists by supervising chemotherapy prescribed by the medical oncologist. This frees up time for the medical oncologist to see new consults or provide advice on managing more complex patients. GPOs can also assist in providing followup care once patients have completed either chemotherapy or radiation therapy. Studies have shown that general practitioners are well suited for these roles and, by providing this care, they can help ease the burden on the cancer care system. There are also some highly specialized GPOs who work in outpatient transplant clinics and on in-hospital transplant wards as part of a multidisciplinary team.

GPOS: COMANAGERS OR BACK-UP FOR BUSY/ABSENT ONCOLOGISTS?

My own personal experience has been to provide outpatient cancer care. Initially I was hired to fill the gap when the solo practicing medical oncologist left our catchment community of 150,000 to join a new regional cancer clinic. I worked mostly solo with telephone support from medical and radiation oncologists from 2 different regional cancer centres. I felt then that my role was well defined: I supervised both adjuvant and palliative chemotherapy prescribed by medical oncologists from one of the tertiary care cancer clinics, and I saw patients (including those previously cared for by my predecessor) on a followup basis after therapy completion.

However, since my first working days as a GPO, the cancer clinic where I practice has undergone major changes. Within a year of starting to work full time as a GPO, medical oncologists from the new cancer clinic began to travel to our clinic — at first once a week and then progressing to several times a week to run clinics where they saw new patients in consultation, supervised chemotherapy and followed their own patients. Now there are medical oncologists present in the clinic every day of the week — sometimes 2 or 3 on any given day. Radiation oncologists likewise are now present in the clinic at least 4 days a week with plans to bring a radiation bunker to our community and provide radiation therapy in defined circumstances. They see new consults as well as patients in followup.

So what role do I fill with all this specialized manpower now present in our clinic? Some medical oncologists are comfortable continuing to comanage patients. Other medical oncologists, usually newer to practice, are less comfortable

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sharing care — at least until they become so swamped with work, and then they recognize that I can alleviate their workload. All of the oncologists are happy to have me cover during their absences due to vacation, continuing medical education (CME), sick leave or when they have difficulty getting to the clinic due to inclement weather! And they are happy to have me ease the workload burden of following patients, especially those who are needy and require a great deal of support.

At the annual meeting and at other CME events where I have had the opportunity to network with my GPO colleagues, I have discovered that they too are “filling gaps.” They provide the inpatient care that the medical or radiation oncologists do not have the time or inclination to provide. Like myself, these GPOs provide coverage in the outpatient clinics due to absences. I think that we are all happy to provide this service — that is, to fill gaps. But, as most professionals, our job satisfaction would be increased if we were recognized as filling an invaluable role as an integral part of the multidisciplinary cancer care team.

While GPOs do rely on the medical and radiation oncologists’ expertise to make decisions about chemotherapy or radiation regimens (in adjuvant or palliative settings, in the face of disease progression or complex symptomatology), GPOs are very capable of supervising chemotherapy in all types of patients, in the palliative as well as adjuvant setting, as well as complex regimens such as those managed by my colleagues in in-hospital transplant settings. GPOs may also have valuable insights that can affect treatment choices. After or during chemotherapy, GPOs can follow both the simple and the complex patients. We can also provide psychosocial support for patients who are struggling with their diagnosis or with personal issues that are occurring concurrently.

**GPO RECOGNITION**

What will it take for GPOs to be recognized as invaluable members of the multidisciplinary cancer care team? It will take recognition by our cancer institutes, both at the provincial and local levels. We need to have our services recognized in billing codes and we need to receive adequate remuneration for our time and expertise — whether we bill for service, are hired as contract workers or are salaried. We need to develop a standardized, nationally recognized training program. These criteria have been identified by our national organization, CAGPO, and are goals GPOs are actively working to achieve.

Meanwhile, on a personal level, I strive to provide a high level of care for my patients while at the same time familiarizing the other members of the multidisciplinary team with the skills that I, as a GPO, have to contribute.

**References**