At the inaugural Cancer Survivorship Symposium held in January 2016, Professor Bijal Balasubramanian from the division of epidemiology, human genetics, and environmental science at the University of Texas presented results of a survey on who should assume responsibility for survivorship care. It revealed that 41% of primary care physicians (PCP) preferred an oncologist-led care delivery model (as compared to 21% of oncologists), and 56% disagreed that PCPs should have primary responsibility for providing cancer followup care. The survey was conducted in a US care setting distinct in that it served uninsured patients and had a shared electronic health record system and clinical infrastructure that facilitated communication and coordination. Interestingly, the PCPs unwillingness to take the lead was not associated with a perceived lack of ability: 73% (along with 58% of oncologists) felt that PCPs had the skills required for cancer surveillance. Worryingly, oncologists more consistently reported that PCPs ordered tests for cancer surveillance, evaluated patients for cancer recurrence and for adverse physical and psychological effects of cancer or its treatment, as well as managed pain and adverse outcomes of cancer treatment, than PCPs themselves reported ordering, suggesting that patients may not consistently be receiving recommended followup care.

Dr. Balasubramanian concluded that, while it seems inevitable and desirable that cancer survivorship care increasingly involve PCPs, their practice needs to become much stronger than it has been until now. Better communication between oncologists and PCPs through treatment summaries and personalized care plans may help, and consensus guidelines are needed to delineate shared responsibilities for cancer survivors between primary care and oncology specialty care physicians.

This study highlights challenges we face in Canada as well, and reveals that we have a lot of work ahead of us. Previous research in the US context had found significant differences between PCP and oncologist attitudes and practices with respect to care of cancer survivors and called for more effective communication and coordination to improve care. What is striking about this most recent study is that even in a context that facilitates communication and coordination, there is a persistent discrepancy between oncologist and PCP views on who should take the lead in cancer survivorship care and misunderstanding about who is doing what. According to Dr. Balasubramanian, the interest in shared care models makes sense as a means of benefiting from primary care physician expertise in chronic diseases, which are often present in older cancer patients, and oncologist expertise in cancer-related issues.

Better communication between oncologists and PCPs through treatment summaries and personalized care plans may help, and consensus guidelines are needed to delineate shared responsibilities for cancer survivors between primary care and oncology specialty care physicians.

THE CANCER POPULATION
“A cancer survivor is anyone who has been diagnosed with cancer, from the time of initial diagnosis and treatment through the remaining years of life. The goal of survivorship care is to prevent, detect, and manage complications that arise from cancer or cancer treatments and to improve overall health and quality of life for survivors.”

According to Canadian Cancer Society projections, the number of new diagnoses per year will increase from about 197,000 now to 277,000 a year in 2030. And based on 2006–2008 estimates, 63% of Canadians diagnosed with cancer are expected to survive for 5 years or more after a cancer diagnosis. There is considerable variation between cancers with regard to long-term survival, with 5-year survival rates of 96% in prostate cancer, 88% in breast cancer and 64% in colorectal cancer. Survival rates in other cancer are increasing quickly. At the beginning of 2005, there were 695,000 people living with a cancer that had been diagnosed sometime in the previous 10 years, and this figure represents only a fraction of the total survivor population. Post-cancer support and treatment can vary widely between and within provinces.

Along with increases numbers of cancer survivors who require ongoing care for general health issues, late treatment effects, and monitoring for recurrence, increasing
numbers of cancer treatments are being provided in the outpatient setting, prompting greater need for community-based care providers equipped to follow patients on active treatment. End-of-life care is another area of expanding need that governments want to see met in the community rather than hospital centres.

**RETHINKING THE CANCER CARE WORKFORCE**

In 2015, there were a total of 517 medical oncologists in Canada, a rate per 100,000 population which has doubled since 1995 to a national average of 1.4. There are significant provincial differences, with four provinces (PEI, New Brunswick, Manitoba, Saskatchewan) and the Territories counting less than 1 medical oncologist per 100,000 population. Looking at future supply, there are 150 postgraduate MD trainees in medical oncology in Canada’s 17 medical schools (though none at Memorial in Newfoundland, University of Saskatchewan or the Northern Ontario School of Medicine). About 40 medical oncology trainees completed postgraduate training each year across Canada.6

The total number of family physicians in Canada stands at 40,571 (2015) or 114/100,000, with number higher in provinces with fewer oncologists (168/100,000 in Nfld; 140 in PEI and 149 in NB). While 65% of Canadian medical oncologists work in academic health centres; 67% of family physicians work in private offices or community clinics.8 The Canadian Association of Nurses in Oncology had 866 members as of September 2015, 22% of whom had upwards of 20 years experience in oncology nursing.7 We will need to better combine the expertise and availability of different professionals to meet the cancer care challenge.

In February 2015, *Oncology Exchange* published an article by Brigden et al encouraging the development of community oncology practice — that is oncologists working outside of major hospital centres — to palliate the current concentration of oncology specialists in major urban centres and support delivery care close to home. The authors reported results of a survey of 6 dynamic community oncology practices across Canada and described an optimal model in which care was shared between a community oncologist, GP in oncology, nurse practitioner in oncology, nurse navigator and pharmacist.8

Models of care such as these, adapted to a wide variety of settings, are required to care for the large and growing population of cancer patients and cancer survivors. Steps are already being taken to increase family physician knowledge about the chemotherapy regimens used in different disease sites, management of treatment side effects, including late radiation effects, symptom management, and distress counselling. For example, the University of Ottawa offers a family practice oncology program, with rotations in hematologic oncology, gynecologic oncology, radiation oncology, in-patient and outpatient medical oncology, and palliative care. Cancer Care Ontario (CCO) is working to integrate primary care physicians into all steps along the cancer journey, from screening through to palliative care and each Local Health Integration Network (LHIN) now has primary care cancer leads working to meaningfully engage PCPs in cancer care.

The BC Cancer Agency’s Family Practice Oncology Network (FPON) works to develop oncology related clinical practice guidelines for use in primary care.

Dr. Malcolm Moore, recently appointed head of the BC Cancer Agency, recognized the challenges in a recent editorial: “Family physicians already play a major role in cancer screening and prevention, for example, but there is opportunity for greater involvement in followup care and in meeting the survivorship needs of patients who have completed treatment. We need to engage in a dialogue about how to most effectively transition to this approach, how best the Cancer Agency can support primary care providers who deal with cancer patients and to ensure we have a funding model to support this new reality.”9

This is an issue that will become more pressing in the next few years. In August *Oncology Exchange* will include a look at the model we are working towards in our Ottawa clinic, and Dr. Malcolm Brigden will look at how one community clinic is meeting the challenge posed by new agents such as immune checkpoint inhibitors.8

**Reference**


3. Canadian Cancer Society, Cancer Statistics at a glance.


5. CMA Masterfile Medical Oncology Profile / Masterfile Family physicians

6. 2014/15 Annual Census of Post-MD Trainees, CAPER

7. CANO 2015 Annual Report
