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The Role of the Primary Care Physician in Cancer Care
Has Anything Changed?

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As the managed care environment continues to mature, so does the role of the primary care physician in oncology care. Several years ago opposing movements threatened to alter how decisions are made in the treatment of patients with cancer. The managed care marketplace dictated the role of the primary care physician as the gatekeeper for all patients, while the oncology community recommended designating the medical oncologist as the primary care physician for cancer patients during treatment. Today, following a patient backlash against rationed health care, and a variety of other factors, the role of the primary care physician in cancer care and his or her relationship to the oncologist are again changing.

A HISTORY OF DIVIDED RESPONSIBILITY

In 1996 the American Society of Clinical Oncology (ASCO) surveyed the medical oncology workforce to determine how medical oncologists in different work settings divide their professional activities. The ASCO survey also sought to find out whether medical oncology represents a primary care specialty in the view of practicing oncologists. In general, the study concluded that "the medical oncology community devotes the majority of its time to providing oncologic patient care and does not provide or appear to wish to provide what the public defines as primary care." [1]

For the most part, the traditional role of primary care physicians (PCPs) in cancer care has been screening and detection. PCP training and education have been similarly oriented.[2] Yet, a study conducted by researchers at the University of Wisconsin as part of the Primary Care Prevention Project suggests that PCPs may not be conducting sufficient cancer screening. Researchers examined the relationship between a patient's chronic disease status and the receipt of cancer preventive/screening services over a three-year period.[3] They found that the presence of a chronic disease reduced the odds that a patient had received colorectal, breast, and cervical cancer screening, as well as counseling about smoking cessation. The researchers explain this finding, in part, by noting that presently PCPs focus more on the individual encounter and symptoms presented than on the continuum of care.

PCPS AND DISEASE MANAGEMENT

The Department of Family Medicine at Ohio State University has described the roles that family physicians typically assume in the management of cancer patients at the eight stages of disease management[4]:

1) monitoring risk factors
2) early disease screening
3) diagnosis (following up positive screening results and pursuing causes of presenting symptoms)
4) staging (using the results of staging procedures to guide patient choice of alternative treatments)
5) treatment (either administering chemotherapy under the direction of cancer specialists and/or counseling patients and families regarding treatment)
6) co-management of the patient with the specialist for the monitoring of treatment progress and side effects
7) follow-up monitoring
8) advanced disease management (palliative care, including pain management and quality-of-life support).

Although in the Ohio State model the family practitioner is trained to assume responsibility for care across the continuum, in reality geographic location dictates the PCP's role. The PCP may, indeed, administer chemotherapy under the supervision of a medical oncologist in the more rural areas of the country, but overall accountability for comprehensive oncology care is consistently relinquished to the oncology specialists as their geographic availability permits.

PREVENTION, SCREENING, AND EARLY DETECTION

Today, certain aspects of the PCP's role—notably prevention, screening, and early detection—are expanding. New clinical guidelines and pathways that mandate early detection, wellness programs that emphasize prevention, and legislative changes that allow coverage for many screening tests are all influencing practice changes.

Counseling and education about cancer prevention practices, particularly smoking cessation, continue to be in the PCP's domain. Although smoking has been implicated in lung cancer for years, cigarette smoking is on the rise in young people. PCPs must assume the challenge required to reverse this trend. To aid in this endeavor, the National Cancer Institute and pharmaceutical companies offer multiple over-

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the-counter aids and structured smoking cessation programs.

Additionally, the PCP has the well-established responsibility to counsel and teach patients about such practices as dietary modification (increased fiber, decreased fat), avoidance of the sun, and use of sunblock.

Primary care physicians are crucial to the development, testing, and use of cancer chemoprevention.[5] It is healthy people who will benefit from cancer chemoprevention. Healthy people do not frequent cancer centers, but do commonly interact with family physicians. Thus, primary care physicians have a critical role in the following areas:

- identifying high-risk subjects for clinical trials
- advising patients and families whether to participate in such trials or take substances that might prevent cancer
- counseling high-risk patients with known genetic risks
- supplying educational material to patients and their families.

The role of the PCP in the prevention of breast cancer is evolving as an outcome of the results of the Breast Cancer Prevention Trial conducted by the National Surgical Adjuvant Breast and Bowel Project (NSABP), as well as from the explosion of information related to cancer prevention, including epidemiology, molecular biology, cancer genetics, preclinical drug testing, and biomarker assays, such as those for the BRCA1 and BRCA2 mutations.

Although patients are increasingly asking their PCPs about the desirability of preventive tamoxifen (or raloxifene) administration, as yet there is no definitive answer. In his recent article detailing the NSABP's results of the Breast Cancer Prevention Trial, Dr. Bernard Fisher, scientific director of the NSABP, emphasizes that the task of recommending tamoxifen for women at increased risk for breast cancer should be undertaken only by those primary health care providers "who are free of personal bias, are knowledgeable about breast disease, know how to determine a woman's risk for breast cancer and how to discuss with and counsel her about her individual course of action, and possess only complete and accurate information on the subject."[6]

Because PCPs have a large role in the responsibility for cancer prevention, PCPs should incorporate the Gail Risk Model, an assessment tool widely used to project individual probabilities of developing breast cancer, into their assessment of patients potentially eligible for breast cancer chemoprevention.[7] Patients determined to be at high risk for breast cancer should be referred to a medical oncologist or a genetic counseling program for additional evaluation and recommendations.

Counseling about the use of estrogen replacement in postmenopausal women must address its benefits of cardioprotection and prevention of osteoporosis, as well as include warnings related to increased incidence of breast and endometrial cancers with prolonged estrogen use.

Screening for cancer continues to be a major component of the PCP's role in cancer care. As a rule, primary care physicians are aware of the screening guidelines and commonly report using the American Cancer Society's guidelines.[8] However, although PCPs are familiar with screening guidelines, there is conflicting information as to their actual implementation in practice.[9,10,11]

Prostate cancer is believed to be "overscreened" for a variety of reasons, including the news media's increased focus on prostate cancer, the ongoing national prostate cancer screening promotion efforts, and high-profile, public figures recently diagnosed who encourage men to be screened.[12] Neither the American Cancer Society nor the American Urological Association endorses routine PSAs; however, both recommend that physicians offer the test to men fifty years of age or older who have a life expectancy of at least ten years.

Colorectal cancer is thought to be "underscreened" by PCPs, with inconsistent adherence to screening guidelines for use of guaiac testing and sigmoidoscopic examination. Some ascribe this underscreening to the lack of reimbursement by insurance companies for sigmoidoscopies performed for reasons other than active rectal bleeding, although there is little in the literature to support this assumption. The issue is undoubtedly more complex and must take into account patient choice as well as physician compliance issues.

Because of the increasing focus on women's health and the growth of women's health programs, screening for breast and cervical cancer is now well established. Generally, good adherence to screening guidelines for mammograms is reported despite the National Cancer Institute's conflicting information several years ago about the age at which women should receive mammograms. Pap smears have long been a standard component of a gynecologic exam.

DIAGNOSIS AND TREATMENT

The PCP is responsible for conducting complete diagnostic workups for suspected malignancy. Failure to diagnose cancer is one of the leading causes of malpractice lawsuits for primary care physicians. The PCP must vigorously investigate the seven warning signs of cancer. For example, rectal bleeding has often been attributed to hemorrhoids when, in fact, further investigation has revealed

the presence of a malignancy.

Treatment, however, remains the responsibility of the medical, radiation, gynecologic, and/or surgical oncologists. In rural areas without access to a medical oncologist, a PCP may administer chemotherapy. In these cases, however, the specialist usually does the treatment planning.

The primary care physician must continue to assume responsibility for maintaining patient health, particularly when the patient undergoes treatment for cancer.[13] Patients who have long-standing relationships with their PCPs often look to them for information and emotional support during their cancer treatment.

LONG-TERM FOLLOW-UP CARE

Key to effective, long-term aftercare are the collaborative and coordinated efforts of the specialist(s) and the PCP. Collaboration can help prevent the duplication of services and clarify conflicting information provided by multiple physicians at follow-up.

PCPs can provide long-term follow-up for a variety of malignancies. For example, the patient with chronic lymphocytic leukemia is often under the PCP's care when active treatment is not undertaken; a medical oncology consult should be obtained when patients present with increasing white blood counts and tumor burden. The breast cancer patient receiving long-term tamoxifen may be followed by the PCP. Whether the PCP or the medical oncologist assumes follow-up responsibility generally depends on patient demands and expectations, geographic accessibility of the medical oncologist, and accepted local practice.

Although there is a consistent thought among many specialists and generalists that follow-up care of oncology patients is within the scope of primary care practice, in question is the willingness of the PCP to assume responsibility for continuing care of patients treated for cancer. It is the experience of many oncologists that primary care physicians tend to relinquish follow-up responsibilities to the oncology specialists.

Primary care, by definition, involves care of the patient throughout the life span. For the oncology patient, however, end-of-life care is most often assumed by the oncologist and hospice staff, with the PCP remaining on the periphery. Some reasons for this lack of involvement in end-of-life care include lack of expertise in pain management,[14] unfamiliarity with hospice protocols, discomfort in dealing with the emotional and psychological needs of the terminal patient and his or her family, and time constraints. However, the dying patient and his or her family might be better served by a collaborative approach to care by the oncologist and the PCP, who would provide additional support at a critical stage of life.

SUMMING UP

As chemoprevention exerts its force in efforts to eradicate cancer, the most significant change in the role of the primary care physician is in cancer prevention. Screening, detection, and diagnosis remain the province of the PCP. Long-term follow-up of patients with cancer is becoming increasingly the responsibility of primary care physicians as the managed care market matures.

Geographic location remains a major factor to be considered in the decision about who follows a patient. Areas with numerous health care resources continue to support specialist care. However, an optimal model for follow-up is a collaboration between oncologist and PCP, with clear delineation of responsibilities and effective physician-to-physician communication.

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