Primary care oncology: essential if high quality cancer care is to be achieved for all

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The importance of primary care in oncology is widely recognized—in the Calman-Hine report it was called “the focus of care”.1 There is, however, less clarity about what primary care oncology is and how it can add value to specialist cancer care. The NHS Cancer Plan in England recognizes that primary care has an important role, recommending lead clinicians for cancer in primary care groups, but is short on specific guidance on what they are meant to do.2 The Scottish cancer plan barely mentions primary care at all.3 This ignorance of the role of primary care in cancer is undermining real opportunities to improve quality of life and survival among patients with cancer. “Primary care oncology” is straightforward to define—if primary care is “first-contact, continuous, comprehensive and co-ordinating care”4 it follows that primary care oncology is exactly the same, with particular regard to cancer. Its four main strands are clearly important in any attempt to provide high quality cancer care.

First, the vast majority of patients with cancer present in primary care. In recent surveys, more than 80% of patients with common cancers first presented with symptoms to their GPs.5 Patients often regard this as the most important part of their cancer journey 6 and with good reason—stage at diagnosis is the most important determinant of survival.7 Diagnosing cancer early is not easy, however, particularly when symptoms are non-specific and poorly predictive.8, 9 GPs know that referrals must be selective or they will swamp expensive and limited diagnostic services.4 Although there is little evidence on how to achieve early diagnosis, there are plenty of recommendations (for example the cancer referrals guidelines) and they all rely on GPs.8 For cancers detectable by screening, primary care has a proven role in optimizing and ensuring equitable uptake, if provided with sufficient support and resources.10

Second, the involvement of primary care continues from diagnosis until after cure or death. Its role in terminal care, properly supported by specialist palliative services, is well recognized. Less well appreciated, however, is the heavy involvement of primary care after diagnosis and before any terminal stage. In the year after diagnosis with early breast cancer, throughout the specialist phases of care, most patients in Glasgow consulted their GPs more than 10 times, about double their consultation rate with specialists.11 This involvement is set to increase as more oral therapies become available, hospital services become swamped with increasing patient numbers, and specialist follow-up is shortened. Most side-effects from cancer therapy occur at home between hospital visits and have important effects on whether treatments are optimized and completed.12 Home treatments can improve patient compliance13 and integrating specialist and primary care services has significant benefits for patients, including less time travelling to and waiting in hospital.14

Third, people with cancer need comprehensive medical care. Two-thirds have significant co-morbidity and a third have at least two co-morbid conditions.15 Illnesses, which can be physical (for example, obstructive airways disease) or psychological (for example, depression), not only impair quality of life, but can limit diagnostic tests and narrow treatment options. Patients with many common illnesses—like vascular disease, asthma, chronic bronchitis, diabetes, and renal disease—have high early mortality rates from cancer.16 In Glasgow, poor breast cancer survival rates in deprived communities when compared to their affluent neighbours have been largely attributed to co-morbidities—during the two years after initial treatment, a quarter of women from deprived areas were admitted to hospital for conditions unrelated to their cancer compared to only 10% of affluent women.11

Finally, with cancer care increasingly involving large numbers of specialists (both doctors and nurses), the co-ordinating role of primary care is becoming more important. Recognition that specialist care has better outcomes and expansion of the ‘nurse specialist’ sector means that specialist (and super-specialist) numbers are likely to continue increasing. This can be bewildering for patients who rely on their GPs to ensure that they see the

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right specialists at the right times. Well directed referrals can improve care, but poorly directed and indiscriminate ones can contribute to unnecessary investigations, delays and substandard treatment.\textsuperscript{4}

So what can be achieved by investing in primary care oncology? Nearly all the priorities for cancer services are affected by actions in primary care—reducing the risk of cancer, early detection and faster access to specialist treatment, improved support for patients living with cancer (including good communication and palliative care), and reducing inequalities. Arguably, this last key priority, reducing inequalities, can only be achieved by primary care. People from deprived and outlying rural areas are less likely to survive cancer, and the main reasons identified in Scotland are later stage diagnosis among rural patients and high levels of co-morbidity among the deprived.\textsuperscript{11,17} Tackling this means optimizing screening, ensuring equally early diagnosis for all and treating co-morbidities aggressively. All these tasks fall largely within the remit of primary care, but will not be achieved easily (or by indiscriminately publishing yet more guidelines). Adequate resources and support (including information technology\textsuperscript{10}), good communication with specialist services, and more primary care based research on which to base recommendations are all needed. The goal of eliminating inequalities in survival would, however, be sufficient to pull the UK’s poor cancer survival rates up to those of the best countries in Europe, so is clearly worth striving for.\textsuperscript{2}

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