GENERAL PRACTICE/
PRIMARY HEALTH CARE TEAMS
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1. INTRODUCTION: THE ROLE AND CONCEPTS OF PRIMARY HEALTH CARE AND GENERAL PRACTICE

General Practice

1.01 In order to understand the perspective of Primary Care Practitioners in managing patients with cancer, it is necessary to review some of the basic principles of Primary Health Care.

1.02 In 1977, a number of medical academic bodies from Europe collaborated to produce a definition of the work of the general practitioner, which was subsequently adopted in its entirety as a policy of the UK Royal College of General Practitioners (RCGP 1977). This statement was presented at a conference at Leeuwenhorst, and has since usually been referred to as the ‘Leeuwenhorst definition’. (The definition is quoted here verbatim; he should be taken to include she)

‘The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families and a practice population, irrespective of age, sex and illness. It is the synthesis of these functions which is unique. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital. His aim is to make early diagnosis. He will include and integrate physical, psychological and social factors in his considerations about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illness. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient, and build up a relationship of trust which he can use professionally. He will practise in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene, through treatment, prevention and education, to promote the health of his patients and their families. He will recognise that he also has a professional responsibility to the community.’

1.03 A useful revision of the Leeuwenhorst definition may be found in the report of a Welsh working group (Welsh Council RCGP and Welsh GMSC 1994). This definition emphasises the importance of the ‘core team’ in the delivery of services.

1.04 Implicit in the use of the phrase ‘general practitioner’ is the notion of the doctor having a generalist function. Pellegrino (1978) describes this function succinctly as follows:

‘The generalist function... subsumes intellectual and practical components that culminate in the process whereby a patient's condition is evaluated, his or her needs identified and placed in some priority, and a plan of management developed efficiently and optimally to satisfy the identified needs. The generalist is differentiated from the specialist by the types of clinical situations with which he or she is confronted. The generalist deals with patients in three categories: 1) those who have not yet been classified into some organ- or technique-oriented specialty, 2) patients in whom, having been so categorised, new signs and symptoms develop that may or may not be related to the previous category, 3) patients with problems simultaneously in more than one organ system.’

1.05 Unfortunately, the role of the generalist is still misunderstood by many. McWhinney points out (1989) that any organisation (including health-care organisations) must have generalists and specialists to remain viable. In organisational terms, generalists have special functions in relating to all parts of the organisation. They operate as communication centres, and identify problems that can be presented to specialists for solution. This function is of special relevance in providing services for patients with cancer - and yet, as we will show later, there is evidence that the role of general practitioners in providing links between various specialist parts of cancer services and the patients is often ignored by specialists.

1.06 In medicine, generalists become knowledgeable about a wide range of conditions that do not reach specialists. General practice is not a summation of the whole range of specialist practice - rather it has special features and attributes of its own, and complements specialist practice. The knowledge of a specialist relates to the detail of those diseases experienced by a small proportion of patients with medical or surgical conditions within his or her specialty. The general practitioner's expertise relates to the breadth of experiences gained from dealing with the vast majority of patients presenting in primary care with conditions that never reach secondary care.
Indeed, health professionals in general practice are sometimes called upon to provide initial assessments of problems that may not have an underlying medical cause at all. Undifferentiated malaise may have roots in social or spiritual distress, or an underlying anxiety about the nature of possible illness; many patients are concerned about the possibility of cancer when presenting to their GP - it is impossible to quantify the proportion.

**Key Philosophies of Primary Health Care**

**Valuing Self-Care**

It is an obvious but neglected truism that self-care is the largest part of the whole health-care system (Williamson and Danaher 1978). Whilst the PHC Team must value self-care it is important to give appropriate messages to patients about seeking help at appropriate times - e.g. with specific symptoms, rather than relying on lay advice or relying on alternative sources of health advice.

**Personal Care**

The personal nature of primary care is one of its undoubted strengths. Yet the very fact that Primary Care is personal, and often involves a long-term professional relationship with patients places special emotional demands on Primary Care Practitioners when dealing with patients with cancer and their families.

**Primary, First-contact Care**

Primary care is the first point of contact of patients with the caring professions. It is important to recognise that primary care professionals have to make an initial decision on any problem that is presented, if the patient believes that the problem is one that legitimately may be presented to that professional - in other words if they are ill, or believe themselves to be ill.

**Continuing Care**

The GP provides a continuing thread of service no matter what other services are provided. A patient with cancer is of concern to the GP from the moment a symptom appears which could be of importance, through diagnosis, management, palliative care, and, on occasion dying.

**Integration and Co-ordination of Care**

Generalists are at the centre of the health-care system and therefore have a major role in integrating and co-ordinating care provided to patients and their families. They must be aware of the strengths and weaknesses of the health-care-system and be able to utilise this knowledge in ensuring the patient has appropriate care. It is often very difficult for practitioners to fulfil this brief when details of services provided by specialists (e.g. specialist cancer units) are not readily available and the tertiary centres are frequently distant, allowing little opportunity for practitioners to develop useful working relationships with them.

**Consultation-based**

The consultation is often seen as the major focus of primary care practice. The value of the consultation in building relationships with patients, in providing the key element in diagnosis and in management of patients has been emphasised by many and been the subject of wide research (Balint 1964, Pendleton 1984, Neighbour 1987). One of Balint's special contributions was to emphasise the role that the doctor himself or herself can play in a therapeutic sense: the doctor can be considered as a therapeutic tool which can be just as important as a drug or a surgical procedure. Interpersonal skills of a high order are required of primary care practitioners, combining the qualities of compassion, empathy and personalised concern. This is of crucial importance when considering the care of patients in palliative care (Maguire and Faulkner 1988).

**Population-based Care**

PHC practitioners are now being expected to take a population perspective in organising and planning services - most notably through the discipline of fund-holding budget-management. Some practitioners find that there are nevertheless some conflicts in day-to-day practise between adopting a community perspective of care on the one hand (managing a population-based budget) and responding appropriately to the expressed needs of individual patients on the other.
Team-based Care

1.15 For many years, since the earliest experiments of attachment of nurses and health visitors to general practice, and indeed since the Dawson report (Ministry of Health 1920), the importance of team care in primary care has long been accepted. However, continual arguments rage about who should be considered as being within the team, and how the team should be managed or led. Many commentators emphasise the need for a team to have common objectives in order to call itself a team. Some emphasise the need for a common geographical base, and regular contact between staff members in the team. If one accepts that the PHC team consists of doctors, nurses (practice and district nurses, health visitors), midwives, practice manager and secretaries/receptionists, it may then be useful to consider other linked services as part of the Primary Health Care Network (e.g., social services, pharmacists, dentists, opticians, professions supplementary to medicine, and perhaps some of the voluntary organisations). Patients with cancer are often served by members both of the core team and the PHC network; as will be discussed later, team-care demands team working and there are certain problems evident in the delivery of such care for patients with cancer.

Prevention and Anticipatory Care

1.16 The WHO has pointed out that primary health care is one of the key factors in achieving the European Targets for Health for All (WHO 1985). Primary health care is in a unique position to integrate preventive and curative care, and to apply the principles of health promotion on a one-to-one basis (Smail 1992). However, there is nevertheless a limit to what can be achieved in PHC: governmental action through the development of Healthy Public Policy and Community Action are required to support PHC initiatives. For example, government food policy (in support of reducing the risks of cancer) should work in tandem with national objectives to improve the national diet; fiscal measures and subsidies can be used to drive the production and marketing of healthier food.

The skills of the Clinical Generalist

1.17 Within the broad function of a general practitioner, special clinical competencies may be recognised (RCGP 1996):

- Personal attributes that are essential in any independent professional person but are not unique to the medical profession;
- Specific clinical competencies that are in combination are essential for the general medical practitioner;
- Clinical competencies that are usefully shared with other professions allied to medicine but are unlikely to be combined as described in 2;
- Managerial skills that can be shared, acquired form or delegated to non-clinical personnel;
- Teaching/learning skills that are acquired form/shared with educationalists/academics;
- Research, audit and evaluation skills.

1.18 The first and second are essential for individual clinical practice, whilst the third and fourth are essential for clinical team-work. The fifth and sixth are essential for reflective practice and maintenance of quality within the service. Yet it is the amalgam of these three categories of competency which is the hallmark of high quality professional practice in Primary Health Care; it is probably unwise to promote the involvement of GPs in 3, 4 and 6 (as has often been the case in some moves to ‘improve’ Primary Care Services) at the expense of neglecting the fundamental importance of the basic clinical competencies listed as 1 and 2 above.

2. PRIMARY CARE WORKLOAD AND SERVICES TO PATIENTS WITH CANCER

2.01 A quarter of all deaths in the UK are caused by cancer, and one in three people will develop cancer at some stage in their lives. All these patients will be registered with general practitioners, who have to provide the necessary initial assessment, and co-ordination of services for the patient, in line with the general principles described earlier. In some cases, the involvement of the GP in the care of an individual patient who has developed cancer may be relatively short-term, although intensive and demanding. In other cases, the patient will survive for many years, yet the fact that the patient has suffered a stigmatising illness may cause a range of other problems in the patient’s care, or the care of his/her family. Further, the PHC team must consider and develop a range of services relating to the prevention and co-ordination of primary care to the population - this work is quite extensive and involves all members of the PHC Team in developing and implementing appropriate policies. Much of this is related to prevention, to co-ordination of diagnostic services, and to co-ordination of care of the patient and family.
Consultations with the Primary health Care Team for Cancer

2.02 Data relating to consultation rates for Cancer with GPs and Practice Nurses is available for England and Wales in the Fourth National Morbidity Survey (NMS), which was conducted over a 12-month period in 1991-2 (McCormick et al 1995). A number of sentinel practices were recruited all over the UK to record practice data for a whole year, but only three practices in Wales were included in the sample. However, a pilot Welsh GP Morbidity Survey was carried out in 1993 (Kaul 1995), involving 16 practices, although the reported data so far involved just 12 of those practices, with a registered population of just over 100,000 patients.

2.03 The overall consultation rate with GPs in NMS was 2.9 consultations per patient per year, although the General Household survey gives higher figures. 78% of patients consulted during the year; the consultation rate of those who consulted at least once was 3.8 (Wales 79%).

2.04 The data in the NMS provides details of patients seen according to the reason for consultation. For cancers, the rates given in NMS refer to consultations for the cancerous condition; a patient with cancer who consults for other reasons would not be included in the analyses for ‘cancer’. Prevalence data in this study refers to the number of patients who consulted for a specified condition at least once during the one-year period. A patient with cancer who does not attend the GP surgery specifically for a consultation concerning the cancer within the year will not be recorded in the prevalence data. If he or she attends for other reason, the fact that they are suffering from a cancer will not be recorded in the data-base and their cancerous condition will not appear in the NMS ‘prevalence’ data. Hence the ‘prevalence’ data in NMS under-reports true prevalence of cancer in the community.

2.05 In Wales, 1.2% of all consultation episodes were for neoplasm with a range 0.6 to 1.6%. By comparison, respiratory disorders (20.9%) were the most frequently recorded diagnoses; rates for other less common conditions included endocrine disorders (1.9%), mental disorders (3.9%) and blood disorders (0.5%). Non-specific symptoms and signs (not otherwise diagnosed) accounted for 12.7% of consultations; some of these non-specific symptoms could of course presage the onset of cancer, emphasising the importance of the assessment of non-specific symptoms in the work of the GP.

2.06 The NMS showed in 1991 an annual prevalence rate of 239 per 10,000 patients for neoplasms, an increase since 1981, when the equivalent figure was 135. Prevalence rates increase with age, from 54 per 10,000 at risk in 0-4 age group to 548 per 10,000 at risk in the over-75s.

Individual Cancers

2.07 The commonest cancer seen in PHC is breast cancer with a prevalence rate of 30 per 10,000 women at risk, and an incidence rate of 11. (NMS)

2.08 Prostate cancer is the second most common, with an overall prevalence of 11 per 10,000 males at risk, and an incidence of 4. For men over 85, the prevalence is 155 per 10,000 at risk. Four people per 10,000 consulted for bladder cancer, which was nearly five times more prevalent amongst men than women. The rate for Cancer of the body of the uterus was 2 per 10,000 women, for cancer of the cervix, 3 per 10,000, and for cancer of the ovary 4 per 10,000.

2.09 For cancer of the trachea, bronchus and lung, the prevalence rate was 7 per 10,000 and the incidence 4 per 10,000. Again, prevalence increased with age. For cancer of the colon, the prevalence rate was 5 per 10,000 and the incidence 2 per 10,000. Prevalence of cancer of the rectum and anus was 3 per 10,000.

2.10 Malignant melanoma incidence rate was 2 per 10,000 (higher in NMS than is reported in the cancer registrations system) and the incidence for other skin tumours 6 per 10,000.

Work-load in Practice

2.11 Undoubtedly the highest workload for General Practice relating to cancer is for preventive services (including cervical cytology - 0.3 consultations per patient at risk per year) and discussions with patients about cancer, fears of cancer and prevention. The subject of cancer may be mentioned by patients consulting for non-specific symptoms as an identified fear; or the practitioner may wish to investigate such symptoms to exclude cancerous conditions.
2.12 A Practice of 10,000 people will have approximately 29,000 consultations with GPs per year, of which 1.2% (348) will be specifically about cancer - i.e. roughly seven consultations per week. But this underestimates the burden of work resulting from the care of patients with cancer in Primary Care. Where consultations with GPs do occur, they are longer and more likely to be at home. 41% of consultations for cancer with patients aged 65-74 took place at home (average home visit rate in this age group is 14% for all consultations); for patients consulting for cancer over 75 years of age, 53% of the consultations were at home.

2.13 Many patients who have cancer will be attending GPs for other problems, and whilst the main reason for the consultation may be another matter, the existence of the cancer will form an undercurrent to the consultation. As has already been pointed out, such consultations would not appear in the statistics of the NMS as having any relevance to cancer.

2.14 Many patients with cancer, and receiving active treatment, will be seen by nurses on a regular basis. A survey of Welsh opinion-leaders in general practice in Wales (reported below) revealed that a mean of 7.4 patients with cancer per practice were being seen regularly by a member of the PHC Team - at least weekly or more often. (The average practice size of those questioned was 7,219; the All-Wales average is 5,441. On the basis of this figure, one patient per 1,000 practice population is requiring at least weekly care/treatment for cancer).

3. CANCER CARE IN GENERAL PRACTICE

3.01 In the earlier sections of this report, the point has been made that the subject of ‘cancer care’ in general practice covers not just the services for patients with established cancer, but preventive advice, the provision of screening services such as cervical screening, and collaboration with services such as the breast screening programme (Austoker 1995). The care of families and carers of patients with cancer is also important - from diagnosis through treatment of the patient to death and bereavement. It is not unusual for relatives and carers to experience deep grief after the death of a patient with cancer, and pathological grief reactions are more likely.

Prevention of Cancer in Primary Care

3.02 The achievement of ‘Health of the Nation’ targets for the prevention of cancer do depend to some extent on a contribution of Primary Health Care. Whilst public policy and community health promotion has perhaps the largest role to play in achieving the targets, PHC Teams can assist in cancer prevention and early diagnosis. The key tasks are as follows:

- Advising people how to stop smoking
- Preventing alcohol misuse (particularly giving advice to heavy social drinkers)
- Giving appropriate dietary advice
- Advising people to avoid excessive exposure to sunshine
- Identifying and advising eligible women about breast screening, and assisting in managing the screening programme; promoting ‘breast awareness’.
- Running an effective cervical cytology programme.

3.03 Practices should have agreed policies on each of the above tasks, so that consistent advice is given to patients.

Early Detection of Cancer in Primary Care

3.04 It is important that patients are encouraged to report early those symptoms that may be significant such as the appearance of lumps on the skin, or a change in a mole, persistent cough, haemoptysis, persistent hoarseness, change in bowel habits, rectal bleeding, blood in the urine, unusual vaginal bleeding, or unexplained weight loss. The investigation of non-specific symptoms will often be carried out entirely within general practice, but clearly it is important that GPs have access to specialist diagnostic services and advice to evaluate significant symptomatology. A general low provision of service may make it difficult to provide the ‘fast-track’ service for patients whose symptoms may be of concern. It is a truism that many cancers present with non-specific symptomatology which may be hard to differentiate from non-cancer pathology without a high level of suspicion and careful evaluation.
A Survey of Cancer Care in General Practice

3.05 In view of the need to acquire data concerning primary care services for patients with cancer in Wales, a survey was undertaken of opinion-leaders amongst Welsh General Practitioners. A survey proforma was developed to assess the support given by the Secondary Care sector to Primary Care Teams, and to assess issues of team-work and education within General Practice. Approximately 200 survey forms were dispatched to GP members of Local Medical Committees, and members of the RCGP Faculties in Wales. 115 questionnaires were returned, and form the basis of the analysis. The sample was geographically representative, although there is a slight over-representation from North Wales (17 respondents each from Clwyd and Gwynedd, 31% of all responses). Overall details of the results are available from the Project Office.

3.06 The survey document utilised a proven method of assessing GPs opinions of NHS services available to their patients (Hicks and Baker 1991).

3.07 In order to compare overall results of the opinions of doctors of diagnostic and treatment services, a score was derived. The ratings for ‘quantity of service’ were scored from 1 (grossly inadequate) to 5 (overprovided), whilst those who stated that they had insufficient experience of the service to offer an opinion were excluded from the mean score. Similarly, the quality of service was rated as 1 = poor, to 5 = excellent, and a mean score computed. Analyses have been carried out of the scores according to the nearest ‘base hospital’ and where significant features of poor provision emerged, these have been identified in the comments section of the report.

3.08 Summary results of the survey can be obtained from the Project Office. It is of note that the rating of ‘Quantity’ of provision was in all cases rated lower than quality, although the two scores are not easily comparable; one would expect lower scores for ‘quantity’ since the highest rating is for ‘over-provided’ service. For every specialty there was no significant difference between the quality of the diagnostic services on the one hand and treatment services on the other. However, there were considerable individual variations within each specialty on a geographical basis.

3.09 The ‘quantity’ of diagnostic and treatment provision for urology, lung cancer, ENT and dermatology were considered least satisfactory, and the provision for breast cancer, and haematology most satisfactory. The quality of services for urology and lung cancer were rated lowest, although the variation in ‘quality’ scores between specialties was not great.

3.10 Clearly, the general message from the questionnaire was that access to urology, ENT and dermatology was most difficult, but there is less concern about overall quality of services.

Gynaecological Cancers

3.11 Prevention of Gynaecological Cancers at present largely revolves around the cervical cytology programme; as yet a satisfactory screening programme for ovarian cancer cannot be recommended, although some techniques show promise (serum markers and selective use of ultra-sound) (Austoker 1995).

3.12 Primary Health Care is actively concerned with the provision of cervical cytology, and clearly there are quality issues for every practice which must be considered in terms of the management of the cervical smear service, and the provision of appropriate communication with patients. Training of staff undertaking cervical cytology is important; these issues have been thoroughly explored in a recent Welsh Office report (Welsh Office 1995). A training pack for those involved in the Welsh cervical smear programme is available (Dept of Postgraduate Studies, 1996).

3.13 Early appointments for patients with irregular and unusual vaginal bleeding are important; one practice in the survey was carrying out endometrial biopsy in the surgery. Colposcopy services have been provided in general practice in some areas, although no respondents to the survey reported such services.

3.14 The level of provision was thought to be generally satisfactory except for poor access and long waiting times in some areas. There were also specific complaints about long waiting times for Colposcopy.

Skin Cancer

3.16 The key preventive message for general practitioners and other members of the PHC Team (especially health visitors) is clearly that of avoiding sunshine.

3.17 Melanoma is increasing in incidence, although, as has been stated earlier, other skin cancers are commoner.
3.18 Forty-three of those answering the questionnaire stated that there was a ‘fast-track’ service for patients who may have symptoms or signs suggestive of skin cancer. In addition, many practices are carrying out biopsy of suspicious lesions in the surgery. It is not known however how many practices follow guidelines on excision. Health Authorities lay down training requirements for access to the minor surgery list, and the School of Postgraduate Studies UWCM is involved (through local CME tutors) in provision of training courses.

3.19 The survey results indicate some problems of provision of the service, and there were a number of specific complaints of long waiting times.

**ENT Cancers**

3.20 These cancers are relatively rare in general practice. Prevention centres around reduction of smoking; early diagnosis of laryngeal cancer is a matter of early referral of patients in the appropriate age-groups with persistent hoarseness.

3.21 For the purposes of the survey, General Practitioners were asked about services provided by Ear, Nose and Throat departments for patients with cancer - based on patterns of referral. Hence the data does not refer to all head and neck cancers, some of which will be managed by oral/maxillo-facial surgeons, plastic surgeons or neuro-surgeons.

3.22 Fast-track diagnostic services were unusual (17 reports).

3.23 Responses to questions about quantity of service varied considerably; in some areas there were complaints about long waits, but in others early opinions were said to be available “within 24 hours”.

**Urology**

3.24 Opportunities for prevention of urological cancers in general practice include promoting smoking cessation (bladder cancer), and - possibly - advising about testicular self-examination. As yet there is insufficient evidence of effectiveness to support a widespread screening programme for testicular cancer.

3.25 Access to specialist diagnostic and treatment services is problematic. Indeed, the services were least well rated of all specialities (West Wales particularly).

3.26 General practice assessment of prostatic symptoms is clearly one issue that must be addressed by the CSEG. There were complaints that ‘fast-track’ services only apply to haematuria in some areas, not to ‘worrying’ cases of prostatism. For example, when should GPs be referring patients for full investigation of prostatism? The availability and use of ultrasound etc. is an important issue. One respondent asked for more guidance over the value of PSA (Prostate Specific Antigen). Generally it has been advised that GPs should refer on the basis of rectal examination and PSA. However, Richie et al (1994) point out that the sensitivity of both tests is not great at 75%. Both sensitivity and specificity can be improved by combining digital rectal examination, PSA and ultrasound (Paul 1995). However, direct access to ultrasound may not be uniformly available, and it is not clear at present if early referral following all these tests will result in improved outcomes. It would be helpful if evidence-based referral guidelines could be developed following a systematic review of the literature.

3.27 The scientific literature on the subject still appears confused in relation to the usefulness of PSA in management of patients (as against its potential use in screening).

**Haematology**

3.28 Leukaemias and lymphomas etc are relatively rare in general practice, but the overall rating given to the diagnostic and treatment services was good, and this was born out in the generally favourable comments. However, there were some adverse comments about communication over treatments, results of tests etc.

**Breast Cancer**

3.29 The main activity in prevention of breast cancer undertaken by GPs is promotion of ‘breast awareness’ in the female population of the practice, and secondly collaboration with the breast screening service. Not only is there a not inconsiderable administrative task to be undertaken when the practice population is screened, but there is an increase in requests for advice at the time.

3.30 The management of breast symptoms and, in particular, breast lumps is a key area in respect of early diagnosis. Recent guidelines have been circulated to GPs from the NHS Breast Screening Programme, although full evaluation will be required to assess their impact.
3.31 So far as secondary care services are concerned, the Welsh GP survey rated them highly satisfactory, with few centres rated as poor for access or quality of service. There were a number of highly complimentary remarks about the services provided - particularly for ‘fast-track’ diagnostic services.

**Lung Cancer**

3.32 Lung Cancer is one of the commoner cancers dealt with in general practice; prevention is of course a matter of reducing smoking. Practices should be expected to have an active policy of promoting smoking cessation, utilising proven methods, including giving advice on the use of nicotine replacement therapy.

3.33 The results of the survey indicated that there were some areas in Wales where there is an excessive wait of appointments for investigation; other comments related to long distances that patients must travel for radiotherapy. Development of Tertiary Centres means that most patients will have to (and do) accept long distances to travel for radiotherapy. Treatment quality overall was rated lower than for any other specialty.

**Gastro-Intestinal Cancers**

3.34 Risks for GI cancers could potentially be reduced by the promotion of an appropriate diet. There is some evidence that risks, for large bowel and stomach cancer, may be reduced by dietary modification. There is good evidence that risk factors, for oral and pharyngeal cancers, do include excessive alcohol intake and smoking. A holistic approach to health promotion, emphasising appropriate diet and avoidance of both smoking and an excessive alcohol intake, is appropriate in primary health care.

3.35 Early diagnosis of stomach cancer demands open access or early access to gastroscopy services. So far as colo-rectal cancer is concerned, there is a suggestion from the literature that screening programmes should be evaluated, but as yet, there is not sufficient evidence to recommend routine screening (Austoker 1995). However, GPs should be aware of all patients who have high risk factors for colo-rectal cancers - family history, previous polyps or inflammatory bowel disease. Many such patients will warrant regular follow-up and some will justifiably require periodic investigation.

3.36 Early diagnosis demands rapid access to flexible sigmoidoscopy (gastric and colonic); there have been descriptions of such services in the literature, although full evaluation studies are not yet available.

3.37 In the survey, the level of access to diagnostic and treatment services was rated quite highly, as was the quality of treatment.

3.38 Comments about the service ranged from compliments about good access to endoscopy to complaints about the long waiting times elsewhere. A ‘rectal bleeding’ assessment service (Singleton/Neath) was complimented.

**Paediatric Cancers**

3.39 Such cancers are rare in general practice, but the services were generally well rated by those who had experience of them. However, there were some complaints about the long distances patients and their families had to travel, and some complaints about fragmentation of the service.

3.40 Over a third of the GPs who responded to the Survey did not have any experience of paediatric cancer services; this places special demands on the providers of such services in terms of giving appropriate support to PHC teams who may be looking after children with cancer. Broad programmes of professional education for GPs and PHC team members may not be seen as relevant, but specific education with regard to the treatment provided for an individual patient is likely to be required.

**In-Patient Palliative Care Services**

3.41 Forty-two percent of those answering the survey felt that access to palliative care in-patient services was inadequate or grossly inadequate, although the quality of service was generally fairly well rated. Dyfed and Powys experienced less good provision.

3.42 Comments referred not only to patchy provision of palliative care beds, but also to lack of provision of pain clinic services.
4. GENERAL ISSUES FOR PROVISION OF SERVICE TO PATIENTS IN PRIMARY HEALTH CARE

Palliative Care Services - Teamwork

4.1 It is accepted that it is part of the generalist service of Primary Health Care teams to provide palliative care. The ‘palliative approach’ is an essential element of primary care provision. Specialist provision in hospices or hospitals must complement and support the services that exist in primary health care. However, a number of problems have arisen with the development of palliative care services, some of which emerged from the Welsh Survey and others are evident from the literature.

4.2 Services have developed in different geographical locations that have individualistic approaches; there is not yet a uniform type of provision in Wales, let alone a uniform level of provision.

4.3 Professional role definitions vary between teams and between groups. There are a number of problems of team working.

4.4 The role on non-statutory bodies is often unclear. In some instances the role is of a main provider, with the agreement of Consultants and GPs; in other areas, the role is apparently to complement key NHS services, but there may be territorial disputes between non-statutory providers and NHS providers. In some instances this operates to the detriment of the service, and sometimes to the detriment of individual patients when it is not clear who is taking responsibility for overall patient care.

4.5 There are sometimes difficulties between generalist providers in PHC, and specialist providers working from specialist centres. GPs tend to feel that they have overall patient responsibility when the patient is at home; specialist advice may be given to the patient without the involvement of the PHC team; drug regimes may be altered without consultation etc.

4.6 Communication barriers exist. This was a regular complaint from the respondents to the questionnaire. Seventeen percent of respondents rated communication from hospitals as poor or very poor, whilst many respondents stated that it was extremely variable between departments. Communication between members of the PHCT is not always good, and there is no standardisation in usage of differing systems of notes in the community. Tensions may exist between nursing and medical staff (Seale 1992).

4.7 Many doctors complained about lack of time to deliver a fully comprehensive service to patients with cancer. It is clear from many comments that some doctors would like to offer holistic services, and more counselling (for example), but are inhibited form so doing by time pressures in practice.

Continuing Medical Education (CME)

4.8 Access to CME for Cancer care in Wales for GPs was felt to be inadequate or very inadequate by 33% of respondents, although it was noticeable that CME was felt to be better where there were strong local services in palliative care - suggesting that the consultant and other staff are having a specific input to the programmes.

5. CONCLUSIONS

5.01 The Calman/Hine report (Calman and Hine 1995) emphasised the importance of Primary Health Care in cancer care:

- GPs will require information about what constitutes best care, both organisationally and for individual cancers.
- Local guidelines for identifying and managing symptoms that indicate a high risk of malignancy need to be established for each cancer with reference to nationally agreed, rigorously evaluated standards.
- Local patterns need to be established in co-operation with primary care.
- The PHCT will act as a link and advocate for the patient with the secondary and tertiary sectors.
- The importance of a close relationship and communication between primary health care and the specialist services cannot be overestimated.
- Each district must have a specialist resource for both primary care and hospital based services, which should allow rapid access to specialist palliative care.

5.02 We entirely endorse these overall aims, although there are some reservations about the usefulness of guidelines in practice.
The Future

5.03 Although the survey undertaken specifically for this report deals with the status quo, it is important to consider the immediate and long-term trends in care for patients with cancer.

5.04 Perhaps the most important impact in terms of technology which will affect PHC over the next decade is the development in tumour markers and in the genetics of cancer. Within a few years, one can envisage PHC practitioners becoming intimately involved, as generalists, in discussions with patients about risk issues, supported by specialist clinical geneticists.

5.05 On the management side, the impact of total fund-holding will bring a new dimension to the work of GPs, who are likely to need new skills to develop this activity.

5.06 Developments in Information Technology may ease some communication problems between different sections of the NHS, yet a number of issues over standards of data transmission and data protection and security have to be resolved at a UK level before any major developments can occur nation-wide. New technologies will need properly formulated implementation plans with appropriate educational support for practitioners.

The Search for Successful Interventions to assist Primary Health Care in Developing Care Delivery

5.07 The development of model policies and guidelines for PHC Teams may be successful if they are sympathetically and systematically introduced with appropriate educational programmes. A number of relevant guidelines already exist, such as guidelines for palliative care in the community (Robinson and Stacy 1994). Yet the evidence is that the production of guidelines alone is a relatively ineffective method of influencing practice.

5.08 A useful systematic review of the Evidence for the Effectiveness of CME was carried out David Davis, a Family Medicine Specialist in Toronto, and colleagues (Davis et al 1994). This review pointed out that there has been a relative lack of research in this area. Nevertheless, there are some useful pointers from the controlled trials that have been undertaken:

"Much of the criticism aimed at methods frequently used in the formal programmes that are the domain of the traditional CME providers would seem to be justified. In contrast, those studies that used enabling and/or reinforcing elements were more effective in changing outcomes.

"...CME is more effective when it incorporates practice-based enabling and reinforcing strategies ......adequate assessment of physicians' needs leads to increased potential for change"

Useful techniques that have been found to be effective in influencing physicians' clinical behaviour include the following:

"...the objective determination of practice or learning needs is a necessary prerequisite for effective education.

"Workshops that provided the opportunity for case discussion and rehearsal of practical behaviours are considerably more effective than more didactic programmes.

"...printed materials alone demonstrate a weak effect on physician performance, but they may be among the many factors affecting performance change.

"Chart review, or chart-stimulated recall appears to be an effective and comprehensive CME activity, incorporating elements of information transfer, competency assessment, reminders of desirable practices, feedback to the physician, and the opportunity for performance-enabling suggestions.

"...'academic detail visits' (visit to practitioner by respected professional/academic colleague to discuss clinical advances) appear to be effective change agents and worthy of further study, both in drug-prescribing and in other clinical domains.

"...two strategies that appear to facilitate practice change are patient education and computerised practice-based information. Practice guidelines, when used alone, were not effective. CME which includes feedback and reminders appears to overcome many of the logistical and sociological barriers to facilitating optimal physician performance.
Robinson and Stacy (1994), commenting on their study of palliative care in the community stated that ‘cohesive teamwork, co-ordinated management, early involvement of nursing staff and the identification of a key worker were essential for good terminal care. ...the majority of concerns were linked to poor communication, either between patient and professionals within the team, or between primary and secondary care.’

In an attempt to evaluate better co-ordination of palliative care, Addington-Hall et al (1992) described a randomised controlled study evaluating the effects of a co-ordinator of cancer care in PHC. Co-ordinators - who were nurses - were recruited for ‘intervention’ practices. The results of the study showed that the intervention made little difference to patient or family outcomes, perhaps because the service did not have a budget with which it could obtain services for patients. The suggestion was also made in the report that the skills of the co-ordinators may not have been appropriate.

The RCGP set up a facilitator project for palliative care 1992-4, which was subsequently evaluated qualitatively (RCGP 1995). The success of the facilitators in developing the services for cancer care appears to have been variable. Many of the interventions were educational; formal educational activity was found to be largely ineffective (in line with evidence quoted above), but small group meetings and workshops were more valuable. Practice visits (educational ‘detail’ visits) and assistance with team development were both well received. Despite the mixed evidence of the overall value of the project, the evaluation group did, nevertheless, suggest that facilitators for community palliative care should still be considered, with a tighter and more well-defined remit than the original facilitators in the project, and the support of a local steering group. However, it is important to conceptualise the work of cancer care in general practice as part of the core work of the team. Good teamwork as a generic skill for the PHC team supports delivery of high quality services across the range of clinical subject areas. Whilst palliative care may be a suitable ‘case study’ we are persuaded that generic team-building exercises are an essential feature of all teamwork in PHC. Such work needs firm support from all employers of staff working with the PHC team, and the provision of resources, including time to undertake such work. Given such team development for the core team, there will nevertheless be a need for the core team itself to set up networks with other agencies, such as the non-statutory bodies involved in cancer care in the community, especially in relation to palliative care.

Educational programmes of CME/CNE should be based on the challenges of the day-to-day working environment, and utilise proven methods of adult education (andragogy and not pedagogy). So local, case-based discussion is likely to be more effective than formal meetings. However, description of developments in secondary care services will be required, so that GPs and other member of the PHC team are aware of options for care.

Whilst there are some 20 CME tutors in Wales for General Practice, there is at present no dedicated support for these tutors in providing educational materials, or formulating courses at an all-Wales level. GP CME is ‘purchased’ by GPs themselves who hold their own budgets for purchasing CME; there is no central operational funding for GP CME programmes apart from sessional payments for CME tutors. Tutors rely on local resources and expertise, which is variable. It would be helpful if the palliative care consultants could be given fixed sessions in their contracts to provide support to PHCTs, which could include some educational activity. In addition, the provision of central support for CME tutors would be allow focused curriculum development rather than relying on ad hoc provision of CME by a variety of providers as at present.
6. RECOMMENDATIONS

The comments given for each of the recommendations below are indicative of the type of action programme that may be required to implement the recommendation, and are not intended to be exclusive of other approaches. Category A = very important; B = important; C = desirable.

<table>
<thead>
<tr>
<th>Recommendation:</th>
<th>Comments/time-scale</th>
<th>Category</th>
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<tbody>
<tr>
<td>1. There is a continuing need for PHC Teams to provide an integrated service of cancer prevention, early diagnosis, and co-ordination of management for patients with cancer.</td>
<td>Key action - Commissioners. Many services will be provided as 'core services' by teams. Commissioners will need to develop service specifications. Some services may need extra-contractual contracts with GPs. Timescale: 2 year programme.</td>
<td>A</td>
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<tr>
<td>Evidence base: a,b</td>
<td></td>
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<td>2. PHC teamwork should be developed. This is seen as a generic requirement for the functioning of the core PHC Team, and not something that is unique to cancer care. Other specialist workers in contact with the PHC team must be sensitive to, and respect the generalist nature of the role of PHC team members.</td>
<td>Key action - PHC Teams and Contractor Services Divisions of Health Authorities. PHC team development essential to provision of co-ordinated service. Commissioners should support and fund PHC development officer to liaise with PHC Teams and other areas of the service. Timescale: 1 - 2 years</td>
<td>A</td>
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<td>Evidence base: b</td>
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<td>3. Practices should set priorities for preventive advice, and agree practice/team approach using the skills of all members of the team as appropriate. High risk patients should be identified; consistent preventive advice should be developed in line with evidence of effectiveness.</td>
<td>Key action - PHC Teams. Largely a professional issue. CME programmes and multi-disciplinary working required. Improved provision of CME and multi-disciplinary education. Timescale: 2 years.</td>
<td>B</td>
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<td>Evidence base: a,b,c</td>
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<td>4. A clinical lead worker should be identified for each patient receiving palliative care in the community. This individual should usually be drawn from generic PHC Team; specialist advice should be delivered via the generic PHCT.</td>
<td>Key action - Community Trust managers, in liaison with PHC Teams. Results of development to be communicated to those involved in palliative care. Timescale: 1 year.</td>
<td>A</td>
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<td>Evidence base: a,c</td>
<td></td>
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<td>5. The Primary Health Care Team is fundamental both to the organisation and delivery of clinical services for patients with cancer being cared for in the community. Where clinical services are provided by non-statutory organisations, these must be supportive to the PHCT who must retain clinical responsibility for the patient in the community, (except on the rare occasion where a specific referral and hand-over is made to a Specialist community service). Where clinical or counselling services are provided for patients in the community by specialist or non-statutory services, they should be provided only with the prior knowledge of the PHCT. Clinical advice must be channelled via the PHCT lead worker.</td>
<td>Key action - Community Trust managers, in liaison with PHC Teams; non-statutory providers. Results of policy development to be communicated to those involved in palliative care. Timescale: 1 year.</td>
<td>A</td>
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<td>Evidence base: a,c</td>
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<td>Recommendation:</td>
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<td>6. There is a real need for improved communication between Primary and Secondary Care. Information should be timely, and relevant. Minimum content of information between GP and hospital is: diagnosis current problem proposed management plan (including follow-up) What the patient has been told other agencies involved current medication and treatment. A local directory of services should be available to the PHC team. Evidence base: d</td>
<td>Key action - GPs and Secondary Care Services. Pro-formas should be discussed between trusts and Local Medical Committees. GP Fundholders to include communication standards in contract specification. Timescale: 1 year.</td>
<td>A</td>
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<td>7. Experiments in improving communication between Primary and Secondary Care based on modern Information Technology should proceed, with due regard to the requirements for data protection and security. Evidence base: c</td>
<td>Key Action - Welsh National Primary Care IT demonstration project. Timescale: 3 years.</td>
<td>B</td>
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<td>8. There is a need for more provision of ‘fast-track’ diagnostic services, especially in urology and ENT. This does not necessarily mean a separate service, but does mean a quick response to a request from a GP for an urgent opinion. (Not all urgent opinions can be categorised into specific symptomatology, such as haematuria, rectal bleeding, etc.) The use of ‘remote consultation’ should be considered for further development- e.g. telephone consultation between GP and Specialist. This type of consultation is much commoner in other countries than in the UK, and we suggest that secondary care services should consider providing facilities for such consultations. Evidence base: a</td>
<td>Key Action: Secondary care Trusts. Service development in line with evidence-based referral guidelines. Action: 2 years. Urgent need to develop evidence-based referral guidelines for prostatic symptoms and provide appropriate service. Action - instigate within 1 year.</td>
<td>A</td>
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<td>9. CME/CNE for the PHCT should be developed with the support of local CME tutors and local specialist resources. One or more All-Wales facilitators for educational activities for PHC Teams should be considered, and specialists in palliative care should expect to be involved on a regular basis in educational activities, such as case-based discussion. Clinical audit must be integrated with educational programmes, and should be utilised both as a method of educational needs assessment, and to assess the impact of educational programmes for the PHC Team and its members. Evidence base: a,b</td>
<td>Action - Welsh Office policy lead in promoting links between CME and Audit. CME resources need to be enhanced (Commissioners). Consultants in Palliative Care should have fixed sessions for promoting professional development. Timescale: 2 years.</td>
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10. The needs of GP fund-holders for advice on purchasing care for patients with cancer should be addressed - especially if total fund-holding is introduced.

**Evidence base:** c

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<th>Action</th>
<th>Timescale: 2 years.</th>
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11. Developments in genetics over the next decade will have a major impact on the work of PHC Teams, especially in relation to provision of advice about risks of cancer (and other diseases) for individual patients or families, and the need for appropriate investigation and follow-up of symptomless patients at risk. PHC teams will require specific educational programmes in respect of the developments in genetics over the next decade; PHC Teams must be involved in the debate both about the principles of any new service provision, and the ethical issues involved.

**Evidence base:** c,e

<table>
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<tr>
<th>Educational programme to be commissioned from Department of Medical Genetics, UWCM. in conjunction with Dept PG Studies, UWCM, &amp; Departments of Nursing Studies in Wales.</th>
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<tr>
<td>3 year programme.</td>
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</table>

**Evidence base:** a. GP Task Group Survey  
 b. Reports of Professional Bodies  
 c. CSEG view  
 d. Published reports on cancer care  
 e. Published health care planning documents

### 7. REFERENCES


29. Annual Handbook of the European Union of General Practitioners - UEMO

8. **ACKNOWLEDGEMENTS**

Dr D Parry, General Practitioner, Porthcawl

Dr J Jones, General Practitioner, Gwynedd

All General Practitioners who responded to the survey conducted to provide data for this Task Group