Who Is Responsible? The Role of Family Physicians in the Provision of Supportive Cancer Care

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Abstract

Purpose: Patients living with cancer identify family physicians (FPs; ie, primary care physicians) as a preferred resource for supportive cancer care (SCC), either through direct provision or referral. However, little research exists on the specific role FPs play in addressing these needs.

Methods: A mailed survey was sent to all FPs in a health care region in Ontario, Canada, to determine their current and preferred roles in the specific provision of SCC to patients with cancer who have been newly diagnosed or are at the end of life.

Results: Completed surveys were received from 84 (64%) of 183 eligible FPs. Most practitioners reported providing for their patients' various SCC needs. However, clear gaps were demon-

strated in psychosocial and nutritional counseling and in providing information about SCC services. FPs were satisfied with their current role reported in SCC coordination, although the type of role varied; FPs who were asked about their end-of-life patients tended to see themselves as part of coordinating teams, whereas FPs asked about their recently diagnosed patients were more likely to defer this responsibly to a third party.

Conclusion: This study identified gaps in the provision of psychosocial and informational care to patients with cancer that may result in unmet needs. In general, FPs do not see themselves as primarily responsible for coordinating patients' SCC and do not wish to assume this role. Accordingly, models that involve FPs as team members in SCC coordination are more feasible for reducing patient need.

Introduction

Patients living with cancer across the disease trajectory identify family physicians (FPs) as a main resource for informational and emotional support and an access point to other health care providers.^{1,2} Surprisingly little information exists on the actual role FPs play in directly addressing the supportive care needs of patients with cancer.

Supportive care is defined as services to meet psychological, social, pain and symptom management, informational, or practical needs resulting from disease and is considered a necessary adjunct to medical treatment for individuals with cancer.³ Supportive cancer care (SCC) services are often community based and delivered through a broad range of service providers. After diagnosis, the time before transfer into the formal cancer system (ie, cancer center) can be a period of high supportive care need. It has been reported in the research literature that up to 40% of patients with cancer have unmet supportive care needs.⁴ Appropriately, the issue of unmet needs in SCC has been identified as a priority, with the aim of reducing the negative impact of the cancer experience.^{5,6}

In Canada and elsewhere, it has been posited that FPs should be responsible for managing their patients' SCC needs after diagnosis.⁷⁻⁹ The rationale behind this belief is that FPs have an intimate knowledge of their patients and their needs,¹⁰ and as previously mentioned, FPs are often the preferred contact of patients with cancer who are seeking supportive care. In addition, research has shown that patients with cancer who were treated only by oncologists received a significantly smaller proportion of recommended care compared with patients who were also treated by an FP.¹¹

Few studies have asked FPs directly to identify their preferred role in SCC, and to our knowledge, none have comprehensively examined the actual role FPs assume in the specific provision of these types of services. We believe the present study is the first to investigate both of these questions. We focused on FPs seeing patients with cancer at the newly diagnosed and end-of-life extremes of the disease trajectory, periods during which SCC is particularly crucial.

Methods

Design and Setting

A cross-sectional survey approach was taken. The study was conducted in the Niagara Region located in south-central Ontario, within Canada's universally funded health care system. The Niagara Region has a population of 410,574 and an area of 1,846 square kilometers. This region was selected because it contains a full range of organizations and services that address the supportive care needs of the local population; the community and health system characteristics of this selected region were established as representative of the province of Ontario.¹²

Participants

All eligible practicing FPs, including palliative care specialists, in the study region were included in the survey. The physician list was generated using medical directories and corroborated with professional association listings and local hospital registries. To reduce the response burden of FPs answering in terms of both their recently diagnosed patients with cancer and those receiving palliative care, FPs (except for palliative care special-

Table 1. Survey Distribution and Responses

	Mailed Survey	No Response	Ineligible*	Indicated Patient Type in Practice
FPs with palliative care patients†	141	50	47	44
FPs with newly diagnosed patients	133	49	44	40
Total	274	99‡	91	84

Abbreviation: FP, family physician.

* Either was not currently practicing in study region or had no patients with cancer of the type requested.

† Including eight palliative care specialists.

‡ Adjusted response rate of 64%.

ists) were equally randomly selected to receive a questionnaire designated to one stage or the other.

Questionnaire

A unique questionnaire was developed on the basis of existing instruments,⁵ the relevant literature, expert opinion, and the judgment of the research team. This questionnaire was pilot tested with 10 primary care clinicians outside the study area for clarity, readability, and relevance. The survey instrument contained three main sections, in addition to questions to capture physician characteristics.

The first section addressed FP care delivery, identifying the key SCC services for which FPs regularly assessed or provided (either through direct provision or referral to other providers). The service groupings specified were: information about cancer and its treatment; information about SCC services; psychosocial support (ie, counseling services such as support groups, peer groups, and professional counseling); pain and symptom management; physician support and services (ie, nursing care, homemaker support, nutritional counseling, transportation, rehabilitation services, and home-based medical equipment/supplies); and palliative care (ie, hospice care and palliative care specialists; asked of palliative group only). This comprehensive list of SCC services was derived from the conceptual literature.³ These are services that can be reasonably expected to be assessed and provided for by FPs. Response options were dichotomous (yes or no) for all service types listed.

In the second section, FPs were asked to define their current role in the coordination of supportive care for their patients with cancer. Response options were whether the FP: referred patients to another individual or agency who then became responsible for SCC coordination; was primarily responsible; or viewed himself/herself as part of a team that was responsible. Physicians were then asked how satisfied they were with the role selected on a four-point scale ranging from 1 (very satisfied) to 4 (very dissatisfied).

Finally, FPs were asked about how well the regional SCC system performed in terms of the comprehensiveness of services available to patients, ease of accessibility to these services, and extent of compatibility between different providers within the system. These three fundamental elements of service delivery must be present for a health system to be coordinated (ie, function efficiently), according to the evaluative framework of Alter et al.¹³ The questions covering these elements were used in one of our previous studies.⁵ Response items were on a four-point scale ranging from 1 (agree strongly) to 4 (disagree strongly).

When responding to each section, FPs were asked to think about patients with cancer for whom they had cared within the last 6 months. Space was provided after most scaled response items for FPs to elaborate on or explain their responses.

Procedure and Analysis

The survey was carried out using a modified version of Dillman's Tailored Design Method,¹⁴ with two mailed contacts and a final telephone contact for nonresponders. The survey period ran from April to September 2002. Ethics approval was obtained from the McMaster University Ethics Review Board (Hamilton, Ontario, Canada).

Analysis was descriptive, considering the proportion of FPs in each group (ie, the newly diagnosed group and palliative group) who reported: assessing/providing for a specific SCC service type; a particular role in the coordination of the supportive care of their patients with cancer; and agreement/disagreement with each statement about system performance. Four-point scales were dichotomized for ease of reporting. Open-ended responses were coded, and themes were extracted.

Results

Response Rate and Respondent Characteristics

From a sample of 274 FPs, 175 responses were obtained, yielding an overall response rate of 64%. Table 1 reports the distribution and survey response rate for each physician group. Eighty-four FPs reported that they had had a patient with cancer who was either newly diagnosed or receiving palliative care in their practice within the past 6 months.

The characteristics of FP respondents are presented in Table 2. FPs reported practicing in the region for a median of 15 years. Just over half (51%) of FPs had a solo practice, with the others indicating that they shared a practice. The median FP practice size was 2,000 patients, with a median number of 33 patients with cancer. A comparison of FP characteristics (eg, sex and years in practice) between respondents and nonrespondents revealed no significant differences between these groups in the study region.

Reported Assessment for and Provision of Services

In general, the physician proportions of provision for each service type mirrored those of assessment. Although it is assumed that if an FP reported having provided for a particular SCC service need, then some level of patient assessment occurred, this does not necessarily imply that assessment by this physician

Table 2. Family Physician Respondent Characteristics (n = 84)

Characteristic	No.	%
Sex		
Male	65	77.4
Female	19	22.6
Solo practice	43	51.2
Years of practice in region		15.0
Median, min to max		1-50
No. of patients in practice		2,000
Median, min to max		25-5,000
No. of patients with cancer in practice		33
Median, min to max		2-500

for that need occurred on a regular basis; hence, some FPs reported on services that they had provided for yet did not regularly assess for.

The two FP groups varied in their reported assessment and provision (either provided directly or referred to third party) for patients' SCC needs (Table 3). A greater number of FPs in the palliative group who were asked about the SCC of their patients provided these services compared with those in the recently diagnosed group. The provision of SCC services associated with psychosocial and informational domains of care tended to be the least considered. Fewer than two thirds of FPs who were asked about their recently diagnosed patients with cancer reported providing information about SCC services. Although most FPs (86% in the palliative group and 85% in the recently diagnosed group) provided emotional support, fewer FPs (61% in the palliative group and 48% in the recently diagnosed

group) provided referrals for professional counseling. Similarly low proportions were reported in terms of regular assessment for this potential service need.

Most FPs reported regularly assessing and/or providing for pain and symptom management, nursing care, and homemaker support in both the recently diagnosed and palliative groups. However, assessment and provision was reported less often for the remaining service types yet to be mentioned, particularly in the recently diagnosed group.

Physician Role and Satisfaction

Table 4 presents FPs' reported roles in coordinating their patients' SCC and their satisfaction in this role. Almost 40% of FPs in the recently diagnosed group reported that they referred these patients to another individual or agency who then became responsible for coordinating SCC services. One third of FPs reported that they were part of a team responsible for coordinating SCC, and a smaller number of FPs (28%) described themselves as having primary responsibility for coordinating patients' SCC.

In contrast, almost half (46%) of FPs who were asked about their patients with cancer receiving palliative care reported being part of a team responsible for coordinating SCC. One fourth of FPs reported that they referred these patients to another individual or agency who then became responsible for coordinating SCC services, and 30% described themselves as having primary responsibility. The breakdown of roles reported by palliative care specialists within the palliative group was similar to that reported by the rest of the group.

Table 3. FPs' Reported Assessment for and Provision of SCC Services

SCC Service	FPs Regularly Assessing for Need				FPs Providing for Need*			
	Newly Diagnosed Patients (n = 40)		Palliative Care Patients (n = 44)		Newly Diagnosed Patients (n = 40)		Palliative Care Patients (n = 44)	
	No.	%	No.	%	No.	%	No.	%
Information on cancer and treatment	26	65.0	37	84.1	31	77.5	34	77.3
Information on SCC services	28	70.0	36	81.8	25	62.5	39	88.6
Emotional support	31	77.5	42	95.5	34	85.0	38	86.4
Group counseling	17	42.5	25	56.8	18	45.0	28	63.6
Professional counseling	18	45.0	28	63.6	19	47.5	27	61.4
Nutritional counseling	25	62.5	37	84.1	28	70.0	36	81.8
Pain and symptom management	35	87.5	41	93.2	38	95.0	41	93.2
Nursing care	35	87.5	39	88.6	35	87.5	42	95.5
Homemaker support or personal care	37	92.5	41	93.2	37	92.5	41	93.2
Physical rehabilitation services	31	77.5	36	81.8	30	75.0	37	84.1
Home medical equipment or supplies	29	72.5	39	88.6	28	70.0	40	90.9
Transportation to appointments	15	37.5	27	61.4	17	42.5	33	75.0
Hospice-based care	—	—	20	45.5	—	—	21	47.7
Palliative care specialist† (n = 39)	—	—	29	74.4	—	—	34	87.2

Abbreviations: FP, family physician; SCC, supportive cancer care.

* Either direction provision of service or referral to appropriate provider.

† Not including responses from palliative care physicians.

Table 4. FPs' Reported Roles and Satisfaction in Coordinating SCC Services

SCC Responsibility	Satisfaction With Role				Total by Role Category	
	Satisfied		Dissatisfied			
	No.	%	No.	%	No.	%
FPs with palliative care patients (n = 44)						
Current role						
Refer and agency is responsible	9	81.8	2	18.2	11	25.0
Solely responsible	9	69.2	4	30.8	13	29.5
Part of team responsible	19	100	0	0	20*	45.5
Total	37	84.1	6	13.6	44	100
FPs with newly diagnosed patients (n = 39)						
Current role						
Refer and agency is responsible	12	80.0	3	20.0	15	38.5
Solely responsible	10	90.9	1	9.1	11	28.2
Part of team responsible	12	92.3	1	7.7	13	33.3
Total	34	87.2	5	12.8	39	100

Abbreviations: FP, family physician; SCC, supportive cancer care.

* One response missing in "satisfied with role" question.

Overall, most FPs (85%) reported being satisfied with their role in coordinating SCC. FPs who held sole responsibility for coordinating their patients' SCC tended to be the least satisfied, whereas all FPs in the palliative group who reported being part of a coordinating team were satisfied with their role.

Perceptions of Service System

Physicians' perceptions of the regional SCC system are presented in Table 5. Most FPs (82% in the recently diagnosed group and 81% in the palliative group) reported that they were satisfied with the SCC services provided to their patients. FPs (59% and 73%, respectively) were less satisfied with the information exchange between themselves and service providers in the region. Lack of communication between providers and lack of timely information were the main problems identified by FPs.

Half of the physicians felt that required SCC services were available within the region. Nursing care and psychological and social support were the main services identified as inadequate. Physicians' suggestions for system improvement included the presence of a central coordinating body, increased resources, and more information for physicians about available SCC services.

Discussion

With this study, we have taken the first step toward developing a more comprehensive understanding of specific SCC patient need assessment and service access through FP self-reported provision or referral for key service types during the initial diagnostic and palliative phases of care. This study also provides insight into important mitigating factors that may influence the level of assessment and service access in the context of a typical Canadian health care services system from the perspective of FPs.

In our examination of FP care delivery, we found most of these clinicians reported assessing and/or providing for their patients' SCC needs in terms of pain and symptom manage-

ment, emotional support, nursing care, and homemaker services; however, this level of care was not evident for needs such as group or professional counseling, nutritional counseling, and information about SCC services.

Where patients were in their illness trajectory influenced the role of FPs in the patients' care. With regard to the SCC needs examined in this study, a smaller proportion of FPs in the recently diagnosed group assessed or provided for these SCC services compared with those in the palliative group, with marked differences in emotional and other psychosocial support services. Overall, considering that 50% to 75% of patients with cancer require specific SCC, and approximately one third require expert psychosocial intervention,⁶ these care practices may pose a barrier to patients with cancer in having their needs met.

Internationally, research has demonstrated that both FPs and oncologists use more instrumental than socioemotional (ie, psychosocial) communication in cancer consultations.^{15,16} In a recent study in the United States in which FPs were interviewed about their involvement in the care of patients with cancer, although all of the FPs played some part in pain management, only one third reported providing emotional support.¹⁷ Another US study, from the perspective of patients with cancer, found that patients believed their FP to be an excellent source of educational support (with 91% providing educational services) but less so for emotional support, with fewer than half of FPs providing this type of SCC service.¹⁸

We found that most FPs were satisfied with their reported role in the coordination of SCC, although the type of role identified varied. FPs who were asked about patients receiving palliative care tended to see themselves as part of a coordinating team, whereas FPs who were asked about recently diagnosed patients with cancer were less likely to view themselves as having any coordinating role in SCC. This difference could be a result of FPs feeling unsure about how to help their patients navigate

Table 5. FPs' Perceptions of Regional SCC System

Statement	FPs in Agreement			
	Newly Diagnosed Patients (n = 40)		Palliative Care Patients (n = 44)	
	No.	%	No.	%
All needed services are available	25	62.5	20	45.5
Resources are adequate	19	47.5	19	43.2
Services are responsive to individual diversity	26	66.7	30	69.8
Services are available when needed	21	52.5	25	56.8
Resources are allocated on the basis of need	31	79.5	32	74.4
Outreach and information are provided	23	60.6	19	43.2
Overall satisfied with service delivery system in the region	25	62.5	23	54.7
Satisfied with information exchange between practice and organizations providing SCC services to patients	23	59.0	29	72.5
Satisfied with SCC services provided to patients	32	82.1	35	81.4

Abbreviations: FP, family physician; SCC, supportive cancer care.

the cancer system after initial diagnosis,¹⁰ a possibility that requires additional investigation. In addition to patient stage of illness and physician preference, variation in role among FPs has also been explained by the extent to which the specialist (eg, oncologist) delegates responsibility to the FP.¹⁰

The impressions from most FPs in this study were that they did not see themselves as having a primary responsibility in the coordination of SCC, nor did they, for the most part, desire to assume this role. These findings coincide with those of other studies^{7,19} examining the role of Canadian FPs, which also found that only a minority of these practitioners wanted to take full responsibility for coordinating their patients' cancer care throughout the illness trajectory. Rather, the management of patients with cancer was described as a team effort. However, how team participation should be organized is not entirely clear.

Considering this finding, along with the current limitations in physician resources, interventions that directly target physicians to become responsible for coordinating patient SCC are likely to meet resistance.²⁰ In our study, the highest level of role satisfaction was expressed by physicians who reported being part of a coordinating team, suggesting that models that involve community physicians as team members and not as sole coordinators of SCC are more practical and ultimately more likely to be successfully implemented, leading to improvements in supportive care for patients. Enabling FPs to become more active in care coordination and support services requires consideration of how current reimbursement practices can be adjusted to reinforce FP practice change. Payment reform in primary care represents a continued debate in both Canada and the United States.²¹⁻²³ Reforming reimbursement models for primary care has been viewed as critical to both sustaining and transforming practice in this field.²¹⁻²³

One important observation in this study was that many FPs felt that SCC services for their patients were unavailable, particularly in terms of psychosocial support and nursing care. This may have contributed to the reported gaps in assessment, provision, and referral in these domains. In addition, a large pro-

portion of FPs were dissatisfied with the cancer system in terms of service delivery, which reflects the issue of fragmentation; however, they were generally pleased with the SCC services that their patients had received. Not surprisingly, poor communication between health care providers and sites was another issue that emerged, in agreement with the findings of Sargeant et al,²⁴ who found gaps in information transfer among FPs, community specialists, and oncologists, which interfered with the provision of timely and compassionate care for patients. The FPs in the current study recommended a centralized body responsible for the planning of SCC in the region to improve coordination of services.

A possible limitation of this study in using reported rather than observed practice data is respondent bias, with physicians overstating their involvement in SCC provision. However, the physicians were quite forthcoming in stating what they did and did not do, as evidenced in the low percentage of FPs who reported providing for many of the SCC service types and in the accompanying open-ended comments within the survey, in which the physicians had little reservation in explaining their positions. The study did not take into consideration the effects of patient characteristics (eg, age, sex, education, income, and disease site) on physician role, an area in which other studies have found relationships.^{2,25} For the purposes of this research, it was reasoned that the role indicated by physicians would be their most common role applied to the majority of their patients.

Understanding how FPs may facilitate access through assessment, provision, and referral for identified SCC services is essential to inform the development of strategies to enhance access to necessary services and service providers in the community. FPs play an important role in cancer care, yet many FPs operate in isolation with regard to the cancer system.^{25,26} There is an emerging trend among both oncologists and FPs to identify shared care as the most appropriate model for addressing the SCC needs of patients with cancer.²⁷ Research is necessary to de-

termine how to better integrate FPs into regional cancer programs to ensure optimal management of patients' SCC needs.

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Authors' Disclosures of Potential Conflicts of Interest

The authors indicated no potential conflicts of interest.

References

1. Bulsara C, Ward AM, Joske D: Patient perceptions of the GP role in cancer management. *Aust Fam Physician* 34:299-301, 2005
2. Gray RE, Goel V, Fitch MI, et al: Supportive care provided by physicians and nurses to women with breast cancer: Results from a population-based survey. *Support Care Cancer* 10:647-652, 2002
3. Fitch M: Supportive care for cancer patients. *Hosp Quart* 3:39-46, 2000
4. Ashbury FD, Findlay H, Reynolds B, et al: A Canadian survey of cancer patients' experiences: Are their needs being met? *J Pain Symptom Manage* 16:298-306, 1998
5. Brazil K, Whelan T, O'Brien M, et al: Towards improving the co-ordination of supportive cancer care services in the community. *Health Policy* 70:125-131, 2004
6. Cancer Care Ontario: GTA 2014 Cancer Report. <http://www.ontla.on.ca/library/repository/mon/8000/244989.pdf>
7. Gilbert R, Willan AR, Richardson S, et al: Survey of family physicians: What is their role in cancer patient care? *Can J Oncol* 4:285-290, 1994
8. Southern DM, Young D, Dunt D, et al: Integration of primary health care services: Perceptions of Australian general practitioners, non-general practitioner health service providers and consumers at the general practice-primary care interface. *Eval Program Plann* 25:47-59, 2002
9. Steinmetz D, Walsh M, Gabel LL, et al: Family physicians' involvement with dying patients and their families: Attitudes, difficulties, and strategies. *Arch Fam Med* 2:753-761, 1993
10. Dworkind M, Towers A, Murnaghan D, et al: Communication between family physicians and oncologists: Qualitative results of an exploratory study. *Cancer Prev Control* 3:137-144, 1999
11. Earle CC, Neville BA: Under use of necessary care among cancer survivors. *Cancer* 101:1712-1719, 2004
12. Statistics Canada: Health regions by peer groups. <http://www.statcan.gc.ca/pub/82-221-x/2005001/pdf/4197394-eng.pdf>
13. Alter C, Hage J: *Organizations Working Together*. Thousand Oaks, CA, Sage, 1993
14. Dillman DA: *Mail and Internet Surveys: The Tailored Design Method*. New York, NY, Wiley, 2000
15. Ford S, Fallowfield L, Lewis S: Doctor-patient interactions in oncology. *Soc Sci Med* 42:1511-1519, 1996
16. Ong LM, Visser MR, Kruijver IP, et al: The Roter Interaction Analysis System (RIAS) in oncological consultations: Psychometric properties. *Psychooncology* 7:387-401, 1998
17. Hickner J, Kent S, Naragon P, et al: Physicians' and patients' views of cancer care by family physicians: A report from the American Academy of Family Physicians National Research Network. *Fam Med* 39:126-131, 2007
18. Crawford ED, Bennett CL, Stone NN, et al: Comparison of perspectives on prostate cancer: Analyses of survey data. *Urology* 50:366-372, 1997
19. Sisler JJ, Brown JB, Stewart M: Family physicians' roles in cancer care: Survey of patients on a provincial cancer registry. *Can Fam Physician* 50:889-896, 2004
20. Taylor D, Lahey M: Increasing the involvement of specialist physicians in chronic disease management. *J Health Serv Res Policy* 13:52-56, 2008 (suppl 1)
21. College of Family Physicians of Canada: Family medicine in Canada: Vision for the future. http://www.cfpc.ca/local/files/Communications/Health%20Policy/FAMILY_MEDICINE_IN_CANADA_English.pdf
22. Bodenheimer T, Wagner E, Grumbach K: Improving primary care for patients with chronic illness: The chronic care model, part 2. *JAMA* 288:1909-1914, 2002
23. Martin J, Avant R, Bowman M, et al: The future of family practice: A collaborative project of the family medicine community. *Ann Fam Med* 2:S3-S32 (suppl 1)
24. Sargeant J, Murray A, Gray J, et al: Responding to rising cancer caseloads: Family physician learning needs and challenges in cancer care. *J Cancer Educ* 20:155-161, 2005
25. McWhinney IR, Hoddinott SN, Bass MJ, et al: Role of the family physician in the care of cancer patients. *Can Fam Physician* 36:2183-2186, 1990
26. Institute of Medicine, National Research Council of the National Academies: *From Cancer Patient to Cancer Survivor: Lost in Transition*. Washington, DC, National Academies Press, 2005
27. Arvik T, Holtedahl KA, Mikalsen H: "When patients have cancer, they stop seeing me": The role of the general practitioner in early follow up of patients with cancer—A qualitative study. *BMC Fam Pract* 7:1-9, 2006

Commentary: Who Should Follow Our Patients?

By Patricia Legant, MD, PhD

The recent ASCO study of the oncology workforce documented what many of us practicing physicians, aging right along with our patients, have suspected for a long time: There is a looming workforce shortage of medical oncologists.¹ It seems indeed hard to recommend that a young physician choose a specialty with long hours, ongoing emotional stress, and declining reimbursement, despite the compensating, and abiding, personal satisfaction of deeply rewarding patient-physician relationships.

The reduction in the number of medical oncologists parallels a growth in the number of patients with cancer, a result of both the aging of the population and our success in creating a growing cadre of cancer survivors. Various proposals have been

offered for dealing with this mismatch of supply and demand.² Canadian researchers in particular have called for delegation of some cancer care, especially survivor care, to primary care physicians.³ An important element in promulgating such a policy is its acceptance by the primary care physicians themselves. In the report by Brazil et al⁴ in this issue of *Journal of Oncology Practice*, Canadian family physicians were asked whether and how they would like to perform so-called supportive care for patients immediately after cancer diagnosis and also near the end of life. Not surprisingly, they wanted some guidance in assuming these new responsibilities. Another recent Canadian study found the same request among family physicians regarding routine follow-up care of cancer survivors.⁵