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

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Corresponding author: Kevin Brazil, PhD, St Joseph's Health System Research Network, 105 Main St E, Level P1, Hamilton, Ontario, Canada L8N 1G6; e-mail: brazilk@mcmaster.ca.

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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

In the United States, and to a certain extent in Canada as well, there are a number of real and potential barriers to a model that presumes that primary care physicians would be willing and able to shoulder a significant part of cancer care. First, oncology services are less centralized in the United States than they are in Canada, and family physicians may be less expected to assume direct responsibility for cancer care. Second, just as for oncologists, there is a similar workforce shortage of primary physicians, who are needed to provide care for all the other ailments of aging baby boomers.^{6,7}

Patient attitudes pose a third potential stumbling block to shifting care out of the oncologist's office. Several studies have shown that patients with cancer prefer the continued involvement of their oncologists in their care.^{8,9} One means of preserving a relationship between the patient and oncologist is maintaining survivor care under the umbrella of an oncology office, with physician extenders providing care, in a so-called collaborative model.¹⁰ There are several advantages to this model, including: continuity of care, with more accurate assessment of individual risk of recurrence, late adverse effects of therapy, and medical and social comorbidities; availability of more knowledgeable personnel, who keep themselves informed about emerging research related to cancer; and potential cost effectiveness, with recognition of which tests are necessary and which are unnecessary in long-term follow-up. Yet another model transfers survivor care to a dedicated clinic, perhaps within the institution that provided the initial care.¹⁰

Fourth, current reimbursement patterns in general fail to sustain the evaluation and management services required for both supportive and survivor care. One specific shortfall is compensation for communication of treatment plans. A recurring theme in studies of patient follow-up in any model is uncertainty about which elements of care each physician should provide. A formal cancer treatment summary has been proposed as a method of assigning such responsibilities clearly and might address some of the concerns observed among physicians in the Brazil et al⁴ study. However, creation of these documents and communicating their contents both to patients and treatment providers cannot happen without financial support. The 2006 Institute of Medicine report on cancer survivorship urged adequate payment for the formulation of cancer treatment plans before chemotherapy and treatment summaries afterward.¹¹ Despite persistent lobbying by patient advocacy organizations,

which recognize the value of these plans,¹² a bill has yet to be passed. Another deficiency in the reimbursement schema involves a different point in the cancer trajectory, namely, end-of-life conversations. These discussions are an essential part of good cancer care, but they are not properly paid for. Unfortunately, recent publicized myths about "death panels" have set back appeals for reimbursement for these discussions for a long time.

Finally, provision of effective survivor and supportive care relies on an entire team of ancillary personnel and services, including social workers, dietitians, home health and hospice nurses, and so on. It is these services that will likely be the first to be eliminated as oncology reimbursement decreases. Thus, cuts to home health and hospice care are among the rumors swirling around the Obama health care plan.

I would suggest one additional, but important, reason to allow oncologists themselves to preserve at least some occasional contact with their long-term survivors. Returning to my initial comment about the emotional toll of a career in oncology, I think it may be vital for our morale to see some of our successes from time to time and to enjoy the special bond created by a journey through cancer together, for caregiver as well as patient. It is these relationships that allay burnout and serve to remind us why we continue to practice.

Driving the suggestions to move less acute care to physician extenders and primary care physicians is not only the shortage of oncologists but also the poor reimbursement for these services. Ultimately, like many critical responsibilities in patient care, the message about cancer care is that someone has got to do it and, one hopes, do it well. The question then becomes not who should do it but how anyone can afford to do it.

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Patricia Legant, MD, PhD, is an oncologist in private practice in Salt Lake City, UT, and is a member of the Editorial Board of Journal of Oncology Practice. Contact her at oncopat@aol.com.

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