

# **Report on Integrated Care in Advanced Cancer Project**

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## **Introduction.**

The Integrated Care in Advanced Cancer (ICAC) project was a joint initiative of the Inner and Eastern, North Eastern Metropolitan and Barwon Breast Services Enhancement Program (BSEP) teams. The project aimed to explore ways of improving integration and continuity of care between the acute and primary care sectors in order to better meet the needs of women with advanced breast cancer. The focus of the project was in accordance with the recommendations of the Cancer Coordination Unit of the Department of Human Services, whose priority is to bring about improvements in the management of women with advanced breast cancer.

General Practitioners (GPs) care for women with breast disease over an extended period of time, usually before their initial diagnosis of breast cancer, throughout active treatment, and in the terminal stages of their care. GPs often also have knowledge of a woman's family and social situation, as well as their coexistent medical conditions. As such, GPs are ideally placed to undertake the role of case manager for women with advanced breast cancer, particularly as they often have extensive knowledge of the woman's psychosocial as well as their medical needs.

Communication between health care professionals managing women with advanced breast cancer was identified as a priority area in a needs assessment conducted by the Inner and Eastern Melbourne BSEP in Eastern Health in November 2002 (1). Women living with advanced breast cancer have the majority of their care managed in the primary care sector, with short but intensive periods of contact with specialist services within the acute sector (2). As a consequence, the project focussed on communication occurring between GPs and medical specialists managing women with advanced breast cancer.

Our initial objectives were to establish the nature of existing communication practices between the acute and primary care sectors, and to identify ways of improving these practices. This was achieved through a review of the literature, and interviews conducted with GPs and breast cancer specialists in both rural and metropolitan settings.

## **Background.**

A review of existing literature concerning the nature and content of communication occurring between health professionals, particularly in cancer care, was conducted.

The literature highlighted the acknowledgment amongst health professionals that effective communication between medical practitioners is important. However, it was clear that both GPs and specialists find that, in general, the communication occurring between the two groups does not consistently provide the information they require. Several studies also identified that GPs and medical specialists have different requirements from letters (3,4,5). In general, GPs wanted more detail in letters than surgeons did (4).

For GPs and referring surgeons, issues of concern included lack of information about current medications, expected side effects of treatment, psychosocial issues and what the patient has been told. Prognosis was found to be a particular area of concern in two studies identified in the literature search concerning correspondence between oncologists and GPs (3,5). In one study more than 80% of GPs requested more information on prognosis and what the patient had been told, yet less than 20% of letters examined contained these details (3).

Both GPs and referring surgeons also noted that at times there was too much detail and repetition in documenting the present complaint and past medical history. In one study, although less than half of the GPs surveyed wanted information on medical, drug or social history, many letters contained these details (3).

Of additional concern to GPs was that oncologists commonly use the letter from the specialist to the referring doctors as the record of their consultation with the patient for the medical history. It was suggested that this was inappropriate given the differing requirements of GPs, surgeons and documentation for the medical history (4).

Common areas of concern for oncologists were missing reports or test results, or insufficient detail in communications from GPs, which resulted in unnecessary repetition of investigations (4). Whilst their major focus was on medical issues, social and psychological needs were also seen as important.

Both GPs and specialists identified the importance of a phone call if a matter is urgent or complex (4). Matters concerning psychosocial issues particularly fell into this category, and oncologists requested phone communication if significant psychosocial factors were likely to affect management. GPs and referring surgeons also requested a phone call if treatment recommendations are different to those expected by the treating doctor.

Although GPs and referring specialists identified numerous desirable items for letters from oncologists that were commonly missing, their satisfaction with the correspondence was confoundingly positive. In one study by Graham and Wilson (6), examination of reply letters from one radiation oncologist showed only 60% of essential information items were included, yet more than 90% of recipients were satisfied with the content of the letters.

Methods of improving GP specialist communication were also documented in the literature (3,4). These included the use of a 'prompt sheet', which gave headings to assist the letter writer to include essential information (such as prognosis, what the patient has been told, and psychosocial aspects of care.) It was found that the use of a prompt sheet did improve the quality of communication, but was difficult to implement. One study trained oncologists in improving the quality of correspondence to referring doctors by use of audit and prompt sheets, with marked improvement in letter quality and the satisfaction of the recipients (3).

## **Method.**

We sought to determine whether the experience of medical professionals in our regions concurred with the experiences and attitudes described in the literature. In order to examine this, a two-stage approach was designed. Interviews were initially undertaken with metropolitan and rural GPs. The issues raised were then explored in 10 interviews with breast cancer specialists (including surgeons, radiation and medical oncologists). These interviews were undertaken by the project officers from each of the three BSEP teams.

### ***GP interviews.***

Dr Josie Samers, a GP and project officer with the Inner and Eastern Melbourne BSEP, conducted interviews with 10 General Practitioners in metropolitan and rural settings. These were undertaken either by telephone or in face-to-face interview. The GPs interviewed included male and female practitioners, working either full-time or part-time.

The discussion included:

- GPs' understanding of the term "advanced breast cancer";
- Each GP's case load of patients with advanced breast cancer;
- GPs' experiences of who makes a diagnosis of advanced breast cancer;
- Communication with specialists;
- Prognosis;
- Areas in which GPs require assistance to manage women with advanced breast cancer.

This informal discussion approach to the GP data collection was beneficial in allowing a broad range of issues to be raised rather than limiting the discussion to a series of set questions.

### ***Specialist interviews***

After identifying a number of key issues concerning GP-specialist communication and management of advanced breast cancer in the interviews with GPs, it was decided to adopt a more structured approach in conducting interviews with breast cancer specialists. This approach was also chosen because several project workers conducted these interviews and it was considered important that the questions asked by the different project workers remained consistent. For these reasons, a structured questionnaire was designed (see appendix 1.)

Ten questionnaires with breast cancer specialists (including two surgeons, five radiation oncologists and three medical oncologists) working in both rural and metropolitan settings, and in public and private practice, were completed. The project officers from each of the three BSEPs either conducted the interviews using the questionnaire as a guide, or gave the questionnaire to the specialists to complete themselves. Dr Josie Samers did not conduct any interviews with the specialists, as it was considered that this might have biased the specialists' responses.

### ***Data analysis***

Given the small number of interviews conducted it was felt inappropriate to undertake advanced statistical analysis. Contents of the answers to questions were grouped and common themes identified.

## **Results**

### **a. General Practitioner Interviews.**

#### ***1. Definition of advanced breast cancer:***

GP's were not necessarily familiar with the term advanced breast cancer. Phrases used by the GPs interviewed to describe their understanding of the term included metastatic cancer; terminal; no hope of cure; ongoing management problem; sense of limited time remaining; complications; disease after the acute breast cancer phase; and local recurrence.

#### ***2. Case load:***

The GPs interviewed managed between zero and four patients with advanced breast cancer per year, depending on whether they were in full or part-time practice, male or female practitioners, and the special interests of their practice. There was a range of four to 12 patients with advanced cancer of any type in a year.

Breast and prostate cancer were the advanced malignancies most commonly encountered. The GP participants from the Barwon area managed a greater number of advanced cancer cases due to their involvement in the Shared Care Oncology Program at the Andrew Love Cancer Centre in Geelong.

#### ***3. Diagnosis of advanced breast cancer:***

If GPs are suspicious of metastatic or recurrent disease, they generally refer the patient back to the surgeon who initially managed their breast cancer, unless otherwise requested by the patient. The GPs interviewed conveyed a sense of 'not wanting to delay the diagnosis', and not wanting to be the bearer of bad news when advanced disease is detected. The GPs reported that they feel unable to adequately discuss the impact of the diagnosis of advanced disease with the patient, particularly in regard to treatment options and prognosis. Depending on the patient's symptoms at presentation, the GPs may occasionally refer to other specialists, such as the medical or radiation oncologist.

#### ***4. Communication with specialists:***

The GPs interviewed reported that their initial choice of specialist for referral when a woman is diagnosed with early breast cancer is influenced by existing good communication with those specialists. In advanced disease, although the most common form of communication is by letter, the GPs preferred a phone call with specialists, particularly to convey prognosis or when the matter is urgent. However, GPs were often reticent to phone specialists themselves as they did not wish to interrupt them at an inappropriate time, and felt that clearer details of when and how to contact a particular specialist would be helpful.

GPs would like letters from specialists to include:

- Details of who attended the consultation with the patient (to identify the key players);
- What the plan of treatment is and what is likely to happen to the patient;
- Expected side effects of treatment and their management;
- Clear directions about follow up (such as blood tests etc required by the specialist); and
- Regular updates on the patient's progress while undergoing chemotherapy or radiotherapy.

They also reported that the letters did not adequately convey the aims of treatment, whether curative, palliative, or for time benefit. GPs also reported that psychosocial needs were not well communicated in letters from specialists.

The participating GPs were unsure to what extent the content of their referral letters was actually read by specialists, and were mindful of the large volume of correspondence the specialists received. The GPs felt that important information was better conveyed by phone.

## **5. Prognosis:**

Communication regarding prognosis was an area of great concern raised by GPs. The GPs interviewed reported that patient's prognosis is seldom communicated in specialist letters but seen as essential, particularly as it may influence their management of other conditions. One GP reported:

*I saw a patient of (another GP in the practice) with metastatic breast cancer who was becoming increasingly demented. It was thought that her prognosis was poor, so she was being managed symptomatically. I wasn't sure how much to investigate, so I rang the specialist, who told me she had quite a good prognosis. I investigated her aggressively then, and her dementia turned out to be from a treatable cause. You often assume the prognosis in someone with metastatic cancer is worse than it actually is, and knowing the prognosis can change your management completely.*

The participating GPs thought that percentage survival figures were less meaningful to them than a general feeling of the likely outcome, and that this was better conveyed by phone conversation with the specialist than by letter.

## **6. Areas of need:**

GPs stated that the following were areas that need to be addressed in assisting them in optimising their management of patients with advanced breast cancer:

- Communication of prognosis;
- Side effects of treatment (common, serious, and those needing referral);
- Clearer contact details for specialists;
- Agencies referred to and contact details for these agencies;
- Medication changes occurring during treatment;
- Local resources available;
- Aspects of palliative care: steps in pain management, morphine conversion, anti-emetics, steroid use, and management of constipation. GPs also felt the earlier introduction of palliative care services would assist in reducing the stigma associated with this care;
- Written resources given to the patient also being provided to the GP; and
- More readily accessible and less costly psychological counselling.

## **b. Specialist Interviews.**

### **1. Case load:**

The number of patients with advanced cancer of any type seen by each of the ten specialists interviewed varied considerably. Four of the ten specialists reported seeing less than ten new patients per month with

advanced cancer, while three specialists saw more than fifty. The range was three to one hundred advanced cancer patients per month. Of these, three of the ten participating specialists solely saw patients with advanced breast cancer, whilst for the other seven, up to half of their case load was comprised of women with advanced breast cancer.

The majority of specialists interviewed reported that less than half the patients referred with advanced breast cancer were referred by GPs.

## **2. Communication with GPs:**

The participating specialists reported that the information they receive from GPs when they are referred a new patient is variable in content and quality. Most of the specialists commented that GPs almost always send a referral letter, but that the letters do not always include test results. Specialists expressed frustration at having to repeat tests that they know the GP has done because the results were not included in the referral letter.

Specialists outlined that desirable information from GPs includes:

- A clear outline of the patient's current problems including their relevant oncological history;
- Any test results that have been conducted in relation to the problem for which they are referring the patient; and
- Any information about psychological morbidity that may impact on the specialist's interaction with the patient.

All of the specialists interviewed said that they usually or always send a letter back to the referring GP. Half of the specialists also said they would make a phone call occasionally if required, such as in the instance of patient distress. Three specialists gave more detail about what information they included in the reply letter to the GP. All of these include the outcome of the assessment and the treatment plan.

Four specialists commented that contact initiated by the GPs who refer to them, was either rare or usually did not occur. Six of the ten specialists commented that occasionally they or their reception staff would receive a phone call from a referring GP. Four commented that they usually receive a letter. One oncologist added the following comment:

*Very rarely do we find out if a patient has died via their GP. We usually find out through the paper or from family. We have a policy of informing GPs when a patient has died.*

Overall, 50% of the specialists responded that their experience of communication with GPs was either adequate or better. One specialist described it as "Generally excellent". However, three of the ten specialists' experiences were less satisfactory. Two specialists were concerned that patients sometimes had to wait longer than necessary for an appointment or were sent to the emergency department unnecessarily because GPs did not contact them directly.

Eight of the ten specialists interviewed indicated that they were contactable by phone either directly, via their receptionist or via a hospital switchboard. Two indicated that if they were not directly contactable, a registrar or alternative on-call specialist was always available.

## **3. Prognosis:**

Six of the ten participating specialists expressed a preference not to give prognostic information to patients, families or GPs, generally because they felt it was not accurate. Alternative information given was percentage survival or similar statistics, extent of disease, estimation of life expectancy or other broader indications of prognosis. Only two specialists said they gave prognostic information in the reply letter to the referring GP. One of these specialists said they preferred to give the information in very general terms such as months to years of life left or median survival.

One specialist made the following comment:

*A lot of patients don't want to know and most GPs don't want to know. If the prognosis isn't good, I would say something like, "We're very concerned about you..." and might suggest treatment such as*

*supportive care. The most important thing is to keep the message to the patient and the message to the GP consistent. The patient might go to see the GP the next day and if you told the GP something that you didn't tell the patient it might impact on the patient's trust in you.*

#### **4. GP follow up:**

Five of the ten specialists interviewed reported that they routinely encourage patients to return to GPs. However, one of these specialists added:

*In some cases we're more easily contactable than the GP. If it's a cancer-related problem they can call oncology.*

Four specialists said they frequently shared care with GPs. This was influenced by the stage of the disease and how much inpatient or outpatient treatment the patient was having.

One specialist commented:

*I usually arrange follow up myself, alternating with the oncologist.*

#### **5. GPs management of patients with advanced breast cancer:**

Seven of the ten specialists interviewed said that GPs were variable in their management of patients with advanced breast cancer. There was agreement among these specialists that some GPs provide excellent management of these patients. However, at the other end of the spectrum, some GPs either hand the patient's management entirely over to the specialist or simply do not know what to do. One specialist made the following comment:

*Patients who have formed long-term relationships with their GPs tend to be followed up well. Patients who go to 24-hour clinics tend not to be followed up so well. Many patients referred to me now have two GPs, one they have known for a long time who is often difficult to get in to see due to waiting times etc. Another one they go to if they need a quick prescription, referral etc, often a bulk billing clinic.*

Two specialists said that their experience with GPs' management of patients with advanced breast cancer was good. One specialist was also positive about the GP's facilitatory role in the management of patients with advanced breast cancer.

There was general agreement amongst the specialists about what the role of the GP in the management of patients with advanced breast cancer entails. The following themes emerged:

- The GP has a coordinating/liasing role, particularly where multiple specialists are involved. At times this may be a monitoring or surveillance function.
- The GP may have a more intimate knowledge of the patient's family and community than the specialist and consequently may be more able to provide support to partners and other family members.
- The GP's role in managing the patient's non-cancer issues was seen as important.
- Several specialists highlighted the increasingly important role of the GP as the disease progresses. This may involve pain management or overseeing the transition from active to palliative care.
- Several of the specialists reiterated that the GPs role is dependent on their relationship with the patient and not all patients or GPs will want the GP to perform these roles.

#### **6. Areas of need:**

When asked what resources would assist in the management of patients with advanced breast cancer, the most common theme among the specialists was a call for more specialist nurses. This included breast care nurses, palliative care nurses and oncology nurses to provide coordination of care and follow-up beyond the early breast cancer stage right through the advanced and palliative stages.

The provision of comprehensive palliative care services was also seen as important. Extra support is needed via hospice beds, particularly in the community, but with strong links to specialist oncology services.

More inpatient services for palliative care patients, more palliative nurses and specialists and upskilling GPs' palliative care knowledge, were also seen as important.

Many of the specialists interviewed stated that more medical and radiation oncologists were needed. They also identified that access to psychological support professionals such as social workers and psychologists and coordinated, multi-disciplinary follow-up were required.

## **Discussion.**

The themes arising from the interviews conducted with both GPs and specialists are consistent with many of those reported in the literature. While the management of advanced breast cancer forms a significant part of the practice of most of the specialists interviewed for this project, it comprises only a small part of most GPs' clinical practice. The GPs interviewed estimated they would manage only one or two patients a year with advanced breast cancer, but also identified that GPs more commonly encountered breast cancer than any other type of advanced cancer.

GPs value communication with specialists highly. The GPs interviewed rated effective communication with specialists as an important factor when they are choosing a specialist to refer the patient to. However, the GPs interviewed also reported that they frequently feel 'left out of the loop' of care and that they wish to be seen as 'part of the team' by treating specialists. This was interesting given that the specialists interviewed placed a high value on the role of the GP, particularly with regard to the management of their patients' non-cancer related medical issues and their supportive role for other members of the patient's family. Despite this, however, it was noted in our interviews that specialists frequently commented on the variability in involvement and expertise they encounter among the GPs they work with.

There was a degree of agreement between the results of the GPs and specialist interviews. Both groups valued telephone communication in addition to a letter, particularly regarding issues that were urgent, complex or sensitive. Sensitive issues include prognosis and patient death, with both groups expressing a desire to be informed if a patient dies. The literature supports the importance of telephone communication where issues are urgent or complex (4). In addition, both groups agree that letters from specialists to GPs should include a treatment plan and information about what is going to happen to the patient.

Another area of agreement between GPs and specialists concerned what additional resources are needed to assist in the management of patients with advanced breast cancer. Both groups agreed that more psychosocial services are needed and more resources are required for palliative care services. In addition, the specialists thought that more specialist nurses and more medical and radiation oncologists were required while GPs thought more information about what is available in their local communities is important. There was also a common feeling among the GPs, particularly those in rural areas, that linkage with palliative care services came too late in the management of patients with advanced disease. However, in general, the rural GPs interviewed had a better knowledge of local services available than metropolitan GPs, contributed to by their participation in the Oncology Shared Care program at the Andrew Love Cancer Centre in Geelong.

There were also notable differences between the two groups, particularly concerning the information each required. Specialists reported that they were frequently frustrated when test results are not included in the GPs referral letter, necessitating repetition of tests that they know have been conducted. This finding was supported in the literature (4). The specialists interviewed in this study emphasised the importance of including details of the tests the GPs had performed as well as the results. The specialists also viewed the inclusion of relevant psychosocial information as important. However, GPs expressed concern about how much of their letters were read and felt important information was better conveyed by phone.

GPs expressed a need for information from specialists about the patient's prognosis. However, six out of ten specialists expressed a preference not to give prognostic information because it is generally inaccurate. Specialists did, however, describe different ways of communicating this information to patients that are less direct, such as via statistical indications of how severe the patient's disease is, or by using words such as 'supportive' treatment rather than 'active'. It is important to GPs that they receive this information as it may impact on the GPs management of the patient's non-cancer related medical conditions. Both GPs and

specialists agreed that it was important to keep the information concerning prognosis given to patients and GPs consistent.

Despite the fact that both the GPs and specialists interviewed reported some deficiencies in communication between the two groups, on the whole both groups were reasonably satisfied with the communication. Half the specialists interviewed described their experiences of communicating with GPs as either adequate or better. However, two specialists were concerned that sometimes patients had to wait longer than necessary for an appointment or were sent to casualty unnecessarily because GPs didn't contact them directly. Despite specialists encouraging this direct contact, GPs are reluctant to contact specialists directly by phone unless they know the specialist or have worked with them before because they are mindful of interrupting them.

**Recommendations.**

In order to assist GPs in their management of women with advanced breast cancer, this project has identified four key areas which need to be addressed:

1. Communication needs of both specialists and GPs;
2. GPs' education needs, particularly regarding natural history of the disease, current best practice management and treatments available, side effects of treatment and prognosis;
3. Availability of resources to assist GPs in their management of women with advanced disease; and
4. GP participation in the multidisciplinary team to enhance patient management and continuity of care.

Three mechanisms for meeting the identified needs regarding the management of advanced breast cancer are proposed.

**1. GP facilitator**

In this proposed model, a resource person (such as an up-skilled GP, cancer support nurse or other project officer) would be appointed and trained in each division to act in a supportive role for GPs in the area. As GPs manage only a small number of patients with advanced breast cancer at any time, this person would have specialised knowledge of the nature of the disease, local resources, multidisciplinary teams, palliative care services, psychosocial counselling and clinical trials available. The GP facilitator would also be able to provide access to community based resources and information for both the GP and patient specific to individual needs.

**2. GP Liaison**

Hospital-based GP liaison roles have been established at many hospitals in Victoria for some time. The role of the GP liaison officer varies widely, but may encompass facilitation of communication between specialists and GPs, coordination of GP attendance at multidisciplinary meetings, provision of GP education programs and coordination of shared care programs. The role provides a link between the hospital and GPs in the community and facilitates communication between the two groups. This model would expand the existing role of GP Liaison officers to target the needs identified in facilitating management of advanced cancer.

**3. Shared care programs**

Shared care programs already exist throughout Victoria, and involve the employment of GPs in specialist clinics and outpatient settings to provide further education and experience, whilst enhancing patient care by involving GPs in multidisciplinary care teams. Oncology shared care programs in areas such as the Barwon region have proved an effective mechanism for improving outcomes for cancer patients. Such programs facilitate communication between participating specialists and GPs, encourage continuity of care, and provide ongoing education for participating GPs. Such programs may include GP placement terms on oncology outpatient clinics and palliative care services.

Issues	Mechanisms	Examples
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<p>1. <i>Communication needs:</i></p> <ul style="list-style-type: none"> <li>• GPs require information from specialists about: <ul style="list-style-type: none"> <li>- aims of treatment</li> <li>- current medications</li> <li>- prognosis</li> <li>- psychosocial issues</li> <li>- referrals to community providers.</li> </ul> </li>   <li>• Specialists require: <ul style="list-style-type: none"> <li>- Copies of investigation results and reports</li> <li>- Information about the GP's needs, particularly regarding prognosis</li> <li>- Information about psychosocial issues</li> </ul> </li> </ul>	<p>GP Liaison (2)</p> <p>Divisions of General Practice</p> <p>Enhanced Primary Care (EPC) items (which provide remuneration under the Medicare schedule for GP participation in case conferences, teleconferencing and care planning)</p> <p>GP liaison (2)</p> <p>Divisions of General Practice</p>	<p>Electronic transfer of information in a standardised format</p> <p>Letter templates</p> <p>Facilitate communication between specialists and GPs</p> <p>Clear instructions on how best to contact specialist</p> <p>Education seminars with local specialists</p> <p>Participation in multidisciplinary meetings</p> <p>Electronic transfer of information in a standardised format</p> <p>Letter templates</p> <p>Prompt sheets</p> <p>Education</p> <p>Participation in multidisciplinary meetings</p>
<p>2. <i>GPs' Education needs</i></p> <ul style="list-style-type: none"> <li>- side effects of treatment</li> <li>- local resources</li> <li>- nature of advanced breast cancer</li> </ul>	<p>GP facilitator (1)</p> <p>Divisions of General Practice</p> <p>GP Liaison (2)</p> <p>Breast Care Nurses</p> <p>Shared care programs</p>	<p>Side effect information for GPs when patients receive a particular treatment regimen</p> <p>Specialist knowledge of resources and aspects of disease</p> <p>Education seminars</p> <p>Provision of management guidelines to all GPs</p> <p>Patient information also provided to GPs</p>
<p>3. <i>Resources for GPs</i></p> <ul style="list-style-type: none"> <li>- Psychosocial counselling services</li> <li>- Palliative care</li> <li>- Specialist nurses</li> </ul>	<p>'Better outcomes in mental health' program</p> <p>GP facilitator (1)</p>	<p>Specialist knowledge of resources and liaison between GPs and local service providers</p> <p>Directories of local services and resources</p>
<p>4. <i>Participation</i></p> <ul style="list-style-type: none"> <li>- Multidisciplinary meetings</li> <li>- Shared care programs</li> </ul>	<p>GP facilitator (1)</p> <p>GP Liaison (2)</p>	<p>Participation in multidisciplinary meetings and care planning</p> <p>GP placements in oncology clinics and palliative care programs</p>

## **References.**

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## Appendix 1.

### Questions for interviews with specialists regarding advanced breast cancer.

#### Introduction:

The Integrated Care in Advanced Cancer project aims to improve the continuity of care occurring between specialists and general practitioners in the management of women with advanced breast cancer. We are looking at the existing communication occurring between specialists and GPs, and the areas of need in integrating care for women with advanced breast cancer. I would like to ask you a few questions relating to your experience of advanced breast cancer management and your communication with GPs.

1. How many patients with advanced cancer (*of any type*) would you see each month in your practice?

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2. What proportion of these patients would have *advanced breast cancer*?

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3. Approximately how many of your patients with newly diagnosed advanced breast cancer would be referred from GPs (when advanced disease is first detected)?

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4. What information is usually provided by GPs when the referral is made? What information would be desirable? (eg what investigations have been performed, are the results available etc)

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5. What communication do you initiate with the GP? (eg letter, fax, phone call)

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6. What communication does the GP initiate with you?

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7. What is your experience of communicating with GPs?

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8. How can GPs best contact you if problems arise?

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9. Do you give the GP details about the patient's prognosis? In what manner is this communicated? (ie phone call, letter/ percentage survival, gut feeling)

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10. Do you routinely encourage the patient to go back to the GP for follow up?

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11. What is your experience of GPs management of patients with advanced breast cancer?

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12. What do you see as the role of the GP in the management of patients with advanced breast cancer?

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13. What resources would assist you in management of your patients with advanced breast cancer?

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*Thankyou very much for your time and assistance with this interview.*