Make Quality Cancer Survivorship Care Possible in the Era of Workforce Shortage

By Jianqing Lin, MD, and Ross C. Donehower, MD

With advances in cancer medicine, patients are living longer. Whether this is measured as an improved cure rate after combined-modality therapy or prolonged survival with a good quality of life, this is an exciting time. As a result of the increasing survival rates after cancer, issues concerning long-term cancer survivorship have become more important in clinical oncology. Many individuals and families continue to face complicated care issues resulting from cancer diagnosis and adverse effects long after completion of their treatments. The growing number of cancer survivors and their unique needs have been challenging our health care system to develop programs that support survivors' transitions from active treatment to survivorship care.[1-3]

After primary treatment, patient follow-up includes screening for recurrence and second primary cancers, management of long-term treatment effects, advice about health promotional strategies, and monitoring and appropriate referral for psychosocial issues.[4] Optimal survivorship care must include appropriate general medical care as well, such as routine colonoscopy (for patients with noncolorectal cancer in the right age group) and management of dyslipidemia, hypertension, bone loss, and so on. It is likely to require considerable involvement from primary care providers (PCPs) with ongoing support from oncology specialist teams.[5]

In the May 2009 issue of *Journal of Oncology Practice*, Shulman et al[6] published interesting and alarming data on the impact of the medical workforce on survivorship care. They documented that the number of internal medicine trainees going into primary practice is decreasing progressively. Together with the acute shortage of medical oncologists and oncology nurses in the near future, as well as inadequate preparation of these providers to address complex cancer survivorship care, we are facing an increasingly urgent problem. The authors discussed the options for care of cancer survivors and suggested that we must develop nonphysician providers in practices to deliver cancer survivorship care.

It is true that there are no current plans that are likely to increase sufficiently the number of either oncologists or PCPs to meet the needs of patients with active disease and remission. For this reason, innovative care models for active cancer care and cancer survivor care are urgently needed. Perhaps at the present time nonphysician providers, or physician extenders, will need to deliver survivorship care. Oncologists not only need to focus on the treatment of active disease and clinical research but also will need to work with their extenders to discuss with patients the additional care that is required and make sure patients have survivorship care plans.

If cancer is considered a chronic disease, general medical education and residency training curricula focusing on cancer survivorship should be strengthened to better equip PCPs for additional care for cancer survivors.[7] So should the training of nonphysician extenders. Oncology fellowship programs should prepare their fellows to lead this effort when they go to practice in the community.

A recent study showed that both PCPs and oncologists were expected to be prominently involved in the care of cancer survivors, although there were discordant expectations with respect to the roles of PCPs and the oncologists.[8] PCPs favor making survivorship care planning a standard component in cancer management.[5,8] Currently, perhaps the most common practice is by a shared model, by which cancer survivors see both oncologists and PCPs.

Because of the shortage of PCPs, survivors may choose either their oncologists or PCPs for follow-up on the basis of their comfort level, although the two groups need to work together to clarify their roles in survivorship care.[5] The treatment summary and survivorship care plan might lead to better coordination of care and optimal use of resources, including oncologist and PCP time, thus eliminating redundant care while not missing anything that needs to be done. This can only be done through adequate and explicit coordination of care, and with the stress on both groups, we can ill afford redundancy.

Implementing coordinated survivorship care broadly will require additional health care resources and commitment from health care providers and payers. Although programs to address these issues have been proposed, there is substantial work to be done in this area.[2] Health care policymakers and residency and fellowship programs should be enlisted to aid this alarming workforce shortage and make appropriate adjustments. We hope we can say yes to the question raised by Shulman et al[6] through coordinated teamwork. Knowing the future shortage of the oncology and PCP workforce, we need to work efficiently and effectively to improve cancer care.

ASCO has developed breast and colon cancer survivorship care plans (http://www.asco.org/treatmentsummary). Similar information also is available from National Comprehensive Cancer Network's clinical practice guidelines in oncology. It is possible to incorporate them and establish the practitioner's (or practice group's, or cancer center's) own follow-up plan that is based on clinical evidence. Oncologists should lead this role for survivorship care and prevent the fragmented care that can occur after active treatment is over.[5] Survivorship care should be guided by a tailored survivorship care plan.[3]

This should be a new measure for the quality of care and become the next priority in refinements and improvements in cancer care.

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ERRATUM

The November article by Luna et al, entitled "Private Practice Administrative Costs Influenced by Insurance Payer Mix" (J Oncol Pract 5:291-297, 2009), contained an error in the spelling of the fifth author's name. It was originally published as Edward Reed and should have been Eddie Reed. *Journal of Oncology Practice* apologizes to the authors and readers for the mistake.

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