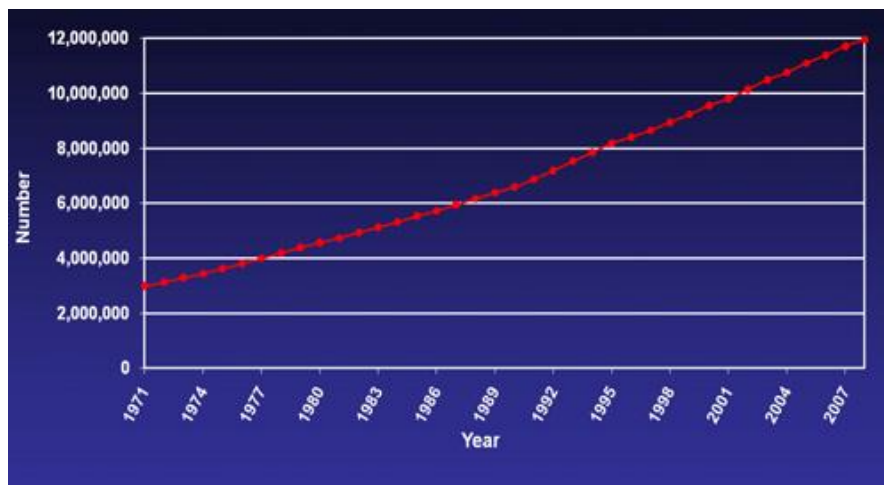


## The Looming Oncology Specialist Shortage—Who will take care of the Cancer Survivor?

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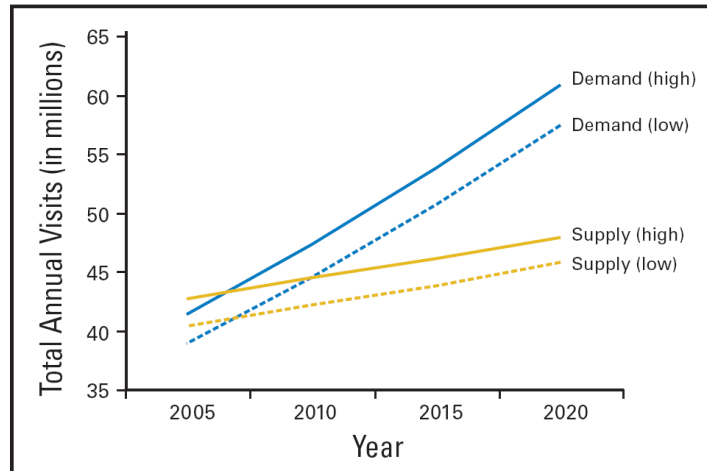
With the population growing, early detection and improvements in cancer treatment resulting in more cancer survivors (~ 12 million currently) , a problem is beginning to surface in the medical world--- a shortage of oncologists to take care of newly diagnosed cancer patients. Specifically for the USA, this shortage is statistically projected to be 41% due to the steady increase in survivors while simultaneously there is projected to only be a 14% increase in the oncology workforce by the year 2020. <sup>i</sup>

### Estimated Number of Cancer Survivors in the United States from 1971 to 2008



Data source: Altekruse SF, Kosary CL, Krapcho M, Neyman N, Aminou R, Waldron W, Ruhl J, Howlander N, Tatalovich Z, Cho H, Mariotto A, Eisner MP, Lewis DR, Cronin K, Chen HS, Feuer EJ, Stinchcomb DG, Edwards BK (eds). SEER Cancer Statistics Review, 1975-2008, National Cancer Institute. Bethesda, MD, [http://seer.cancer.gov/csr/1975\\_2008/](http://seer.cancer.gov/csr/1975_2008/), based on November 2010 SEER data submission, posted to the SEER web site, 2011

Researchers in Canada recognized the impending problem and early on conduct research in this area. This research was published in the Journal of Clinical Oncology in 2006 by Grunfeld, et al. The purpose of the prospective study was to determine if breast cancer survivors had worse clinical outcomes if their long term survivorship care was performed by PCPs rather than by medical oncologists who had taken care of the patients throughout their treatment. The clinical outcomes were survival and recurrence rates. The PCPs who participated in the research study received specific breast cancer survivorship care training as part of the study. There was no statistically significant difference in mortality (6% among the PCP group vs 6.2% among the oncologist group) or recurrence (11% among the PCP group and 13.2% among the oncologist group) when comparing those survivors followed by their PCP vs those who were continually followed by their oncologist. <sup>ii</sup>



**Baseline Projected Supply and Demand for Oncologist Visits**  
*Erikson et al. J Oncol Practice 3:79, 2007*

So what are the ramifications of this deficit of oncology specialists and what are the causes? People choosing to go into the medical field as a physician are not choosing oncology as their preferred specialty area. In the US, a primary reason is due to poor reimbursement.

What does this mean for cancer survivors? Cancer survivors need to be informed early on (preferably at the time of the initial consultation about their new diagnosis) what the treatment plan will be, who is responsible for what during their treatment AND how will they be followed post treatment to monitor for recurrence and for the development of new primary cancers. Knowing what to expect will help in the patient understanding the treatment plan and survivorship care clinical pathway so that there should be less confusion and anxiety later when the transitional process back to his/her community providers takes place.

This can be a difficult transition for many, however—the oncologist and the patient. Patients have naturally bonded with the oncology team who has “saved their lives” and therefore can be quite resistant to having to discontinue seeing their oncologist and required to migrate back to their PCP for whom they may not feel as attached. The patient may even have doubts that their family doctor knows how to monitor him/her in the same way an oncologist has been trained to do. And in turn, the PCP may not feel comfortable either, having historically referred patients to oncology specialists for treatment of cancers with the expectation that the oncologist will follow this patient “forever”. Research conducted at Johns Hopkins has reiterated these concerns. Additionally, oncologists are concerned they will miss seeing their long term patients and become burned out if required to devote more time to more newly diagnosed patients.<sup>iii</sup>

What has not appeared in prospective clinical research to date is the knowledge of base of PCPs in knowing how to manage long term side effects as well as delayed onset side effects from cancer treatment. The data below reflects the myriad of clinical side effects that can result in impacting a

cancer survivor's quality of life and well being long term and the need for patients to have their voices heard and their side effects discussed and minimized by all providers involved with their care short and long term.

#### **Percentage of patients not receiving care for their concerns:<sup>iv</sup>**

According to a survey from the Living Strong Organization, out of 2,307 participants:

1,356 cancer survivors had concerns about Energy - 56% of these did not receive care  
1,261 about Concentration - 83% did not receive care  
1,058 about Sexual function – 71% did not receive care  
963 about Neuropathy - 60% did not receive care  
780 about Pain - 37% did not receive care  
527 about Lymph edema – 33% did not receive care  
503 about Incontinence – 69% did not receive care  
367 about Lungs – 47% did not receive care  
184 about Heart – 32% did not receive care

#### **What are the solutions to this paradigm shift that needs to happen?**

1. **Empowering patients**—patients need and deserve to be educated about their diagnosis, treatment, and survivorship issues so that they can actively participate in the decision making about their treatment as well as learn how to do self monitoring for local or distant recurrence of their cancer. Patients should also understand how cancer rehabilitation can help them function at the highest possible levels and should be offered this care when appropriate.
2. **Educating PCPs** (and gynecologists) about cancer survivorship care—what should a healthcare provider be looking for and monitoring a patient for after his/her treatment is done? This doesn't necessarily mean that the PCP needs to be an expert in cancer treatments; instead they need to be well versed on long term side effects and the management of those side effects as well as how to physically assess a patient for cancer returning or developing a new type of cancer. Without such education, which can be provided by oncology specialists in the form of conferences, educational dinner meetings, and written guides, there is risk that the patient will lack confidence in the healthcare provider now responsible for her cancer survivorship care and demand to have a staging work up every 6 months. (Staging work ups that include scans and blood work are no longer the standard of care for patients without known metastatic disease elsewhere in their body). PCPs should also be educated about cancer rehabilitation care and when it is appropriate to refer patients for these medical services.
3. **Creating protocols** that provide guidance based on clinical profiles and risk of recurrence. Determining when is the optimum time period to transition a patient back to her PCP. (For example, a patient with stage 0 breast cancer who opted to do bilateral mastectomies as her treatment can usually be transitioned back to her family doctor and gynecologist in one year since her risk of recurrence (local and distant) is so extraordinarily low (1%). On the other hand,

someone who had stage III breast cancer carries a high risk of local and distant recurrence and may need to be followed for 7-8 years by her oncology team).

4. **Encouraging dedicated healthcare providers** to specialize in cancer survivorship. This can mean the development of physician extenders (for example, nurse practitioners) functioning in such a role. There may also be internal medicine doctors who have an interest in this type of specialization too. This could be accomplished through the expansion of the medical curriculum currently taught in nursing schools and medical schools.
5. **Working with health insurers** to electronically facilitate ways to monitor a patient's compliance with screening exams, adherence to medications for prevention of recurrence, and annual physical examinations.
6. **Tapping into the expertise of cancer center leaders** who have implemented successful survivorship program and can share their strategies with others. Not every method will work for all, but assessing various models of survivorship care can save time and prevent re-inventing the wheel for those cancer specialists who are just about to get started.
7. **Researching and publishing new studies** about cancer survivorship issues. We know a lot about side effects during treatment and shortly thereafter. We need to learn more about late effect side effects, psychological well being of survivorship long term, and other burdens that may have resulted due to a diagnosis long ago of cancer.

The good news is however that more and more people are beating this disease. It's important that healthcare providers no longer focus on this being the only goal—surviving cancer—and including other goals—such as quality of life—as being equally important to the well being and livelihood of a cancer patient. Communication among patients and all providers involved in the care (acute and chronic care) of cancer survivors is key to coordination of care too. Going forward, we should seek opportunities for patients and providers to actively participate in survivorship research so that we can ultimately improve the lives of long term cancer survivors.

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<sup>i</sup> Hortobagyi G. A Shortage of Oncologists? The American Society of Clinical Oncology Workforce Study. JCO Vol 25, No 12 ,April 20,2007 p1468-1469

<sup>ii</sup> Grunfeld E, Evine MN, Julian JA, et al. Randomized trial of long term follow-up for early stage breast cancer: a comparison of family physician vs specialist care. J Clin Oncol. 2006; 24(6): p848-855

<sup>iii</sup> Melinda Kantsiper, MD, Erin L. McDonald, MPP<sup>2</sup>, Gail Geller, ScD, MHS, Lillie Shockney, RN, BS, MAS , Claire Snyder, PhD, Antonio C. Wolff, MD. Transitioning to Breast Cancer Survivorship: Perspectives of Patients, Cancer Specialists, and Primary Care Providers. Journal of General Internal Medicine. 1 November 2009 24 Suppl 2: p459

<sup>iv</sup> Ruth Rechis, P. L. (2010, June). *HOW CANCER HAS AFFECTED POST-TREATMENT SURVIVORS: A LIVESTRONG REPORT*. Retrieved Sept 2, 2011, from Live Strong. org: <http://www.livestrong.org/pdfs/3-0/LSSurvivorSurveyReport>