What role does the general practitioner in France play among cancer patients during the initial treatment phase with intravenous chemotherapy? A qualitative study

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KEY MESSAGES
- French cancer patients often consult their GPs during the initial therapeutic phase of cancer despite the fact that they consider them to be less skilled in treating medical problems than oncologists.
- Reasons cited by cancer patients for seeing their GPs were management of administrative problems, reassurance and emotional support, medical interpretation, and less frequently, medical care.

ABSTRACT
Background: France’s ethical and legal principles place general practitioners (GPs) at the forefront of cancer patient management, coordination, and follow-up. The objective of this study was to determine the actual role of GPs in the follow-up phase as well as patient perspectives on their GPs.

Method: A multidisciplinary group of researchers conducted this qualitative study based on in-depth interviews of 50 patients managed at two cancer centres. A content analysis method was used to analyse the study data.

Results: According to the patients interviewed for this study, their GPs were relatively ineffective at managing medical problems related to cancer by comparison with their oncologists. Nonetheless, the patients had all consulted their GPs during the interval between the diagnosis and our interview. Reasons given for consulting their GPs included administrative matters, psychological support, reassurance, and advice, but also to a lesser extent, medical management.

Conclusion: Patients’ perspectives called attention to two aspects of the role of GPs in the French healthcare system: (a) the importance of GPs within an effective system for managing cancer patients, and (b) for some patients, GPs’ relative lack of medical skill compared to oncologists.

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Introduction

The healthcare conduit in France between the community and hospitals has recently become better organized thanks to ‘le Plan Cancer’ (the Cancer Plan). Healthcare coordination continues to be somewhat underdeveloped in France, however, partly due to persistent communication problems between general practitioners (GPs) and hospitals.[1] Since 2009, French law mandates that GPs coordinate their patients’ healthcare and help monitor chronic illnesses. The national healthcare plan requires French patients to select a primary care GP or médecin traitant (‘treating physician’). Patients are encouraged to consult their primary-care physician first, but they are also free to consult other doctors.

When a health problem arises during the initial treatment phase, cancer patients who have returned home are faced with a choice between hospital or primary care consultations. The role of the GP in this situation has been the subject of much published discussion. Most studies of GPs are based on data gathered either from GPs themselves using qualitative research techniques [2–4] or from patients via

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quantitative techniques.[5–9] Six qualitative studies in which patients were interviewed, stressed the importance of GPs in the early follow-up phase, particularly for emotional support and medical management.[10–15] To a very significant extent, these issues are specific to the healthcare system in the country in which they occur.

The present article is part of a larger study analysing cancer patients’ perspectives on medical practices. Owing to a lack of data in France concerning GP involvement of in cancer care, the initial phase of the study involved collecting patient perspectives. This article presents research based on patients’ perspectives regarding their GPs, as well as on GPs’ role in the initial cancer treatment phase. The study addressed the following questions: (1) Do cancer patients consult their GP, and if so, why? (2) What was their assessment of their GP’s role in their treatment?

Methods

Study design

A multidisciplinary research team consisting of one GP, three sociologists, and one anthropologist was formed to conduct a qualitative study. None of the researchers had personal or professional ties to the patients recruited for the study.

This qualitative study employed in-depth, semi-structured individual interviews because few studies of this type—and none in France—have focused on how cancer patients view their GPs’ role in their treatment. The interview protocol applied a phenomenological approach to each participant’s personal experience as a cancer patient and their previous and current relationships with their GP.

Participants were given a leaflet of information during recruitment, and the study protocol was approved by both the French National Committee for Private Freedoms (CNIL) and a French ethical board (CCTIRS).

Patients

Between March 2012 and June 2013, 85 participants were recruited by on-duty oncologists at two cancer centres, one in the Île-de-France region (Gustave Roussy) and the other in the Provence-Alpes-Cote d’Azur region (Centre Antoine Lacassagne). In order to participate, volunteers had to be over 18 years of age, to have received intravenous curative or palliative chemotherapy for less than six months for breast, lung, colorectal, or prostate cancer, and be in satisfactory physical condition (ECOG score ≤2). Participants with psychiatric illnesses and those unable to express themselves in French were deemed ineligible. The choice of studying patients receiving intravenous chemotherapy was based on the hypothesis that such treatments typically are associated with a high incidence of adverse physical and psychological effects.

Recruitment was conducted sequentially in order to achieve purposive sample and to allow the authors time to transcribe and analyse the interviews. The recruitment process was designed to include a range of ages, occupations, and cancer stages.

Interviews

The overall purpose of our approach was to take patients’ voices into account. Therefore, semi-structured individual interviews following a phenomenological approach was applied. Questions focused primarily on the management of pre-existing diseases, the adverse effects of cancer treatments, and the need for psychological support, without prejudging the response between different health professionals. Participants’ reasons for consulting their GPs were also recorded.

Interviews were conducted three to six months after the beginning of intravenous chemotherapy. Forty-five patients were interviewed in their own homes and five in a cancer centre.

Analysis

Interviews were transcribed in their entirety using word-processing software. Qualitative content analysis was derived from the participants’ discourse about their GPs. Because the umbrella study design was defined early in the study, saturation was sought during the analysis,[16] allowing themes to emerge from the data.[17] All of interviews were read, manually coded, and member-checked. Analysis was performed by individual researchers and cross-referenced during 12 working meetings in order to establish topical agreement. The research team determined socio-economic status based on patient occupations, spousal occupations, and homes observations during interviews. A few topics were quantified to underscore certain indicators that the researchers judged significant, such as the number of patients and categorical percentages.

Results

Patient characteristics

Eighty-five patients were recruited, but only 50 were retained for the study. Of the patients who were eliminated, 16 did not respond to telephone calls, 10 declined to be interviewed without offering a reason,
four were hospitalized following a deterioration in health and they chose not to participate in the study, and five were deceased before the interview appointments were made.

Average interview length was one hour 30 min, ranging from 20 min to three hours and 35 min. Patient characteristics are presented in Table 1. In regards to emergent themes, data saturation was achieved retrospectively after 21 interviews.

### Consultations with GPs

All 50 interviewees had declared their GP to the French national health insurance service, although three patients had done this only after receiving a diagnosis. For two patients, this was due to a change of GP after moving closer to the care centre; for the third patient, the reason was a change of GP following a diagnostic delay for which she held her GP responsible. Two other patients were seen by two different GPs, located near their primary and second homes. Nearly all (48/50) of the interviewees had consulted their GPs since beginning intravenous chemotherapy. These GP consultations were medical, psychological, or administrative in nature. Several recurring themes appeared in patient interviews, including managing the adverse effects of chemotherapy, managing pre-existing diseases, and managing psychological needs. Other themes, taken verbatim from patients, include administrative management and the management of medical information.

### Managing the adverse effects of intravenous chemotherapy

Adverse effects most often reported were acute fever, fatigue, nausea, vomiting, diarrhoea, mucositis, and hypertension. For the most part, the treating oncologist or oncology department staff managed these symptoms. When a GP was consulted for these problems, GPs generally prescribed treatment based on written recommendations from the oncologists:

> So, we were given a prescription that read “The GP should use such and such... In case of a fever, he should use this or that... and for a fever above, above 38, he should call the department”. (63-year-old woman with breast cancer)

### Managing pre-existing diseases

Thirty patients reported having a chronic ailment, generally either cardiovascular disease, diabetes, chronic bronchitis, or hypothyroidism, in order of frequency. Seeing a GP for these conditions often appeared to be a voluntary decision on the part of patients to avoid mixing the different diseases:

> I saw him again for other reasons. Since I need, among other things, treatment for my thyroid, I see him every three months for that. (58 year-old woman with breast cancer)

### Managing psychological needs

Patient needs or expectations with respect to their GPs included listening and providing support:

> For sure, I can discuss this with my GP on a more casual basis, since I've known him for a long time. (59 year-old woman with breast cancer)

More generally, GPs served a reassuring function by being available, often by telephone.

### Administrative management

Qualifying for sick leave was a frequent additional reason for consulting a GP during the initial treatment phase. This concerned 20 out of the 24 professionally active patients. At the time of the interviews, 18 patients remained on sick leave.

### Managing medical information

Interviewees indicated that they sometimes benefited from their GP’s advice or explanations and information about their diseases:

> I went to see him after the first few chemotherapy treatments, and he gave me some advice. (74 year-old man with colon cancer)

Afterwards, he read the reports to me. He gave me the details because I always ask for the details. I’m a bit inquisitive. (50 year-old woman with breast cancer)

The GP’s role as medical interpreter is sometimes part of an effort to reformulate the oncologist’s
discourse when it is difficult to understand, especially for patients of lower socio-economic status:

She explained things to me a bit better. She’s more accessible than my oncologist. (75 year-old man with prostate cancer)

Patient perspectives regarding GPs

Patient’s opinions about their GPs were either positive or negative and were rarely indecisive. Themes related to the GPs ranged from the quality of the doctor–patient relationship, confidence in the GP’s professional capabilities, physical and telephone availability, and GP effectiveness.

Occasionally negative views of the GP and the GP’s role.

Three patients offered harsh criticism of their GPs. Their dissatisfaction was longstanding, having originated in medical events that predated their cancer and was generalized to all physicians in this specialty:

But GPs certainly are a disaster. Mine’s as dumb as a doorknob. (58 year-old man with colon cancer)

Time of diagnosis appeared to represent another moment when patients’ confidence in their GPs could be undermined. This could be because the patient perceived a delay in their diagnosis:

My GP hasn’t been very responsible, because when he weighed me and I saw that I had still lost about 15 kg . . . it’s not normal. Now I think he should have been a little more reactive. He gave me treatments during six months before I go to the specialist. (47 year-old man with colon cancer)

Some patients seemed to feel abandoned by their GPs:

I really realized that there, from the moment she told me that I had breast cancer, I think she thought: “Now it’s the hospital that will handle her!”. (58 year-old woman with breast cancer)

A number of other patients (n = 22) referred to a lack of competence, albeit to a lesser extent. This was specifically with regard to cancer management. These patients appeared to believe that GPs are not able to deal with cancer-related problems:

He won’t take the place of the oncologist, for sure. He’s not the one to say, “You should have been given some other chemotherapy instead of this one.” or things like that. That’s not his role. (52 year-old man with colon cancer)

Most patients’ opinions of their GPs were positive. The relationship between patients and their GPs was based on trust that had often been built over time. This trust was found to be complementary to, rather than in competition with, the oncologist. For three interviewees, this closeness even extended as far as friendship.

Interviewees measured the effectiveness of their GPs by the effectiveness of their diagnosis during the initial treatment phase. As a consequence, the time of diagnosis appeared to be an important moment in shaping the patients’ level of trust in their GPs.

GPs’ skills in treating medical problems were criticized by nearly half of the interviewees. However, some patients had indeed consulted their GP, but either did not remember the consultation or recalled it as an aside. When asked if their GP played a role in their home care, one interviewee replied,

Not really. Because I didn’t need anything . . . What I was being given was fine, except that time, with mucitis. (63-year-old woman with breast cancer)

Discussion

Main findings

The primary objective of this study was to elicit cancer patients’ views of their GPs. Nearly all of the patients interviewed had consulted their GPs since the beginning

| Table 2. Themes related to GPs’ patients’ assessments of GPs. |
|-------------------------------------------------------------|
|                                                                 |
| Positive discourse                                           |
| Negative discourse                                           |
| Confidence at the core of the relationship                   |
| ‘I have more confidence in him [the GP] . . . not more than in my oncologist, but in the end, outside of cancer, because the others are perhaps too specialized to have a more realistic idea than GPs.’ (80 year-old man with prostate cancer) |
| ‘the GP . . . We cannot ask them anything.’ (58 year-old man with colon cancer) |
| Feeling about GP                                              |
| ‘A friendship is formed.’ (54 year-old man with prostate cancer) |
| ‘My GP is a case of virtual reality.’ (47 year-old man with colon cancer) |
| Physical and phone availability                                |
| ‘I can, day or night, as soon as I have a concern, call him. If he needs to come over, he’ll do that.’ (50 year-old woman with breast cancer) |
| None.                                                        |
| Effectiveness                                                 |
| ‘Two months ago, I had a urinary tract infection. I went to see my GP. We’ve known well now. I had a temperature spurt, and he did the right thing.’ (77 year-old man with lung cancer) |
| ‘I still see her. We’re maintaining a good relationship. The problem, I find, is that my GP’s a bit ineffective.’ (81 year-old man with prostate cancer) |
of treatment, regardless of their type of cancer. This study found or confirmed five reasons for which patients consult their GPs during cancer follow-up: (a) medical problems related to cancer, (b) pre-existing diseases, (c) administrative activities, (d) psychological needs, and (e) information concerning cancer treatments. These reasons have constituted a global, patient-centred system in the form of various bio-psychosocial consultations within the care continuum.[18]

With regard to patients’ assessments of their GPs, most patients referred to trust, availability, closeness, and effectiveness. When their opinions were negative, participating patients tended to cite their lack of effectiveness compared to oncologists.

**Strengths and limitations of the study**

This study is one of the few qualitative surveys to give cancer patients a voice, despite the fact that the need for this type of research has long been acknowledged.[19] It is the first qualitative study in France to examine the GP’s role in caring for cancer patients. The sample size \(n = 50\) enabled the researchers to generate reliable, valid data on patients under treatment in two French cancer centres. These results should be treated as tentative, however, and should be corroborated with quantitative approaches.

The socio-occupational profile of the sample of study participants contained relatively few disadvantaged patients and a corresponding overrepresentation of patients of higher socio-economic status. Two hypotheses could explain this profile: (a) status-driven bias in how patients were recruited in the French cancer centres or, (b) a higher refusal rate among disadvantaged patients. The specific nature of the recruitment process makes it impossible for us to answer this question satisfactorily.

Another potential source of bias is that participants for the study were recruited in two cancer centres, despite the fact that in 2012, according to the French Institut National du Cancer, only 15% of French patients receiving intravenous chemotherapy were treated at a cancer centre. The remaining 85% were treated either at public hospitals or private facilities. Consequently, our findings cannot be generalized to the general population of French patients in the initial cancer treatment phase.

**Comparison with published literature**

To date, there have been only a small number of qualitative, patient-based studies that have explored GPs’ role in cancer treatment.[10–15] These studies, which have been conducted in the UK, Denmark, Australia, and Estonia, confirm the importance of GPs based on their proximity to patients, their ability to offer advice or provide emotional support and reassurance, and their capacity to help manage side effects. Halkett, however, confirmed that cancer patients tend to prefer to be cared for by oncologists.[13] This finding was interpreted as suggesting the need for GPs to receive oncological training. In France, the lack of specific GP training in the care of cancer patients has been referred to for years.[20] With respect to managing cancer treatment side effects, many differences were noted. The French patients observed for this study did not tend to consult their GPs to manage medical problems as often as patients in Israel, Estonia, or Australia.[3,6,13,15,21] Little literature exists on the subject of GP management of pre-existing conditions, but their significance has been demonstrated.[22,23]

GP involvement in the follow-up care of cancer patients has been noted in a number of studies, but only at patients’ request.[3,5,9,11,14] These results seem to be not only country-dependant, but also method-dependant, particularly if the studies questioned GPs but not patients.[2,4,24]

GPs’ roles as medical interpreters were observed in this study, and in others,[9,11] particularly for patients with a lower socio-economic profile.

Clearly, the role of GPs and oncology specialists should be redefined worldwide. A French quantitative study of GPs’ roles in cancer management asked questions about collaboration and competition between GPs and specialist teams.[1] The study found that for 78% of the GPs surveyed, their role in the initial treatment phase was primarily psycho-socio-administrative management and secondarily medical management. These findings corroborate our emergent hypotheses.

**Implications**

The question is how this system can be changed in France. Training GPs to manage cancer treatment side effects, and more generally, to play a follow-up role during the active treatment phase should be a priority for the French primary care system. Our team has also discussed creating a French website that provides information regarding the side effects of chemotherapy that could serve as a reference guide for concerned GPs. Other strategies should be developed to provide better care for cancer patients. As a recent Danish study demonstrated, an intervention encouraging the early involvement of GPs does not suffice to improve patients’ satisfaction with their GPs.[7]
This study potentially provides GPs with the key to understanding cancer patients’ behaviours and attitudes. During the initial cancer treatment phase, GPs were found to play a special role in the physician–patient relationship. GPs have often been described using terms of trust, knowledge of patients’ lives, and physical proximity. They play a global, holistic, longitudinal role in a patient-centred approach. Still, the majority of cancer patients interviewed in this study did not seek GP care during their treatment. Their discourse suggests greater involvement of French GPs in following up cancer patients during the initial treatment phase, with a particular emphasis on psycho-administrative management. Treating oncologists and oncology departments were preferred for problems related to cancer, and most patients referred to their GPs’ lack of competence in this area.

The task of fully understanding and describing the GP’s role as perceived by disadvantaged patients remains to be achieved. The authors intend to conduct a further qualitative study of interactions between GPs and disadvantaged patients in public hospitals, in an attempt to understand the obstacles to high-quality, fully inclusive healthcare.

Conclusion

Patients’ perspectives called attention to two aspects of the role of GPs in the French healthcare system: (a) the importance of GPs within an effective system for managing cancer patients, and (b) for some patients, GPs’ relative lack of medical skill compared to oncologists.

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Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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