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TITLE PAGE

CANCER SURVIVORSHIP CARE AND GENERAL PRACTICE: A QUALITATIVE STUDY OF ROLES OF GENERAL PRACTICE TEAM MEMBERS IN AUSTRALIA

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CONFLICT OF INTEREST STATEMENT

The authors have no relevant financial or non-financial interests to disclose.

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This study was approved by the Queensland University of Technology Human Research Ethics Committee (1900000798). Informed consent was obtained from all individual participants in the study.

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AUTHORS CONTRIBUTION STATEMENT

All authors contributed to the study conception and design. Preparation, data collection, and analysis were performed by JF and RJC. The first draft of the manuscript was written by JF and RCT. All

authors read and reviewed various versions and the final manuscript. All authors read and approved the final manuscript.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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TITLE

CANCER SURVIVORSHIP CARE AND GENERAL PRACTICE: A QUALITATIVE STUDY OF ROLES OF GENERAL PRACTICE TEAM MEMBERS IN AUSTRALIA

ABSTRACT

Primary care providers, including general practice teams, are well positioned within the community to integrate cancer survivorship care into ongoing health management, However, roles of general practice team members in delivery of cancer survivorship care have not been explored. The purpose of this study is to explore these roles from the perspectives of General Practitioners (GPs), Practice Nurses (PNs) and Practice Managers (PMs). An interpretive qualitative study using semi-structured in-depth telephone interviews with ten GPs, nine PNs and five PMs was conducted. Interviews were recorded, transcribed and analysed using grounded theory methods. Perspectives of roles in delivery of cancer survivorship care were highly variable. Variation was evident among perceptions of needs of cancer survivors, individual team members' scopes of practice, and individual professional knowledge and skills. A lack of clarity in roles and responsibilities of general practice team members was thought to contribute to a lack of consistency in survivorship care. Reducing variations in perceptions of survivorship care in the primary care setting should be a priority. Such efforts may include development of practical guidance to support general practice team members to clarify scopes of practice within the team. In addition to accessible comprehensive education programs, other innovative, tailored individualised education approaches may be helpful. System-level support in clarifying and supporting the roles of the primary care team is needed to facilitate a survivorship delivery system at general practice level where those within general practice team can ensure that individual patients' needs are met in a timely and effective manner.

KEYWORDS

Cancer Survivorship; General Practice; Post-Treatment Care; Primary Care; Practice Nurse

WHAT IS KNOWN ABOUT THIS TOPIC

- Cancer survivors often have complex needs and are less likely to receive optimal, holistic care if they do not see a primary care provider.
- Primary care providers are well positioned to manage cancer survivorship care in the community.

WHAT THIS PAPER ADDS

- Variation in perceptions of roles in terms of cancer survivors' needs, individuals' scopes of practice and professional knowledge and skills was evident.
- Development of practical guidance to clarify scopes of practice and system level support from cancer centres in clarifying roles of primary care team is needed.
- Innovative and tailored education approaches specific to team members' learning needs should be developed and tested.

INTRODUCTION

With an aging population and continued improvements in survival rates, over 1.1 million Australians are now living with a cancer diagnosis (Cancer Council Australia, 2018). Many cancer survivors experience consequences from their cancer and its treatment for many years (Cancer Council Australia, 2018). Although it is acknowledged that cancer survivorship care should optimise the health and wellbeing of a person living with cancer from diagnosis to the end of life, there is an emphasis on improving outcomes in the post-treatment phase of survivorship (National Cancer Institute, 2019; Vardy et al., 2019). Cancer survivors can have complex needs and remain at risk of relapse, development of a second cancer, and long-term morbidity related to the physical and psychosocial effects of their disease and related treatment (Leach et al., 2015; Lisy et al., 2019). Furthermore, the complex health profiles of adult cancer survivors often include chronic medical conditions beyond cancer (Hohmann et al., 2020; Leach et al., 2015) and cancer survivors are less likely to receive optimal, holistic care if they do not see a primary care provider (Snyder et al., 2015). It is therefore critical that the involvement of primary care providers is optimised (Rubin et al., 2015; Vardy et al., 2019). Novel survivorship models of care involving primary care providers are being investigated (Chan et al., 2021a; Chan et al., 2020; Emery et al., 2017; Jefford et al., 2017). These models have shown similar outcomes across a range of domains, with the potential for reduced costs to the health system (Chan et al., 2021a; Chan et al., 2020; Emery et al., 2017; Jefford et al., 2017). However, many of these efforts are not yet widely implemented across Australia and many other countries where primary care holds an essential role in chronic disease management. Efforts in understanding and addressing the barriers to implementing such models are required.

Primary care providers, including the general practice team (GPT) (AIHW (Australian Institute of Health and Welfare), 2020; AMA (Australian Medical Association), 2017), are well positioned within the community to manage healthcare, integrating cancer survivorship care into ongoing health management (Brennan et al., 2011; Hebdon et al., 2014; Lawrence et al., 2016; Nekhlyudov et al., 2017; Rubin et al., 2015). Indeed, cancer survivors value a survivorship delivery system that provides quality care co-ordination and clear processes for transitioning care back to primary care providers (Mead et al., 2020). However, the role of the GPT in delivering this care is variable, with studies highlighting a lack of sustainable funding models to facilitate GP involvement, suboptimal regular information sharing, insufficient contact with oncologists and patients during treatment phase, and minimal formal training for GPs in survivorship care (DiCicco-Bloom & Cunningham, 2013; Halpern et al., 2015; Lawler et al., 2020; Lawrence et al., 2016; Lisy et al., 2020; Lisy et al., 2021; Meiklejohn et al., 2016). In addition, professional roles and expectations between GPT members and cancer specialists are not well defined (Lawrence et al., 2016; Weaver et al., 2013).

Perspectives of GPs and patients have been explored across several studies, supporting a greater role for GPs to improve the quality of patient care for cancer survivors (Brennan et al., 2011; Crabtree et al., 2020; Geramita et al., 2020; Halkett et al., 2015; Khan et al., 2011; Margariti et al., 2020; Meiklejohn et al., 2016; Mitchell et al., 2012). However, less is known about how care is delivered, and the respective roles of Practice Nurses (PNs), and Practice Managers (PMs). These models of care may depend on the business model and configuration of the practice, which can range from small business, GP owned practices, which may or may not have access to services of PNs and/or PMs, to listed corporations (AMA (Australian Medical Association), 2017). A recent Australian Primary Health Care Nurses Association (APNA) study found that close to half of primary care nurses reported they could better utilise their skills to perform more complex clinical tasks or extend their role within their scope of practice (Australian Primary Health Care Nurses Association, 2019; Halcomb & Ashley, 2019; Halcomb et al., 2020). In addition, PMs have an integral role as key stakeholders to ensure a general practice operates efficiently and effectively in providing patient care while guaranteeing financial goals are achieved (Aggar et al., 2016). Despite the potential of the GPT to work together in providing and/or facilitating survivorship care in the primary care setting, there are limited qualitative studies in the international literature exploring the perspectives of the GPT including GPs, PNs and PMs on their roles in providing or facilitating cancer survivorship care. The objective of this study was to explore the perspectives of GPT members in the delivery of cancer survivorship care.

METHODS

Design

This study employed a qualitative interpretive design using semi-structured interviews with GPs, PNs and PMs. A social constructivist framework and grounded theory methods, which are applicable when addressing unexplored areas of inquiry was used (Charmaz, 2017). This framework recognises the unique experiences of participants and the methods allow the researcher to explore the ways in which participants view the world and construct meaning in everyday life (Charmaz, 2014). The approach explicitly provides an interpretive portrayal of the studied world (Charmaz, 2014). A semi-structured in-depth interview guide (Table 1) based on study aims and previous research, provided a way to elicit rich information. The research team comprised members with clinical and research backgrounds in oncology, primary care, nursing, qualitative research methodologies, mostly with PhDs in health-related disciplines.

Setting and study participants

Participants were GPs, PNs and PMs working in general practices in Australia and were recruited from February 2020 to August 2020. Recruitment included purposive sampling through investigators' professional networks via email invitation and promotion through Cancer Australia's Primary Care Cancer Collaborative Clinical Trials Group (PC4). Eligibility criteria was necessarily

broad to ensure a diverse level of experience and clinical interests. Participation was voluntary with consent obtained prior to interview. Participants self-reported current role, size of practice, location of work, professional years of experience and demographic (age, gender) characteristics. The study was conducted in accordance with the ethical standards of the approving Human Research Ethics Committee (QUT UHREC 2000000050).

Data generation

One investigator (JF), experienced in qualitative interviewing, conducted telephone interviews with participants. An interview guide exploring the roles of GPs, PNs and PMs was used and adapted for subsequent interviews. Interviews were flexible and iterative, and framed as a conversation allowing the interviewer to respond to individual participants' narratives and probe for more detailed responses. Data generation continued until the investigator ascertained that sufficient depth of understanding had been achieved in relation to theoretical categories (Saunders et al., 2018). All interviews were recorded and transcribed. Identifying information was removed and transcripts were labelled with an identifier code. Field notes were made to document relevant social and contextual factors, and emerging insights.

Data analysis

Two research team members (JF and RC) separately engaged with and analysed the data. Transcripts were coded inductively, initially employing open coding to categorise and organise the data. Independent iterative coding using the constant comparison method was used to identify similarities and differences in the form of deviant cases, to explore relationships, and to refine codes and develop categories and sub-categories (Charmaz, 2014). Through an iterative process of reviewing and discussing data, early ideas identified in the process of coding became more focused and refined, and patterns in participants' perceptions were identified. Regular researcher meetings facilitated review and discussion of alternative interpretations, groupings of categories, and interrelations between categories. Analytical rigour was augmented by constant comparison (Charmaz, 2014). The credibility of concepts was enhanced by examining key concepts across and noting differences between the three participant groups (Charmaz, 2014). Throughout the research process a level of reflexivity was maintained by researchers examining their assumptions, preferences, roles in the study and context of the research topic.

FINDINGS

Interviews were conducted with 24 participants (Table 2), from a range of 20 practice settings. Participants included 10 GPs, nine PNs and five PMs. Age range of participants was 26 to 68 years. Thirteen had less than 10 years of professional experience and 18 reported that they spent 10% or less of their time with cancer survivors. Most practices had six to 10 GPs and employed either one or two PNs. Interviews ranged in length from 20 to 52 minutes (mean 29.5 minutes).

Key Findings

Differences in and across roles was identified as a core category. This emerged as an important issue for GPs, PNs, and PMs in the delivery of cancer survivorship care. Specifically, differences were evident in team members' perceptions of needs of cancer survivors; perceptions of scopes of practice; and individual team members' perceptions of professional knowledge and skills. These differences are explored below with further supporting quotations in Table 3. These key areas of variation provide insights into core concepts that can ultimately be addressed to develop capacity and support GPs and PNs in their roles in cancer survivorship care.

The needs of cancer survivors

- **Differences in individual understanding of needs of cancer survivors**

GPT members held divergent perceptions and beliefs around the needs of cancer survivors. In applying a whole-person approach, some GPs and PNs did not categorise or consider cancer survivors as different from patients with other diagnoses. As such, no distinction was made for patient needs based on a cancer diagnosis versus other chronic diseases. Furthermore, some GPs and PNs indicated there was no reason to focus on specific needs and challenges specifically attributed to cancer, but rather the focus was on comprehensive holistic care:

> I*t's not a formal cancer survivorship thing. I suppose my cancer survivor's like any other patient really…*the nurse is very much involved in day-to-day care for all our patients, and survivorship is really just a part of general practice.GP06

By contrast, some GPs believed that cancer survivors should be identified and prioritised for additional screening as they were at an increased risk following a cancer diagnosis:

> There really is a lack of awareness that these patients, depending on what treatment that *they've had…*are at an increased risk*…there should be alarm bells, it isn't the same as someone else, they can't be categorised and just treated holistically…So, if you're* not*…*separating it out a little bit as cancer survivor and*…triaging in your head, then you're* not doing the cancer survivorship care that you should be.GP10

Some members noted the necessity to consider current needs of patients which may be cancer specific at times, while not attributable to cancer at other times.

> *We don't see them as cancer patients. That's why as I'm talking to* you, *I'm thinking of more people that I care for with cancer, but I see them as John, for example, and I've completely* forgotten that he came to see me with this issue about cancer.GP04

- **Differences in delivery system/models of care to meet the needs of cancer survivors.**

Given the complex and highly individualised nature of survivorship care, variability in delivery systems/models of care added challenge when post-treatment cancer survivors transitioned to GP care:

> Some specialists are very good to keep the GP involved, and some they just disappear…down some blackhole, and you never see them again until they get to that other end. Some patients, they're totally sucked into the hospital system, and they don't see the role of GP. Others are very happy…*They'll come* and talk to the GP. *So, it's* really variable…it depends on the level of interest of the GP, and the relationship they have with the patient.GP06

No formalised system for survivorship care appeared to be recognised. Cancer survivorship follow-up was often driven by patient need at the time rather than a well-thought-out comprehensive care plan:

> *But we don't actually have a real lot to do with them after they're finished treatment and things, unless they're coming into the clinic or having a care plan or* things like that.PN02

There also appeared to be a lack of communication and clarity around the respective roles of the GP and the specialist team during treatment programs:

> Communication often from the speciality teams is not timely, not detailed enough, GPs *therefore aren't quite sure what their role is and what they should be doing*.GP10

Furthermore, there appeared to be a lack of clarity in terms of individual roles both within specialist care and general practice:

> There were quite a few medical *oncologists that weren't really feeling confident about cancer* survivorship and its role and what it really is.GP10

- **Differences in optimal and actual support of needs**

GP participation in survivorship care varied according to a number of factors including the patient/GP relationship, GP skill level and cancer centre involvement:

> *Really depends on the GP, how comfortable they are with cancer care…I'd say for a few of* the people out there, that a lot of the care may just be handled in a large part with the o*ncologist…The patient doesn't have a good relationship with a GP or isn't engaging with the same GP every single time. I think in a perfect world, it'd be a much larger split towards* the general practitioner looking after a lot of things, and then through that primary care co-ordinating a lot of the shots for patients.GP02

Time constraints within general practice also influenced the level of involvement by the GP. Concise and clear recommendations from specialist colleagues were key for GPs in managing time constraints:

> As *a GP, we're always going to bow to our specialist colleagues' recommendations and* follow-ups…*I know that when I'm busy and I see a note from an oncologist, I go down…*I skip

the entire letter and go straight to the bottom and say *'Right, what do I need to do?' I'll set a reminder in the chart.'GP08*

Scope of practice of the practice nurses

- **Differences in views *of the practice nurse's* scopes of practice**

Within general practice, PNs scopes of practice were not always recognised by other team members. Indeed, a lack of understanding and recognition of practice scope led to variation in individual team members' roles. Variability was particularly evident with some GPs' views of the PN's scope of practice:

It really is variable in my practice I know a nurse and I get on quite well*…there's some GPs* there that give her tasks that a*re menial and she's not quite sure they're her role to do*. I*t's so* variable, particularly when you do have a practice nurse…and varying experience levels and then you have multiple GPs at a practice.GP10

Furthermore, lack of clarity around scopes of practice resulted in an underestimate of skills and abilities by some GPs and an overestimate by others:

There's also the GPs not really understanding what the scope of practice of nurses is. There's misaligned understanding between GPs and nurses in terms of what GPs think nurses can do or is within their scope. That goes both ways, in overestimating what nurses can do and also underestimating what they can do.PN09

- ***Practice nurses' v*iew of own scope of practice**

Some PNs believed they could take a more proactive approach and be more involved in a clinical role in survivorship care. They expressed a concern that their role was not fully utilised:

I couldn't be much help because the GPs tend to not involve us to be honest.PN07

Indeed, for some team members there was a belief that everything a PN does is done on behalf of a GP:

Nurses just follow the doctor's orders with a patient. Whatever the doctor says, they do.PM03

The PN role varied not only between, but within practices. At times, PNs were involved in preparing care plans, while at other times, within the same practice, the PN did not have a role:

We do a mixture (re care plans). I mean, occasionally the nurses are involved. We definitely have to be involved obviously with Medicare (Australian universal health coverage scheme). It depends, sometimes they are, and sometimes we just do it ourselves.GP08

Indeed, a lack of transparency around the GP and PN roles in providing survivorship care was expressed in terms of a need for clarification about respective roles:

> The GP can be driving things a little more and then the nurse could be driving things a little bit more. I think stratifying and having some form of triage or risk certainly can alter the *roles of all the individuals and that's all fine, but I think everyone just needs to know.GP10*

Professional knowledge and skills

- **Differences in skill level and confidence**

A lack of confidence in their own survivorship knowledge and skills was expressed by some members. They believed their skill level was not adequate to provide an appropriate level of care:

> So, nurses, we definitely lack the experience or the knowledge. We need more training to build up our confidence, so that in the future I can just stand in front of the GP and say, *'Hey doctor, I can help you with this patient'*.PN08

By contrast, it was suggested that PNs have the necessary skills. Guidance and role clarity was needed to provide the required care:

> *They (PNs) have the skills, they're just not sure of their place…they don't need all the minutiae of it, but just a bit of guidance that, yeah, this person's had this treatment, and* therefore this treatment, this is how we like to follow up into the future, and also a bit of guidance on when to/how to reach back into the tertiary centre.GP10

Further, it was suggested that GPs had the required survivorship skills. Indeed, with some guidance and a framework, they would be in a position to provide adequate care:

> *GPs know about it, the majority, and they're not stupid, but it is nice for them to be just given* a little bit of framework, a little bit of guidance, it would just make the role a lot easier because the *actual skills are all there, we do it all the time, but it's just applying it* and knowing, when to apply it.GP10

- **Differences in continuing education/guidelines**

Continuing education was highlighted, with ongoing training needs identified for both GPs and PNs:

> I wonder if any of the nurses ever did some extra training and cancer-related care, it could be a sub-special interest I suppose. So, as well as during their normal duties, they could be that kind of port of call if there were cancer related issues *with some patients. But yeah, I'm just not sure how much work there'd be in terms of that for the nurse.GP09*

More specifically, an accessible framework (e.g., communication of a care plan from a cancer centre), would support GPT members in provision of care:

> *I think we don't really have a clear, easy, accessible framework. So, as a nurse, as a GP, I don't have one place where I can go, 'Hey, this is an example of what cancer survivorship can look like in general practice'.* Those examples are so fragmented, or they are in guidelines and resources that sometimes are just so overly wordy and just jargon without even intending to, and just so overwhelming that it just immediately goes into the too-hard *basket and go, 'I don't even have that many patients tha*t applies to some so I'm not even going to *bother looking into that'.PN09*

Indeed, in many areas, divergent perceptions and beliefs around the needs of cancer survivors, scopes of practice, and professional knowledge and skills were articulated by GPT members. This in turn influenced perceptions of the optimal roles of GPT members in survivorship care.

DISCUSSION

Exploring the role of the GPT in cancer survivorship care from the perspectives of three separate groups within the GPT, namely GPs, PNs and PMs, provides a unique contribution to the existing literature. In the past, GPs views have been presented on the basis of one cohesive group, without recognition of the different players and perceptions of roles within the GPT. This study found that GPT members' perceptions of roles in providing survivorship care within the GPT were complex and variable. Participants' perceptions varied based upon understandings and attitudes towards the needs of cancer survivors, GPT members' scopes of practice (in particular PNs) and self-perceived confidence in individual professional knowledge and skill level. Indeed, the addition of PN and PM perspectives generates several novel concepts.

This study confirms a number of previously identified concerns, including communication disparities resulting in an absence of role clarity between cancer specialists and GPs (Dossett et al., 2017; Easley et al., 2017; Lisy et al., 2020; Mitchell et al., 2012; Tsui et al., 2019), and a need for greater role clarity for PNs working in primary care (Aggar et al., 2016; Hohmann et al., 2020; McInnes et al., 2015, 2017; Yuille et al., 2016). Further, as previous studies highlighted, GPs indicated an interest in increasing their role in survivorship care (Lawrence et al., 2016). However, it is apparent that divergent views on what cancer survivorship really is, the appropriate cohort in primary care, and the complexity of care given that one size does not fit all, resulted in variation in what the GPT is able to actually deliver. Indeed, differences in what the GPT can deliver and what they do deliver were identified in both short-term and long-term survivorship needs, and the optimal response from the GPT. Limitations between optimal and actual survivorship care included time and resource constraints, communication between cancer centres and general practices, re-establishment of GP and patient relationship after periods of active cancer treatment, and perceptions of gaps in

relevant training and knowledge (Dossett et al., 2017; Meiklejohn et al., 2016; Rubinstein et al., 2017).

High degrees of variability perceived by GPs in preparedness and scope of practice of PNs in providing survivorship care was a key study finding. Differences in team members' perceptions of the scope of practice and the skill set of other GPT members, and in particular the PN, resulted in some PNs working to limited scopes of practice. PNs bring a broad skill set to the PN role based on previous experience (Aggar et al., 2016). It has been reported elsewhere that PNs are not working to their full scope of practice and supporting nurses to achieve this remains an important goal in general practice (Australian Primary Health Care Nurses Association, 2019; Halcomb & Ashley, 2019; Halcomb et al., 2008; Lukewich et al., 2020). Developing policies that ensure the ability of PNs to work to their optimal scope of practice, and implementation of these within the Medicare framework is required. While there is a lack of consistency concerning the PN scope of practice, the role of the PN in survivorship care will remain underutilised. Such findings suggest that a consensus approach (within the GP clinic) and a standard general practice procedure, where the PNs role is clearly defined, in terms of handover from the specialist cancer centre and within the general practice setting, is critical to empower nurses to work within their scope of practice (Franklin et al., 2020).

Variation in GPT members' understanding of the needs of cancer survivors and the resultant variation in survivorship care in general practice was evident in this study. Indeed, in general practices where no systematic identification of cancer patients is instigated, specific patient needs in relation to survivorship could be overlooked. Survivorship care is complex and highly individualised, thus a patient-centred approach to care delivery is warranted (Mead et al., 2020). In recognising the variation and complexity of survivorship care, it is acknowledged that the primary care approach is based upon a broader holistic model rather than the disease-based model of specialist cancer care. In fact, it may be possible that some aspects of survivorship care are being delivered within a generalist, comprehensive approach to care, and this is just not being recognised as survivorship care. However, it is important that specific needs of cancer survivors, such as fear of recurrence, prevention of secondary cancers and surveillance are recognised (Sung et al., 2020). Further, general practices implement different styles of care, with some more focused on episodic care and less on continuity with one GP. Indeed, the idea of follow-up and surveillance could be challenging to implement if continuity of care with a principal GP is not encouraged in the practice model. On the other hand, a team approach, where a PN may provide additional continuity by implementing a nurse-facilitated screening and assessment tool followed by a GP review, may be a reasonable strategy (Franklin et al., 2020).

Two strategies will likely be helpful for reducing these variations in primary care providers' recognition of survivors' needs. First, the use of a formalised survivorship care plan should become a standard of care as it allows the acute cancer care teams to flag potential or likely health concerns and facilitate improved co-ordination and communication (Jacobsen et al., 2018). Further, it allows

clarification of the role of the GPT and encourages implementation of best practice care. While RCT evidence for the use of survivorship care plans failed to detect improved patient outcomes (Jacobsen et al., 2018), the use of such care plans as a communication tool is absolutely necessary to enhance structured follow-up care in the primary care setting (Blanch-Hartigan et al., 2014; Vardy et al., 2019). Systematic provision of the care plans will ultimately reduce the variation in provision of survivorship care by the GPT. While these survivorship care plans are cancer specific, the cancer-specific information included in the survivorship care plans can directly inform the relevant part of a broader General Practitioner Management Plan, as well as Team Care Arrangement for appropriate allied health referrals. Second, in addition to comprehensive programs that address all core learning needs related to cancer survivorship (Nekhlyudov et al., 2017; Shapiro et al., 2016) (e.g., surveillance for recurrence and second malignancies, management of late and long-term effects, management of psychosocial wellbeing, and health promotion), tailored approaches specific to addressing the GPT members learning needs and the needs of their patient currently attending/about to attend their practice are needed. For example, in two current implementation efforts (Chan et al., 2021a; Chan et al., 2020), the specialist cancer nurses with cancer survivorship expertise address the information and educational needs of the GPs and PNs via case conferencing specific to their patients' health concerns. Such innovative methods should be further tested and widely implemented if successful. It is both unrealistic and unreasonable to expect all GPs and PNs to develop expertise in every medical specialty. Therefore, a tailored approach is particularly helpful when it is unrealistic to assume all GPT members will undertake the comprehensive education and/or training programs (Chan et al., 2021b) .

The study participants did not highlight a key role of practice managers in cancer survivorship. This may be due to the single disease focus of this study. However, we argue that the role of the PMs in facilitating and ensuring quality survivorship care is critical (Australian Association of Practice Management, 2021). Within large corporate practices, the PM needs to enact the policies dictated to them from the corporate owners (King & Green, 2012). They can feed back to the owners suggestions as to how to improve patient outcomes within the corporate framework, thereby improving outcomes across the organization (Australian Association of Practice Management, 2021; King & Green, 2012). In GP owned practices, the PM has a similar role. As the person who operationalises the practice objectives, they can influence practice by introducing ideas and resources to facilitate more effective use of practice resources and personnel (Australian Association of Practice Management, 2021). It is important to also acknowledge that role expectations, job scope, and expertise of PMs can also vary widely depending on the context of the practice. For example, a PM in a small boutique practice with clinical background may have very different focuses compared with a business-trained PM in a busy corporate practice of 20 GPs. Future engagement strategies involving the PM should take these considerations into account.

Strengths and limitations

To our knowledge, this is the first qualitative study to examine the perspectives of GPT members including GPs, PNs and PMs, providing a broad perspective of the roles within the GPT. In addition, a wide range of general practice settings were represented rather than practices where team members already have a special interest in survivorship care. One limitation is that the study did not distinguish between general practice business models (King & Green, 2012). It is possible that practice culture, time constraints, continuity of care and ongoing relationships between GPs and patients may be impacted by corporate business models. This may be an area for future research. Further, the study was conducted within a single country so the results may not be applicable to countries with different health systems.

Implications for practice and policy

Findings of this study have several important implications for practice. The study highlighted broad differences between individual GPT members' understandings of the needs of cancer survivors. As a result, survivorship care was often provided on an inconsistent basis. Several efforts may be helpful in reducing the variations and inconsistencies. First, a framework is required at policy and professional levels to establish consensus around the needs of cancer survivors in primary care, and to clarify the optimal sharing of responsibilities between specialist and GPTs, and between GPT members (GPs vs PNs vs. PMs). Second, development of practical tools and guidance to support GPT members to recognise and to clarify scopes of practice within the GPT, and to allocate responsibilities to ensure team members work together to provide appropriate care is needed. Third, in addition to freely accessible comprehensive education or training programs which already exist, other innovative, tailored individualised education approaches, specific to the GPT members learning needs and patient's care needs within different practice environments, should be developed and tested.

CONCLUSION

This study highlighted broad differences between individual GPT members' understanding of the needs of cancer survivors. GPs treat patients with multi-morbidities and offer individualised care. However, cancer survivorship care is complex and requires a survivorship delivery system at general practice level where consensus between those within the team ensures that patients unique needs are met in a timely and effective manner.

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Table 1. Interview Guide

- How do you identify people who have survived cancer in your practice?
- What do you think are the issues people who have completed their cancer treatments are likely to have?
- How is cancer survivorship care operationalised in your practice?
- How do you see your role in providing care to cancer survivors?
- What has been helpful in supporting your role in providing cancer survivorship care?
- What do you find challenging in providing cancer survivorship care? And how do you think these challenges could be addressed?
- What do you see as the optimum standard of survivorship care?
- What would need to change within your practice setting for this to be achieved?
- What do you see as a minimum standard of survivorship care for your patients?
- What are the roles of individual team members (consider Practice Managers, GPs, Practice Nurses and Administrative staff as appropriate) to deliver cancer survivorship care for patients?

Table 2. Participant self-reported demographic information, n = 24.

Participant group	**GPs**	**PNs**	**PMs**
Characteristic	N=10	N=9	N=5
Gender			
Female	5	9	5
Male	5	0	0
Age category (years)			
21-30	0	1	0
31-40	6	6	3
41-50	2	1	2
51-60	1	1	0
61-70	1	0	0
Years of professional experience (years)			
<5	2	3	1
6-10	4	3	0
11-15	1	2	3

16-20	1	0	0
21-25	0	0	1
> 25	2	1	0
Location of general practice			
Metropolitan	10	5	5
Regional/rural	0	4	0
Time spent with cancer survivors %			
< 5	2	5	1
6-10	4	2	4
11-20	3	1	0
21-30	1	0	0
>30	0	1	0
Number of GPs in practice			
< 5	2	4	0
6-10	6	5	4
11-15	2	0	1
Number of PNs in practice			
0	2	0	0
1-2	5	7	3
3-5	3	2	2

Note. GP = General Practitioner; PM = Practice Manger; PN = Practice nurse

Table 3. Additional supporting quotations from participants

The needs of cancer survivors
• ***Differences in individual understanding of needs of cancer survivors***
I think it just really comes down to the GP and what their view of cancer survivorship is and if they think it needs to be *structured or if it's very patient initiated. PM02*
*But we probably haven't tended to really focus on the cancer pati*ents really. Well, *I hope that we don't have a real lot of them. We've probably got more than I realise*. W*e're losing a little bit of touch I suppose with them, until they sort of come* back in the latter stages maybe, and a bit more supportive role then wh*en they're at end of life, but it's probably made me a bit more aware now that you've talked about it, that we really should be probably focusing on those type of patients. PN02*
We probably see our role more as about trying to get them (cancer survivors) back to life. Just assisting them as much as we can to return to the life that they would like to return to rather than focusing necessarily on the disease itself. PM02
We don't have any formal things that happen at all (re cancer survivorship). We see the patient and follow whatever guidelines the specialist has requested. GP01
I think there is a sense that the intent of cancer and follow-up and monitoring for recurrence of cancer, there seems to be an *understanding that that's the realm of the specialist. We generally don't get asked to take on any of that. GP04*

- ***Differences in delivery systems/models of care to meet the needs of cancer survivors***

.. it (cancer survivorship care) is very clinician driven. That's where you'd find there's a lot of discrepancy across primary care as to what level of care is actually given to a cancer patient when they come into the surgery. PM05

I suppose a lot of GPs are doing this (cancer survivorship care) *all the time anyway. It's not* – not formally branded as a *survivorship thing, because a patient with cancer is also a patient with asthma and diabetes. So, it's more than the* pigeonhole, I suppose. GP06

- ***Differences in optimal and actual support of needs***

I see the GP acting as the quarterback, for them to be able to access whatever services they need, be that through their *specialist, oncologist or surgeon or anything else that they need in terms of recovery. I've done, you know, plastic surgery* referrals for women who have had mastectomies and making sure that patients are aware of all of the services that are available, and having good, honest conversations about what their needs are. So much of the time, particularly with cancer patients, they get this d*octor fatigue, and coming to see just their GP feels very, like, you get the impression that they've got bigger fish to fry. You know, we're, like, 'Let's do your GP management plan,' they're, like, 'Okay, whatever,' and you're like, 'Okay,' and I'm, like, 'When do you next see your specialist?' They're like, 'Really looking forward to seeing where I'm at with my specialist in three months.' You're, like, 'Okay,' which is fair enough because we're small fish – we're small fish* in the pond when it comes to a *lot of the stuff that they've been subjected to during that time. GP07*

… if there was an item number associated with cancer survivorship care then it would just probably be something at the *forefront of their (GPs) minds … Medicare item numbers are often* helpful for that side of things just to make the doctors aware of the different services that they could be offering. PM02

Scope of practice of the practice nurse

- ***Differences in views of the practice nurse scope of practice***

… some practices, they do use the practice nurses as clinical scribes sometimes. Theoretically they could be adding in *recalls if they're going through specialist notes and looking for plans or what not. In my own practice, with the practice nurses, they're very helpful for if anythin*g needs to be sorted out with regards to liaising with the patient, or tracking down past pathology, or imaging. Also, for recalling patients more urgently rather than the automated SMS system being sent out *to patients, they'll actually give the patient* a call to get them in a little bit earlier. GP02

So, you have GPs who just want to keep very tight control over their patient care, so they will be very protective, and they *won't necessarily refer anything to the nurse unless it's something very specific like, 'Just give this immunisation' or, 'Just create this care plan'...So, they almost treat them like an admin assistant or a technician essentially or like, 'Dress that wound' or it's very kind of technical, specific and limited. Then you have the other GP*s who are the complete opposite, that assume a level of scope in nurses that is just not there.PN09

We've got some experienced nurses in our team and some very young nurses. So, the young nurses that are graduates haven't actually dealt with any of this during their education, but they learn from the doctors and the more experienced nurses as to how things are done. PM05

The practice nurse is there, and we do ask for her input. Say for example the patient had a non-healing wound that needed frequent dressing, *the nurse would come in and help with that. Things like if they needed injections or vaccinations; that's* something the nurse would help me do as well. I guess recording observations for the patient as well. GP05

- ***Practice nurses' views of own scope of practice***

As nurses, what we normally do is follow what our doctors tell us. So, we would mostly just do the care planning and then a review just to see how they go under the plan. We call them if their result or their reports are in. Of course, reminder for probably, say the flu vaccine every year and other vaccines like pneumonia vaccine. PN01

I*t's very much a coordination role I suppose, coordinating appointments and referrals to people that might be needed. PN02*
Our job as a nurse – we have to chase up. So, we have to keep contacting the hospital to get letters and then make sure we have the correct post-care. PN05
I try and help and support with some self-management, supportive care, maybe some transition to end of life, linking them with the palliative care team if needed. So, I could do a care plan with them in conjunction with the GP and I also do wound care and I also take bloods as well. PN06
We see oncology patients but we're often seeing them for something else. It might just be a basic injection or to be *procedural things rather than other things. I think the nurses probably could be utilised more to some extent…I think mental health is a big part but without having that scope of practice I wouldn't feel comfortable. I feel I would need to have th*e skill set to be able to effectively assist with something like mental health. Otherwise, I am not quite sure apart from making sure *that we're up to date with things and what else I could contribute to. PN07*

Professional knowledge and skills

- ***Differences in skill level and confidence***

Treatments have changed so much. When I get the letters and specialists are describing new treatments… that it is quite difficult for the GP to keep up to date with what the latest treatments are, and we may not always be confident in, "What are the adverse effects for this drug?" and so on. GP04
*Most of the clinics that I've worked in, it's been very divided, kind of like we refer off to the oncology services, they dea*l with all of that and then you come back to us *with anything with 'GP related matters'. So, there's a disconnect there. When it* comes to practice nurses, even more of a disconnect because nurses already can have a bit of an imposter syndrome as a concern, working in general practice because there's so much to cover and a lot of nurses come into general practice from different backgrounds. Very few nurses actually study primary care nursing as their major and then go into general practice. They usually come from other fields... Because of that, when it comes to cancer in particular, nurses tend to really shy away *and go, 'I'll just let the doctors deal with this or I won't even bring it up or I won't touch it' mainly because of the fear* of saying the wrong thing or just being caught out, that imposter syndrome. PN09
We do get a lot of CPD (continuing professional development) *and we're confident in things like managing diabetes and cardiovascular disease on the metabolic side. With cancer I think there's less of the general practice management. Maybe it's because the chance of survivorship is changing, whereas in the past survivorship levels were much lower, so GPs didn't* play a great role, but now there is an increasing need to provide some kind of care to live with cancer. GP04

- ***Differences in continuing education/guidelines***

A lack of knowledge and experience in that area are the biggest challenges and the oncology side of things is quite specialised, so having enough understanding that you can still support the patient can be difficult, but all that is about education and experience. GP01
I know from my practice management point of view I will direct the nurses to a webinar that's going to benefit the business and the doctors. For instance, in a practice where it's a fairly young population, you hardly see any cancer patients of any type, I would not be putting a nurse through any of that kind of training. Whereas, at another practice where you have a lot of older patients, you have a lot of patients that you see these cases with, then you would think, look, this is actually going to benefit the patient because the nurse will be able to provide more education, free up the doctors' time a little bit, assist the doctors, guide them as well to anything new that might be happening; then I would certainly put the nurses through that education. PM05
I'd probably like to do some CPD stuff on being able to support those who have been diagnosed a lot more. I haven't honestly searched for that, I'm sure it's out there… I probably might Google a bit more of where to get some extra CPD stuff *based on cancer survivors perhaps. I don't know the first place to look, but I'm sure that there's some out there. PN06*