
The role of general practitioners in cancer care

PERSPECTIVES

BENTE THORSEN

E-mail: bente.thorsen@ous-hf.no

Bente Thorsen, specialist in general practice and community medicine, senior coordination consultant and head of the practice consultant scheme at Oslo University Hospital.

The author has completed the ICMJE form and declares no conflicts of interest.

KARIN FRYDENBERG

Karin Frydenberg, specialist in general practice, GP at Skreia Medical Centre and head of the practice consultant scheme at Innlandet Hospital.

The author has completed the ICMJE form and declares no conflicts of interest.

KNUT-ARNE WENSAAS

Knut-Arne Wensaas, specialist in general practice, GP at Kalfaret Medical Centre and senior researcher at the Research Unit for General Practice, NORCE Norwegian Research Centre, Bergen.

The author has completed the ICMJE form and declares no conflicts of interest.

LINE CECILIE CHRISTIANSEN

Line Cecilie Christiansen, specialist in general practice and GP at Stavanger Medical Centre.

The author has completed the ICMJE form and declares no conflicts of interest.

BODIL AASVANG OLSEN

Bodil Aasvang Olsen, specialist in general practice and GP at Tvedestrand Medical Centre.

The author has completed the ICMJE form and declares no conflicts of interest.

KARSTEN KEHLET

Karsten Kehlet, specialist in general practice and GP at the Silsand department of Senjalegen Medical Centre.

The author has completed the ICMJE form and declares no conflicts of interest.

ELLEN ANITA FAGERBERG

Ellen Anita Fagerberg, specialist in general practice, GP at Abildsø Medical Centre and practice consultant at Oslo University Hospital.

The author has completed the ICMJE form and declares no conflicts of interest.

KJELL OLAV B. SVENDSEN

Kjell Olav B. Svendsen, GP at Frogner Health Centre and assistant professor at the University of Oslo.

The author has completed the ICMJE form and declares no conflicts of interest.

TOVE BORGEN

Tove Borgen, specialist in general practice, GP at Frysja Medical Centre and practice consultant at Diakonhjemmet Hospital.

The author has completed the ICMJE form and declares no conflicts of interest.

EIRIK VISTE

Eirik Viste, specialist in general practice, GP at Byhaugen Medical Centre and practice consultant at Stavanger University Hospital.

The author has completed the ICMJE form and declares no conflicts of interest.

High quality cancer care is an important and highly prioritised part of general practitioners' daily work. It is expected that the effort will increase in the future. In order to reach new targets the regular GP scheme must be strengthened.



Illustration: Martin Mauseth Hvattum

The new national cancer strategy [\(1\)](#) imposes a larger responsibility on GPs, in line with international signals [\(2\)](#). There is a broad political consensus that the population should have equal access to healthcare services of high quality [\(3\)](#). Key goals in the cancer strategy include user-oriented cancer care, better pathways for cancer patients, increased survival rates and the best possible quality for patients and their families. The prevalence of cancer is increasing, mainly because of the growing number of elderly people, and patients tend to live longer with cancer or are cured. Many will therefore need follow-up of health complaints caused by the disease and the treatment.

The lack of continuity in the contact with therapists and constant change of doctors during the treatment pathway are a challenge [\(1\)](#). The GP can play a key role in collaboration with the specialist health services both during and after treatment. The Directorate of Health has taken the initiative to have a group of GPs appointed by the Norwegian Association of General Practitioners (NFA) describe the role of the GPs in the national action plans for cancer. The GPs tend to use the same ways of working for all types of cancer [\(4\)](#), and in this article the working group will describe the GP's main tasks and roles.

Prevention and screening

The GPs address harmful lifestyle, obesity, physical inactivity, alcohol use and smoking habits according to the methods of general practice. In addition, they identify patients at increased genetic risk for disease, including various types of cancer, and manage this in line with national guidelines. The GPs have a special responsibility for providing evidence-based guidance regarding what the patients themselves can do to promote their own health and avoid disease. A key task is to provide balanced information and participate in the national

cancer screening programme. The GPs undertake most of the tests under the cervical cancer screening programme and are informed about findings in the mammography programme. Evidence shows that a recommendation from a GP increases participation in colorectal cancer screening (5).

Examination for possible cancer

There must be a low threshold and short waiting time in general practice for patients who wish to be examined for cancer-related health complaints. The GP, on the other hand, must balance such disadvantages as overdiagnosis, overtreatment and unnecessary medicalisation with the benefits of an early diagnosis of cancer, while avoiding giving rise to health anxiety and burdening a healthy population with unnecessary follow-up by the health services. Guidelines and recommendations for dealing with and examining patients with possible cancer must be based on the best available data, preferably from primary care. When data from primary care are lacking, research should be encouraged.

Start of the cancer patient pathways

The standardised pathways for cancer patients provide more specific recommendations than previously for the selection of patients whom should be referred for rapid investigation (6). However, the starting point of these pathways can vary. In some cases, such as breast and colorectal cancer, the GP may refer the patient to a standard pathway based on his or her own clinical findings and simple supplementary investigations. Other types of cancer require radiological investigation prior to referral. For some cancers, such as prostate cancer, a secondary care specialist must decide whether the criteria for a standard pathway are met. Developing the diagnostic manuals further may lead to more similar practice, where this is appropriate (7). Patients throughout the country must have equal access to recommended radiological examinations. Referral addresses and contact information for the cancer patient pathway coordinators ought to be easily available on the hospitals' websites.

The GP's role during the treatment process

Advanced cancer treatment may require hospitalisation, but a lot of cancer treatment is also provided in outpatient clinics. Most often, cancer patients are monitored closely by the hospital during the treatment stage. However, many also maintain contact with their GP. The GP can provide advice and treat adverse effects, complications of the cancer treatment and cancer-related mental health problems, and follow up the patient's general state of health. In order to be able to provide appropriate and relevant assistance to the cancer patient at this stage, the GP needs to receive copies of updated discharge notes

and outpatient journal records. These should provide a plan for further management of the patient and whom the GP should contact if problems arise. When the hospital treatment is completed, the GP will assume responsibility. This transition will be smoother if the GP has been involved throughout the cancer pathway.

«There is a broad political consensus that the population should have equal access to public services of high quality»

An increasing number of cancer patients are living with incurable cancer, many of whom have major health complaints [\(1\)](#). New therapies are being adopted at a rapid pace, sometimes without sufficient evidence of their long-term effectiveness and adverse effects. Research and the experiences of patients, families and health workers must form the basis for provision of the best possible follow-up. The distribution of tasks and responsibilities must be agreed in an ongoing collaboration between the GPs and the specialist health services. A growing proportion of the patients are elderly and suffer from comorbid conditions when cancer develops [\(1\)](#). The GP should be systematically involved in decisions concerning the examination and treatment of cancer in elderly patients. For patients with a major disease burden, the GP can provide advice on prioritisation in order to reduce the treatment burden. The GP should also offer follow-up to patients who do not wish to receive cancer therapy. Dialogue with the patient and his or her family and collaboration between the specialist health services and the GP are important to ensure that the decisions made are in line with the patient's needs and wishes.

Follow-up and scheduled appointments

For many cancer types, standardised and sometimes extensive follow-up programmes have been established, spanning many years after the completion of primary treatment [\(8\)](#). The action programmes outline that many of these planned appointments should be managed by the GPs. However, there is little evidence that the patients' will benefit from standardised cancer follow-up [\(2\)](#). A revision and reduction of the follow-up programmes in the action plans for cancer might help ensure more appropriate follow-up, better use of the GPs' time and less demand for radiological investigations..

An appointment after completion of primary treatment is often appropriate. Further follow-up ought to be based on conditions linked to the specific type of cancer in question and the general state of the patient's health. Follow-up by the GP is provided partly through scheduled appointments and partly through the patient making contact as needed (Box 1). In a dialogue with the patient, the GP must balance life-prolonging treatment and intensity of follow-up appointments with overall quality of life. Good decisions require a confident dialogue between the parties concerned, preferably in joint decision-making sessions.

Box 1 In cancer patients, the GP should follow up (4):

- recurrence of cancer and treatable metastases
 - delayed effects or complications that can be treated or alleviated
 - rehabilitation and recovery of function
 - sick leave and collaboration with others to aid return to work
 - the need for palliative treatment
 - the risk of new cancers
 - the patient's overall state of health, where cancer can be one of several diseases
-

Cancer rehabilitation

The GP provides medical follow-up during the rehabilitation process, with a focus on encouraging the patient to engage in self-care, physical and social activity and a healthy lifestyle. The objective is to achieve the best possible recovery. There is a need for new research on cancer rehabilitation. Good evidence may help clarify which services that ought to be expanded or developed, how responsibilities should be distributed between the specialist and municipal health services, the responsibilities that the patients themselves may assume, and how these programmes should be funded. An overview of the rehabilitation programmes for cancer patients should be available nationally as well as locally, and include the options provided by the municipal health services.

Some patients suffer from life-long delayed effects of cancer therapy. More evidence is needed here as well. There should be a demand for a better description of the knowledge gathered from experience in the health services. The Norwegian Labour and Welfare Administration (NAV) must recognise these complaints as an illness that can impair the ability to work, even though the patient is declared to have been cured of the cancer itself.

Palliative treatment

Starting from the time of the cancer diagnosis, the GP should remain aware of whether the patient needs palliative treatment and follow this up in collaboration with the specialist health services, other primary health service providers and families, if any (4).

«The GP can play a key role in collaboration with the specialist health services during and after the completion of treatment.»

An increasing number of cancer patients wish to die at home (1). In such cases, medical responsibility and collaboration must be agreed between the hospital and the GP. The GP should be notified through a same-day discharge note

when seriously ill patients are discharged to their home, and preferably also contacted by telephone by a hospital colleague to permit direct delivery of important information. The GP must know specifically whom to contact in the specialist health services if the need arises. The cancer nurse, the home-based services, the GP, family members and other services involved constitute the dying patient's follow-up team. The parties agree on how the GP can be reached, including how a doctor can be called outside regular office hours. The team must be aware of the patient's needs in matters concerning faith and life stance, and help take care of any children involved.

Collaboration is the key

In the health services, good collaboration is crucial for ensuring high quality and assurance for patients in cancer care. GPs have found that this collaboration plays a key role in enabling them to assume their share of the responsibility for cancer patients (4, 9). This collaboration needs to include the patient and their families, if any. Patients must be given the responsibility that they can cope with in their own process, but also be ensured help as needed.

Through their contracts, the GPs are an integral part of the municipal health services, and they have a long tradition of collaborating with the health and care services for shared patients.

Home-based standardised pathways are being prepared by the Directorate of Health. These ought to describe the collaboration between GPs, other municipal health and care services and the specialist health services. This would help further develop public Norwegian cancer care as a unified, coordinated service to the population.

LITERATURE

1. Leve med kreft. Nasjonal kreftstrategi (2018–2022). Oslo: Helse- og omsorgsdepartementet, 2018.
https://www.regjeringen.no/contentassets/266bf1eec38940888a589ec86d79da20/regjeringens_kreftstrategi_180418.pdf Lest 18.3.2019.
2. Rubin G, Berendsen A, Crawford SM et al. The expanding role of primary care in cancer control. *Lancet Oncol* 2015; 16: 1231–72. [PubMed][CrossRef]
3. Prop. 1 S (2018–2019).
<https://www.regjeringen.no/no/dokumenter/prop.-1-s-20182019/id2613728/> Lest 18.3.2019.
4. Helsedirektoratet. Fastlegens rolle i handlingsprogrammene for kreft – Generell del. <https://www.helsedirektoratet.no/tema/kreft/fastlegens-rolle-ved-kreft> Lest 18.3.2019.
5. Hewitson P, Ward AM, Heneghan C et al. Primary care endorsement letter and a patient leaflet to improve participation in colorectal cancer screening:

results of a factorial randomised trial. Br J Cancer 2011; 105: 475–80.
[PubMed][CrossRef]

6. Helsedirektoratet. Pakkeforløp for kreft.

<https://helsedirektoratet.no/kreft/pakkeforlop-for-kreft> Lest 18.3.2019.

7. Helsedirektoratet. Pakkeforløp for kreft – Diagnoseveiledere.

<https://helsedirektoratet.no/retningslinjer/pakkeforlop-for-kreft-diagnoseveiledere/seksjon?Tittel=diagnoseveiledere-1164> Lest 18.3.2019.

8. Helsedirektoratet. Nasjonale handlingsprogram for kreft.

Helsedirektoratet. Nasjonale handlingsprogram for kreft.

<https://helsedirektoratet.no/kreft/nasjonale-handlingsprogrammer-for-kreft>
Lest 18.3.2019.

9. Norsk forening for allmennmedisin. Anbefalinger om samarbeid mellom fastleger og sykehus.

<https://beta.legeforeningen.no/contentassets/4c680a9c307640efaffda379b98f7528/anbefalinger-om-samarbeid-mellom-fastleger-og-sykehus-faggruppe-samhandling.pdf> Lest 18.3.2019.

Publisert: 5 June 2019. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.19.0180

Received 26.2.2019, accepted 20.3.2019.

Copyright: © Tidsskriftet 2025 Downloaded from tidsskriftet.no 29 December 2025.