

# Adapting patients' oncological treatment through remote participation of general practitioners in multi-disciplinary consultation meetings: A feasibility study

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## KEY MESSAGES

- GP participation in multi-disciplinary consultation meetings is feasible if adequately prepared in advance.
- The GP's contribution can change the proposed treatment through patient-centred information and knowledge of the patient's lifestyle.
- Simple telecommunication tools enable coordination between primary care and the hospital.

## ABSTRACT

**Background:** The general practitioner (GP) is central to managing patients with cancer, whose numbers are increasing worldwide. The GP's involvement requires better coordination between involved partners, in particular oncologists and GPs.

**Objectives:** To conduct a feasibility study of remote participation of GPs in multi-disciplinary consultation meetings (MCMs). We analysed participation, participants' satisfaction, and their impact on therapeutic decisions.

**Methods:** We conducted a feasibility study in the regional cancer centre of Toulouse, France. All patient cases discussed in the MCMs for myelodysplasia from 1 January to 31 March 2016 were included. Cases of patients aged over 18 years, with a diagnosis of myelodysplasia and registered with a GP were included if patients gave informed consent. One investigator collected the data provided by GPs during three telephone or video calls: before, during, and after the MCM, respectively.

**Results:** Of 86 patient cases discussed during three months of MCMs, 44 were eligible for GP participation; 27 GPs participated in discussions of 27 patient cases. The GP's participation in the MCM led to a change in management in five cases, with four times treatment intensifications and once de-intensification. Medical, social, family-related, and psychological domains were discussed with input from the GPs. Overall, all participants were satisfied with the MCMs.

**Conclusion:** Remote participation of GPs in MCMs is feasible and may result in adapting oncological and haematological management for patients. This patient-centred approach requires a specific organisation that, when implemented, satisfies the needs of all participants.

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## Introduction

Cancers are the second cause of mortality worldwide. In 2018, there were 18.1 million new cases and 9.6 million deaths worldwide, with 4.2 and 1.9 million, respectively, in Europe [1]. Oncological management

makes it possible to reduce the mortality of cancer patients [2]. Their management is increasingly prolonged, requiring greater involvement by those who care for these patients. The general practitioner (GP) plays a central role in managing and coordinating

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cancer care [3]. They take part in all phases of care: prevention, screening, diagnosis, treatments (adherence, follow-up of adverse effects, treatment at home, therapeutic education, and support care), survivorship care or the initiation of palliative care [4,5]. Better coordination of care shared patient-centred decision-making [6], and improved quality of life are all based on good cooperation between all those involved in primary care and between hospital professionals and professionals in outpatient care [7]. Communication and exchange of information between the hospital and primary care are essential, but there remains room for improvement [8]. Several interventions have already been tested to improve coordination between the hospital and primary care in oncology. Direct and oral communication between all health professionals seems to merit further development [9]. However, hospital staff rarely establishes a link with primary health-care professionals.

Multi-disciplinary teams bring together specialists from different disciplines to optimise the management of patients with cancer. To reach a concerted, shared decision on the medical management of these patients [10], it is essential to take into account the GP's viewpoint during multi-disciplinary consultation meetings (MCMs) [11]. Their participation in these meetings is very infrequent; in Belgium, in 2014, it was estimated at <4% [12]. Nevertheless, GPs can provide the hospital teams with valuable information, particularly concerning the patient's socioeconomic and family environment, history, and psychological profile. Their participation could be important in formulating the patient's proposed treatment plan. The MCM provides an opportunity to pass on useful information from the hospital to primary care and from primary care to the hospital [8]. Participation of GPs in MCMs requires GPs to go to the hospital to attend the meeting at a fixed time on the appointed day to discuss the case of one of their patients. Organisational issues are a barrier to their effective participation in these meetings [13,14].

The main objective of our work was to study the feasibility of remote participation of GPs in MCMs. The secondary objectives were to study the impact of GP participation on the therapeutic decision made at the meeting and the satisfaction of GPs and oncologists with the communication and information exchange.

## Methods

### Study design and setting

This study was a single-centre prospective interventional feasibility study. It was conducted during the

**Box 1.** The five objectives and guiding questions of Orsmond and Cohn [16].

- I. Evaluation of recruitment capability and resulting sample characteristics
- II. Evaluation and refinement of data collection procedures and outcome measures
- III. Evaluation of acceptability and suitability of intervention and study procedures
- IV. Evaluation of resources and ability to manage and implement the study and intervention
- V. Preliminary evaluation of participant responses to intervention

haematology MCMs from 1 January to 31 March 2016, at the Institut Universitaire du Cancer Toulouse-Oncopole, France, a regional reference centre for myelodysplasia. We chose myelodysplasias as a management model. These diseases alternate phases of active management and phases of watchful waiting, during which interaction between the GP and the specialist is critical. Myelodysplasias are the most frequent blood disease in elderly persons [15].

The methodology of the study was based on the work of Orsmond and Cohn [16]. The five objectives and guiding questions for a feasibility study were all adhered to (Box 1). We could not fully carry out the fourth objective since the study objective did not include the evaluation of proposed pharmaceutical treatments with their known adverse effects.

### Study population

Inclusion criteria were MCMs for patients aged over 18 years, who had myelodysplasia, were capable of giving their free and informed consent, were registered with a GP, and whose file could be presented to the regional MCM on myelodysplasia.

MCMs on cases of patients who were unable to give their free informed consent, patients who had myelodysplasia that required emergency treatment that prevented the timely provision of consent, and patients who had no known GP were excluded.

### Study procedures and data collection

All data were collected by phone by the same investigator, who was not involved in the MCMs. At all stages of the study, data were collected using a support sheet (Supplementary Appendix 1). A secure

videoconferencing channel was set up for each video conference call.

**Stage 1.** Seven days before the date of the MCM, a list was made of eligible patients. After the patient gave consent, the GP was invited to participate in the patient's MCM by telephone. A telephone conference or video conference appointment was agreed with the GP for the time of the MCM. The data collected during this first telephone call related to the characteristics of the GP, the willingness to take part, the form that the meeting should take (telephone or video conferencing), the information that they considered they would be able to provide and, if relevant, the reasons why they declined to participate.

**Stage 2.** During the MCM, the panel of present physicians put forward an initial treatment proposal before the GP gave his/her opinion. The patient's registered GP was then contacted (second telephone or video call). The proposed treatment was discussed with the GP taking into account the patient's medical, social, family, and psychological profile as reported by the GP. A final treatment proposal was concerted. The oncologist's satisfaction with the exchange, the impact on the therapeutic decision, effective participation of the GP, and the reasons for non-participation, if applicable, were recorded.

**Stage 3.** One month after the virtual MCM, the GPs were contacted for a third telephone call. Data on satisfaction were collected: communication with the oncologist, evaluation of the first call (timing and relevance), GPs' ability to free up time to attend the MCM, appropriateness of the use of video conferencing for

the GPs concerned, and willingness to renew the experience or not. These elements served to define the acceptability of the study.

### Statistical analysis

All the variables of interest were expressed as numbers and percentages for qualitative variables and as means for quantitative variables. Comparative analyses of sub-groups were carried out using Fisher's exact test as the expected number of each item was <5 and a Wilcoxon–Mann–Whitney test for average comparisons.

### Ethics

Patients gave their written informed consent, and the GPs gave their oral consent before participation. The ethics committee approved the study of the University Department of General Practice of Toulouse: n°2015-011 dated 2015/11/25.

### Results

The cases of 86 patients were discussed in MCMs. Forty-four patient cases were eligible to be included in the study. Six GPs did not respond after three call attempts and they were considered unreachable; five were not available on the date of MCMs, and six did not join the meeting. The characteristics of the 38 GPs who initially agreed to participate in MCMs are described in Table 1. Finally, 27 GPs effectively participated (Figure 1).

Eleven of the 27 patients were female, with an average age of 74 years (no significant difference with eligible patient cases). Of the 27 patients in whom the

**Table 1.** Characteristics of the general practitioners who agreed to take part in the meetings.

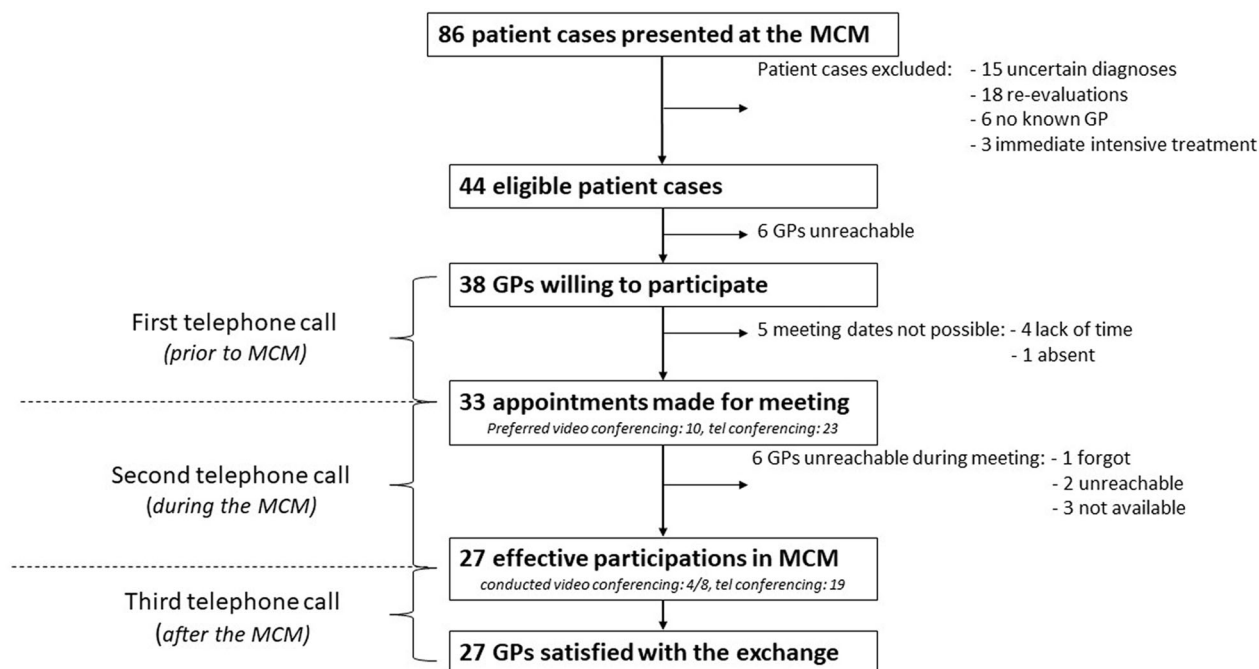
Characteristics of GPs participating in MCMs	Willing to take part (N = 38) n (%)	Effectively took part (N = 27) n (%)	Did not take part (N = 11) n (%)	p
Female	6 (16)	6 (22)	0 (0)	0.15*
Mean age, years	55.9	55.5	56.9	0.77**
Location of practice				
Rural or semi-rural	22 (58)	15 (68)	7 (32)	0.73*
Urban	16 (42)	12 (75)	4 (25)	
Type of practice				
Solo	15 (39)	8 (53)	7 (47)	0.07*
Group	23 (61)	19 (83)	4 (17)	
Supplementary training				
Training <sup>a</sup>	12 (32)	10 (83)	2 (17)	0.44*
None	26 (68)	17 (65)	9 (35)	
Number of current oncology patients followed per GP (mean)				
Patient with solid tumours	25.6	25.1	26.8	0.30**
Patient with blood disease	6.8	6.8	6.8	0.42**

N: number; GPs: general practitioners; MCMs: multidisciplinary consultation meetings.

Pain relief and palliative care 2, geriatrics 9, both 2.

\*Fisher exact test.

\*\*Wilcoxon–Mann–Whitney test.



**Figure 1.** Flow chart of general practitioner (GP) participation in multidisciplinary consultation meetings (MCMs).

GPs participated, 13 were low-risk myelodysplasia, 12 were high-risk myelodysplasia, and two were secondary acute myeloid leukaemia.

### Participation according to GP profile

In our population, no characteristic of the GPs studied appeared to affect their effective participation (Table 1). The three main reasons for non-participation in all phases of this study were lack of time (four GPs), not being available at the time of the call (three GPs), and being unreachable (two GPs).

Twenty-three (72%) of the GPs preferred telephone rather than video for the second call to organise the meeting (Figure 1). Video conferencing encountered difficulties (three problems of installation, one problem of compatibility). It was free of technical issues in only four of eight GPs.

### Impact of the GP on the therapeutic decision during the MCM

In five of 27 patient cases, the dialogue between the GP and the oncologist influenced the therapeutic decision. In four cases, the GP's knowledge enabled treatment intensification, and in one case, the outcome was de-intensification.

The GP provided the oncologist with a wide range of information, whether during the first or the second telephone call: medical, social, personal, and psychological. Diverse information was collected during each

call (Table 2). The combination of calls before and during the MCM provided the most information on the patient's lifestyle. Participation of GPs was considered relevant by the oncologist and by the GP in each case with interesting and complementary inputs (e.g. patient's entourage, description of housing circumstances, acceptance of usual care).

### Acceptability of GP participation in MCMs

Overall, GPs were satisfied with the dialogue, as 93% were satisfied with the quality of communication and 96% felt that they had been listened to, while 74% found that it was reasonably easy to free up time to attend the meeting. Oncologists were satisfied with their exchanges with GPs in communication (89%) and considered GPs' input relevant in 96% of their interventions during therapeutic decision-making. All participants wanted to continue the experiment and were willing to participate again.

## Discussion

### Main findings

Remote participation of GPs in MCMs on myeloproliferative disease seems feasible. Their participation rate was good at 61%, with 19 participating by telephone and four by videoconference. The GPs provided relevant information in the medical, social, family-related, and psychological domains. Their participation had an

**Table 2.** Number of topics discussed by general practitioners during the telephone calls before and during the multi-disciplinary consultation meeting.

	Number of topics discussed among medical, social, personal and psychological domains, n (%)					Total
	0	1	2	3	4	
By the GP						
Before the MCM	4 (11)	11 (29)	6 (16)	10 (26)	7 (18)	38
During the MCM	0	1 (4)	9 (33)	13 (48)	4 (15)	27
Number of new topics discussed during the MCM	10 (37)	7 (26)	6 (22)	3 (11)	1 (4)	27
GP willing to participate						
Yes	0	3 (9)	2 (6)	13 (39)	15 (46)	33
No	2 (40)	1 (20)	1 (20)	0	1 (20)	5
GP effectively participated						
Yes	0	0	1 (4)	12 (44)	14 (52)	27
No	0	3 (49)	1 (17)	1 (17)	1 (17)	6

N: number; GP: general practitioner; MCM: multidisciplinary consultation meeting.

impact on the therapeutic decision in 19% of MCMs. All participants were satisfied with their involvement.

### Strengths and limitations

Several studies have discussed the merits of including GPs in the management of cancer patients [17,18]. Some have studied the possibility of using videoconferencing to increase GP participation in MCMs [8,19]. Our study is of interest because it examines the feasibility of remote participation (by video or telephone conferencing) of GPs in MCMs conjointly with the impact of such participation on the conduct of the meeting. There was no initial selection of GPs since all GPs whose patient cases were discussed in the MCMs were contacted, the study was free of selection bias. Some studies have highlighted the value of involving the GP in managing the cancer patient earlier before announcing the cancer diagnosis by the oncologist, particularly in MCMs [8,12,18,20,21]. They showed an improvement in communication between volunteer GPs and oncologists as well as participant satisfaction. These were not, however, feasibility studies and did not examine the impact on decision-making. All relevant tools currently used are employed after the therapeutic decision has been made [9]. However, involvement of the GP earlier and during therapeutic decision-making facilitates starting treatment in a coordinated manner [22].

Our small sample size allowed us to carry out a feasibility study but a larger sample would be needed to examine the real impact of the presence of GPs on MCMs. The real-life situation helped us understand GP's difficulties in freeing up time to attend meetings while dealing with the consultations and emergencies of daily practice. We chose MCMs on myelodysplasia to limit selection bias since, in these regional meetings, the cases of all patients with this disease are

presented exhaustively. The use of the objectives and guiding questions of Orsmond and Cohn enabled the study to be rigorously carried out and validated the research process [16]. Data were collected in 2016, and the results were analysed in 2019. This interval was due to a change in the computerised medical information system at the hospital that made data extraction more complex and required new authorisation to adhere to the anonymity procedure. However, this did not affect the study of the feasibility of remote participation of GPs in MCMs.

### Participation according to GP profile

We organised this feasibility study to investigate the real-life remote participation of GPs in myelodysplasia MCMs. Although it is difficult to compare our study with the literature that examined face-to-face participation of GPs in MCMs, other authors found the effective participation of GPs was meagre at 0.8–4% [12]. In contrast, the participation rate of GPs in remote meetings in our study was 61%. The first telephone call made it possible to organise the MCM and allow the first exchange of information between the GP and the oncology team. Other studies have set up the participation of voluntary GPs in each MCM, resulting in improved two-way communication [18]. However, these GPs were volunteers who were not the patients' treating physicians. This way, the expertise of the patient's GP is not used, and no knowledge of the patient's environment and living conditions is provided.

We believe this call before the MCM is of primary importance. It provides a clear understanding of the expectations and objectives of the different professionals and provides valuable information about the patients. This first stage is crucial, but it requires considerable administrative organisation (preliminary collection of patient cases and a telephone call to each

GP). The willingness of GPs to take part in MCMs has been reported in the literature [8,20,23], showing the relevance of GPs' presence in MCMs [8,21]. They willingly participated in our study (61%), but heavy workload, the difficulty of attending [14], logistic or organisational issues, and communication or information problems are all potential barriers to their participation [13]. We believe remote participation by technological means decreased the logistic and organisational barriers. Some studies have revealed that some GPs are concerned about conducting video MCMs [8]. The high participation rate in our study is reassuring concerning the effective participation of GPs in real life. In practical terms, the GP's participation in MCMs requires the first call to collect initial information and decide when the second call will occur. During the MCMs, the meeting must be organised to enable the GPs to participate remotely through the second call. This task should be entrusted to dedicated healthcare professionals.

Video conferencing was rarely used by GPs, and when it was used, it was cumbersome to set up, with failure in half of the cases. Although it is one of the methods that GPs suggest for conducting MCMs remotely [8], the technical problems of video conferencing make telephone conferencing more feasible in real-life practice. Advances in telemedicine in oncology during the Covid-19 pandemic and the use of digital communication tools between patients and professionals [24] may encourage the development of more effective tools for participation in virtual MCMs.

### ***Impact of the GP on the therapeutic decision during the MCM***

The participation of the GP in MCMs was all the more satisfying as it led to a change in management for five patients, with treatment intensification in most cases. This change demonstrates the importance of the various domains of knowledge provided by the GP [25] during the MCM, whether this knowledge is medical, social, family-related, or psychological. These domains are often not sufficiently addressed during MCMs [20]. In addition, the GP can provide information on the patient's resilience [26]. Therefore, the therapeutic proposal is made genuinely collegially, centred on the patient [23].

By combining various tools for multi-disciplinary coordination between primary care and the hospital, care can best be adapted to the patient's needs [6,7] at the various management stages. It is difficult to assess the ideal composition and organisation of MCMs [27], but the inclusion of GPs seems promising

[18]. If care is to be patient-centred, the patient must have the benefit of both inpatient (hospital) and outpatient (general practice) expertise [23]. Remote participation of GPs in MCMs needs to be completed by exchanges of information between healthcare professionals at other time points in patient management. The introduction of a 'time-out consultation' after the announcement of the diagnosis would include the GP in the therapeutic pathway from the outset. Tripartite consultations (patient, oncologist, GP) when the patient returns home after the start of treatment would make it possible to organise follow-up of treatment compliance and adverse treatment effects [22].

### ***Acceptability of the study***

***Collaboration between GPs and oncologists.*** There is room for improvement in communication between oncologists and GPs [28]. General practitioners often feel alienated from the hospital system and would like greater involvement [28]. For their part, more than half of patients wish for a follow-up to be shared between the GP and the oncologist, i.e. that the GP should centralise all the cancer-related symptoms (such as adverse effects) together with the non-cancer-related symptoms in a holistic patient-centred approach [29]. A lack of communication can complicate the overall management, and the patient will more frequently use emergency services [30]. Making the GP part of the process before the MCM improves coordination and communication [8,9]. The majority of GPs and oncologists in the MCMs expressed great satisfaction with the relevance of the calls and the quality of communication between medical doctors. This finding is encouraging for the pursuit and improvement of such collaboration.

***Opinion on organisation.*** GPs' involvement in MCMs by remote participation requires organisation and a strong commitment by the oncology team organising the MCMs. In addition to the time needed to organise the GP's participation (first and second calls) and the need for speed to avoid delaying the treatment, the MCMs must be conducted appropriately. The information provided by GPs must be taken into account. Given the information provided and the benefits received, it seems relevant to continue this experiment.

### ***Conclusion***

Remote participation in MCMs by GPs through telephone conferencing or video conferencing is a promising approach to improve coordination around patients

with cancer. GP participation is feasible and relevant. It requires preparation and organisation before the meeting. Such coordination helps to ensure that each patient receives the most appropriate treatment.

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## Disclosure statement

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

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