



Comparative Healthcare Series 1.

In this comparative healthcare series health care professionals across the world describe their approach to a specific clinical problem in the context of their local health care services. This month we focus on colorectal cancer. The prognosis for colorectal cancer remains variable across the world. Although colorectal cancer is one of the most common malignancies diagnosed globally typical five year survival is quoted between 45-55%. Those who survive have usually been diagnosed at an early stage and without metastasis when effective surgical treatment is possible. Most cases are diagnosed after the condition becomes symptomatic and not as a result of screening asymptomatic people. In many countries around the world it is a general practitioner (GP) who must decide when to refer a patient to a specialist before that patient is seen at a hospital clinic. The GP therefore plays a central role in the diagnosis and support of colorectal cancer patients in those countries. Australia and the United Kingdom share a commitment to general practice and the role of the GP is pivotal to the delivery of health care to cancer patients and their families. This month Dr. Andrew Knight and Dr. Michael Gordon describe their approach to a symptomatic patient, writing from their experience as medical practitioners in Australia and the United Kingdom respectively. The views expressed below are their own and do not necessarily reflect health policy or practice elsewhere in their countries. However we believe they offer an interesting perspective on their health care systems and commend the article to our readers.

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Colorectal Cancer

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Australia

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United Kingdom

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Mr. John Smith is a 49 year old taxi driver. He develops several weeks of rectal bleeding and diarrhoea. He eventually presents to your general practice clinic. How soon can a patient access a general practitioner in your country?



In our practice there would usually be an appointment available on the same or the next day though not necessarily with Mr Smith's doctor of choice. This reflects findings of studies of GP access in Australia in which around 80% of patients could access a GP in what they considered a timely way. It is likely that remoteness is an important constraint in accessing GP services. Studies have found lower income is associated with delay in accessing GP services.



This will vary from practice to practice and depend to some extent on how the patient presents his need to the receptionist. If he claims urgency then many practices will be able to accommodate on the day of request. The 2000 National Health Service (NHS) plan, the UK Department of Health's strategic vision for the NHS, sets the target of being able to see a GP within 48 hours but this is only a target not a contractual obligation. Nevertheless recent data for England shows that overall 87% of patients are seen within 48 hours of their request for an appointment and that this figure is increasing each year.

How would you manage this patient if he had no physical signs to account for his bleeding?



A good history is essential. Anal symptoms make cancer less likely. It is important to enquire about constitutional symptoms associated with infection or other inflammatory process. The type of bleeding is important also. Is the blood mixed with the faeces? Is the mucus present? Has there been a prior change in bowel habit or weight loss? Is there a family history of bowel cancer?



Take a good history. Enquire about other general and bowel symptoms, ask about foreign travel. Send off stool for culture and microscopy and send blood for full blood count. If these were normal I would allow time for spontaneous resolution and assume a benign cause. If however on review at around 6 weeks, symptoms persisted I would fax a referral to a colorectal surgeon at the local hospital using the 'Two Week Wait' cancer referral scheme. This national scheme obliges the hospital specialist department to see any patient fitting specified criteria within 2 weeks of the GP referral. Had the initial haemoglobin level been less than 11g then a qualifying criterion would have been met at presentation and a two week wait referral justifiable. I would refer for exclusion of sinister pathology even in the presence of a potential explanation of the anaemia e.g. an iron poor diet.



You examine Mr. Smith and decide he requires a colonoscopy. How can you access diagnostic tests in the public system in your country?



Pathology services are widely disseminated in Australia through private and government funded health services. There is a pathology office down the corridor from our practice where Mr Smith could organise his blood and stool tests immediately. These tests would be fully covered by his universal government insurance. Mr Smith requires referral to a specialist service for colonoscopy. In our area this involves seeing a private specialist surgeon or gastroenterologist. In a worrying situation like this I would ring the specialist rooms and request an urgent appointment. Through personal contact this can usually be organised within two weeks. Rurality and remoteness can cause variations to accessibility in Australia.

Access to colonoscopy is influenced by insurance status. A privately insured person can get a colonoscopy in a private hospital within two weeks in our area. forty four percent of Australians had private insurance as of December 2008. There will often be a 'gap payment' between the charges of the private hospital and specialist charges and the combined refund of the insurance company and the universal government insurance provider. Uninsured patients can elect to pay privately and receive some refund from public insurance system leaving them about \$A1000 out of pocket.

A colonoscopy in a public hospital if the patient is identified by the specialist as highest priority will usually occur within six weeks in our underserved urban fringe area. Public hospital services are administered by state governments with variation in availability across the country depending on workforce issues, remoteness and other factors.



If the picture met the 'lower GI two week wait' criteria I would fax a letter to the hospital on the day I saw the patient. In almost every case, barring administrative error, the patient would be seen within 2 weeks. Typically, at the first hospital visit, the patient would see a specialist nurse who would perform a flexible sigmoidoscopy and arrange for colonoscopy and further tests e.g. Computed Tomography (CT) scan. If cancer was detected then treatment would be arranged quickly. The NHS Cancer Plan 2005 set targets for speed of treatment. It allows 63 days from urgent GP referral to treatment and 31 days from diagnosis to first treatment. Recent figures show that these standards were met in 99 and



94.5% of cases respectively. In the event that the presenting symptoms could not meet the two week wait criteria I would refer routinely using the Choose and Book system. This computerised system makes hospital appointments directly bookable by the GP from his desktop computer. The patient could choose any appropriate department in England, a feature which is particularly helpful if supportive relatives live in another part of the country. Normally, for a routine appointment, the patient would be seen within a few weeks

Mr. Smith is reported to have a cancerous mass in his sigmoid colon. Would be referred back to you to arrange treatment or would he be immediately referred to a colorectal surgeon at colonoscopy?



My experience is that the colonoscopist will usually communicate directly with surgeons and organise a prompt referral. The surgeons will in turn communicate with the referring general practitioner. The inter-specialist referral is valid for insurance purposes for three months. The patient will usually return to primary care for ongoing referral.



Once referred to the colorectal clinic, care would be taken over by that specialist service. The colonoscopist would refer directly to an appropriate surgeon. The GP would have no further part to play in making arrangements for investigation or treatment. The GP would be made aware of the new cancer diagnosis by a fax from the specialist. The Quality and Outcome Framework (QOF), a device which rewards GP practices financially for being able to demonstrate that specified standards are met in patient care, encourages GPs to offer a cancer care review. This review must take place within 6 months of the confirmed diagnosis. Often patients who enjoy a close relationship with their GP will consult spontaneously seeking support during the diagnostic and treatment phases of the illness.



Mr. Smith has an anterior resection and colostomy. What support is available to manage patients like Mr. Smith in the community?



If required Mr Smith may be provided with transition arrangement as an outreach service from the hospital to ensure successful discharge to home after major surgery. This may involve specialist nursing care of wounds, stomas and intravenous injections. Depending on Mr Smith's home situation and physical state after surgery he could receive income support from the government, home support with meals, shopping and housework. Community based stoma therapists and community nursing may be available in his area. These services are usually funded by state governments and communication with nationally funded general practitioners can be variable.

We would provide Mr Smith with GP support through visits to our surgery or if necessary home visits. Home visits are becoming increasingly rare in Australia. They decreased by 51% in the decade to 2007 (7.7 per 100 persons or 0.9% of GP encounters) in 2007. They are not adequately funded under the universal medical insurance scheme.



The UK National Health Service provides free care to all and so no medical treatment costs would be incurred. The patient would be able to consult his GP at the surgery, by telephone or have the GP visit him at home. Home visiting in 2007/8 accounted for only 3.6% of GP consultations in the UK. This percentage has dropped steadily over the last decade. By contrast telephone consulting has become much more acceptable. Although home visits remain free for the patient they are expensive in doctor time. Many GPs will try where possible to deal with issues by phone where previously they would have attended the house at the patient's request. The District Nurse, employed by a government funded Trust, would visit at home to dress wounds and give advice about colostomy use. With the support of hospital based specialist colostomy nurse consultants many practical colostomy problems can be resolved in the community.



Mr. Smith has a very poor prognosis and is requires palliative care. He wishes to die at home. What support is available allow Mr. Smith to die at home?



Our practice would provide Mr Smith with GP support including home visits. The government funded Pharmaceutical Benefits Scheme will provide access to affordable palliative medications. In our area there is an excellent state government funded palliative care service with nurse specialists and doctors who will consult and if necessary visit regularly. They are backed up by palliative care beds at the local hospital which will provide hospice care if necessary.



GP, District Nurse, 'End of life' Specialist Nurse, night sitting services, social services, respite care in a local hospice and possibly local clergy would all be available. The local hospice in my city is funded by public donation but free for the user. There are additional palliative care beds available in nationally funded hospitals locally. Although 70% of patients express a desire to die at home, recent figures from Birmingham reveal only around 25% achieve this with over 50% dying in hospital. My experience is that fragmentation of care may be part of the reason for this. Specifically good communication with out-of-hours providers, who will be available for 75% of the week, helps to enable the dying patient to stay at home. 'Flagging' patients who are to be offered end of life care with out of hours providers is easily done by fax of essential details using *pro forma* handover forms. Recent initiatives e.g. promotion of the Gold Standards Framework aim to equip primary care better and enable better patient choice for place of death. Currently the GP's role is often that of a coordinator of care and a 'fire fighter' reacting to acute problems. Much of the day to day care for the patient in their own home is provided by the district nurse with specialist nurse back-up.