

## Communication between physicians and with patients suffering from breast cancer

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van der Kam WJ, Branger PJ, van Bommel JH and Meyboom-de Jong B. Communication between physicians and with patients suffering from breast cancer. *Family Practice* 1998; 15: 415-419.

**Background.** The communication between GP and specialists is vital for the patient suffering from breast cancer.

**Objectives.** The aim of this study was to investigate (i) the speed and type of communication between GPs, specialists and patients with breast cancer, and (ii) the problems that GPs encounter in the communication with specialists concerning these patients.

**Method.** In April 1995, 246 Dutch GPs from the Zwolle region (600 000 inhabitants) were invited to complete a questionnaire, using the information from the medical record and focusing on the last patient consulted with a confirmed diagnosis of breast cancer.

**Results.** Valid replies were received from 150 (61%) GPs. The median period between initial referral date and receipt of the definite diagnosis from the surgeon was 4 weeks. After the patient's first appointment with the surgeon, the GPs received reports for 24% of the patients within 3 days; for 31% within 3-7 days; and for 16% of the patients after more than 2 weeks. After the first consultation between patient and surgeon, 68 (45%) of the 150 GPs reported that the patient contacted them; at this stage only 30 (20%) of these GPs had received a report from the surgeon. Thirty-one (21%) GPs did not contact the patient after receipt of the definite diagnosis. GPs stated that the communication on patients with breast cancer is too slow (49%), or not frequent enough (25%); 25% of GPs found that the distribution of tasks between them and the specialists are not well described.

**Conclusion.** In the diagnostic stage of breast cancer the communication between GPs, specialists and patients varies widely, is too slow and is incomplete. An effect of this unsatisfactory communication is that the patient herself is the messenger of the bad news.

**Keywords.** Breast cancer, communication, family practice, GP, medical oncology.

### Introduction

In The Netherlands, all patients first consult their GP, who operates in a primary care setting and handles 90% of all patient problems independently, i.e. without referring to a specialist. If deemed to be necessary, the patient is referred to a specialist of the GP's choice. The specialist reports back to the GP after examination and/or treatment of the patient.

Patients suffering from cancer need unambiguous advice and information about various aspects of their disease. This information is vital for the support of the patient.<sup>1,2</sup> From the onset of the disease, the psychological balance of the patient is disturbed, often leading to feelings of panic, despair, fear and depression.<sup>3,4</sup> Patients with cancer are often seen by different physicians, including GPs, radiologists and surgeons. Particularly in this group of patients, the more frequent the communication between physicians involved and the better their tasks are defined, the more positive their opinions on the collaboration<sup>5</sup> and the better the continuity of care.<sup>6</sup>

Several types of communication problems are known to exist between GPs and specialists.<sup>5,7</sup> Branger *et al.* reported that communication problems mainly arise from information being delivered too late and a lack

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Received 8 October 1997; Revised 15 March 1998; Accepted 14 May 1998.

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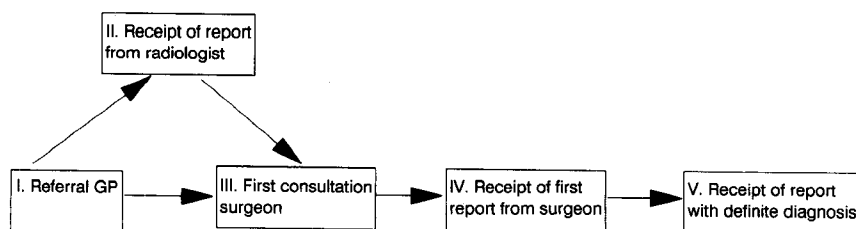


FIGURE 1

of understanding of the information needs of the GP by the specialists.<sup>6</sup> Concerning written communication, referral letters from GPs and discharge letters from specialists have frequently been the subject of research.<sup>8-13</sup> However, in communication on patients suffering from breast cancer, little is known about the speed and type of communication, and the problems experienced by physicians and patients. In communicating on such patients, several stages can be distinguished. In this study we concentrated on the first stage: the communication on the diagnosis and the initial medical treatment.<sup>14</sup> During this stage the GP refers the patient for diagnostic examinations and treatment to a radiologist and/or a surgeon. At this stage, the patient is in a state of uncertainty about the prognosis.<sup>14-15</sup> Medical procedures during this first stage are well structured, but communication between care providers and with patients is only vaguely defined.

In order to obtain insight into existing communication problems between care providers and patients, we investigated: (i) the speed and type of communication between GPs, specialists (radiologists and surgeons) and patients with breast cancer in the period starting from the first referral by the GP to the specialist, to receipt by the GPs of the definite diagnosis based on the pathology report, and (ii) bottlenecks and problems that GPs encounter in the communication with specialists concerning patients with breast cancer.

## Methods

The study was performed in The Netherlands in the Zwolle region in April 1995. This region is a predominantly rural area with about 600 000 inhabitants, seven hospitals and 250 GPs. A total of 247 GPs, who in 1994 had referred patients suffering from breast cancer to specialists in the hospital 'De Weezenlanden' (one of the two hospitals in the Zwolle region) were asked to complete a paper mail questionnaire. The GPs were requested to answer the questions focusing on their last patient with a confirmed diagnosis of breast cancer and to use their medical record. The first part of the questionnaire focused on the speed and type of communication between GPs, specialists and patients with breast cancer.

Figure 1 shows the moments of communication between GPs, specialists and patients in the diagnostic stage of breast cancer. Data were collected on: the name of the hospital, date of referral, first visit to the specialist, receipt of the first report by the GP from the specialist and receipt of the definite diagnosis (results of the pathology examination, including examination of the axillary lymph nodes). In cases of referral to a specialist, the type of communication was also noted. Questions concerning the communication between patient and GP, after the first consultation with the specialist and the GP's action after receiving the first report, and on the report with the definite diagnosis from the specialist, were also part of the questionnaire. The questionnaire also contained questions on the bottlenecks and problems that GPs encounter in the communication with specialists concerning patients with breast cancer. It was possible to indicate that the questionnaire could not be fully completed. Multiple responses were allowed for questions related to the type of communication.

Six weeks after mailing the questionnaire, non-responders received a postal reminder. After another 6 weeks the persisting non-responders received a second reminder followed by a telephone call. In the ensuing weeks all non-responders were contacted.

In analysing the data from the questionnaires, means and medians, and minimal and maximal periods between dates were computed. Statistical analysis was carried out using the software package SPSS/PC+ data entry II.

## Results

A total of 196 (80%) replies were received from the 246 GPs. Of these, 42 GPs (17%) were unable to complete properly the questionnaire for the following reasons: the last patient with a confirmed diagnosis of breast cancer was seen too long ago; no patient with breast cancer had been seen; or they had recently started their practice. Four (2%) questionnaires were not completed for unknown reasons, leaving a total of 150 (61%) valid replies. Of the 150 responders, 89 (59%) referred their last patient with breast cancer to the hospitals in Zwolle, 15 (10%) to the nearby hospital

TABLE 1 Times from GP referral to first radiology report and to first surgical appointment; times from first surgical appointment to first surgical report and to definitive surgical report (number of valid answers, median in days, distribution in terms of percentage)

	n	Median	% (days)					
			<3	3-7	8-14	15-28	29-56	>56
Time from GP referral to:								
First radiology report	57	2	60	35	4			
First surgical appointment (all patients) <sup>a</sup>	85	3	48	33	14	1	4	
First surgical appointment (telephone) <sup>a</sup>	74	2	49	30	10	1	1	
First surgical appointment (letter) <sup>a</sup>	42	5	38	31	24	2	5	
Time from first surgical appointment to:								
First surgical report	146	6	24	31	29	16		
Definitive surgical report	128	26	1	4	17	42	31	

<sup>a</sup> In cases of referring directly to the surgeon.

TABLE 2 Time from receipt of surgeon's reports to GP's contacting the patient (number of GPs contacting the patient, distribution in terms of percentage)

	n	% (days)		
		<1	2-7	>7
Time from receipt of the first report to GP's contacting the patient	116	39	60	2
Time from receipt of the report with the definite diagnosis to GP's contacting the patient	119	27	59	14

in Meppel and 46 (31%) to 10 other hospitals in the region; 57 (38%) referred first to a radiologist and afterwards to a surgeon, and 93 (62%) referred directly to a surgeon.

#### *Speed of communication between GP and specialists*

Table 1 shows (i) the time from GP referral to first radiology report and to first surgical appointment and (ii) the time from surgical appointment to first surgical report and to definitive surgical report to the GP. In cases of GP referral to radiology, 57 valid answers were given for the time between referral and the first radiology report. The median was 2 days and the distribution in terms of percentages of patients was as follows: 60% within 3 days, 35% within 3-7 days and 4% within 8-14 days.

In cases of a direct referral to the surgeon, 8 GPs noted that a mamma screening had been performed

previously. In 66 cases (44%) the first report from the surgeon contained the confirmed diagnosis of breast cancer based on the pathology examination.

Eight GPs (5%) never received a report with the definite diagnosis from the surgeon.

#### *Speed of communication between GP and patient*

Of the 150 GPs, 68 (45%) indicated that the patient took the initiative to contact the GP after the patient's initial visit to the surgeon. At that time only 30 of the 68 GPs had received a report on the visit to the surgeon. In the remaining 48 cases, the patient often informed the GP of the bad news.

Table 2 shows the time from receipt of surgeon's reports to the GP's contacting the patient. In cases of the time from receipt of the first report to the GP's contacting the patient, 116 GPs indicated that they contacted the patient and the distribution in terms of percentages

TABLE 3 *The way in which GPs (n = 150) are informed about the definite diagnosis of breast cancer*

Type of communication	No. of GPs	%
Telephone	23	15
Discharge letter	41	27
Written note	61	41
During conference	10	7
By patient	35	23
Other	14	9

of patients was: 39% within 1 day, 60% within 2–7 days and 2% more than 1 week.

The GPs emphasized that it was necessary to see the patient after receipt of the definite diagnosis.

#### *Type of communication when referring to surgeon or radiologist*

GPs referred to radiologists by telephone in 11 (7%) cases, wrote a letter in 39 (26%) cases and did both in six (4%) cases. The type of communication was unknown in the remaining one case.

GPs referred to surgeons by telephone in 63 (42%) cases, wrote a letter in 35 (23%) cases and did both in 46 (31%) cases. Six (4%) patients were referred to the surgeon by the radiologist.

#### *Informing the GPs about the definite diagnosis*

Table 3 shows that the GP received the first notification of the definite diagnosis in different ways: 35

patients informed the GP themselves; 24 GPs spontaneously remarked that the patient being the messenger of the bad news is totally unjustified.

#### *Problems encountered by GPs in the communication with specialists*

Problems in communicating with specialists were experienced by 66 GPs (44%). Table 4 shows that 73 GPs (49%) stated that the communication was too slow and 38 (25%) found that it was not frequent enough; moreover, 37 (25%) GPs stated that the tasks of primary health care and hospital care were not sufficiently well defined.

## Discussion

As pointed out previously,<sup>1,2</sup> the treatment of patients suffering from cancer requires reliable and timely information exchange between health care professionals and patients. On the basis of our study we conclude that present communication at the diagnostic stage of breast cancer between GPs, specialists and patients needs clarification and improvement.

Other researchers have pointed out the importance of specialists' reports for general practice.<sup>13</sup> Our inventory of the speed of communication between GPs and specialists has revealed great variability in the interval between (i) the initial referral of patients by the GP and (ii) the receipt of specialists' reports by the GP. No less than 68 (45%) of the referred patients contacted their GP after the patient's initial visit to the surgeon and 48 (32%) did this before the GP received a first report from hospital. Even the definite diagnosis was delivered to the GP by the patient herself in 35 (23%) of the cases. This situation places the patient in the role of messenger of the bad news.

TABLE 4 *Problems experienced by GPs in communication concerning patients with breast cancer*

	Number (%) of GPs		
	Yes	No opinion	No
Communication is:			
Too slow	73 (49)	5 (3)	72 (48)
Too infrequent	38 (25)	13 (9)	99 (66)
Incomplete	30 (20)	13 (9)	107 (71)
Incorrect	2 (1)	9 (6)	139 (93)
Inaccessibility of specialist	11 (7)	10 (7)	129 (86)
Tasks not well-defined	37 (25)	19 (13)	94 (63)
Other bottlenecks	49 (33)	none	101 (67)

Shifting our focus to the GP, however, we conclude that not in all cases did the GP undertake action towards their patients after receipt of a specialist's report. Of the 150 GPs, 25% did not initiate contact with the patient within 1 week of receipt of the first report. Of the 150 GPs, 119 (79%) initiated contact with the patient after receipt of the definite diagnosis; 32 of them did this within 1 day. No less than 31 (21%) GPs, however, did not contact the patient after receiving the definite diagnosis.

In our study, we asked the GPs to express their opinion about the quality of the communication with the specialist. No less than 66 (44%) of the GPs indicated that they experienced problems with the communication from the specialist. The main bottlenecks and problems encountered by GPs in communicating with specialists occur because communication is too slow (49%), too infrequent (25%) or incomplete (20%); it is noteworthy that 37 (25%) of the GPs stated that the delineation of tasks between themselves and the specialist is not well defined.

One limitation of the present study is that only one region in The Netherlands was covered. Also, there are weaknesses in a retrospective analysis using data derived from medical records, especially when not all considerations and verbal communications are noted. Another limitation of our study is that the opinions of the patients and the specialists were not asked for. Our results, however, are in accordance with those from other studies, i.e. that the communication between GPs and specialists is considered to be inadequate and the standard paper communication is often too late and incomplete.<sup>5,6,11,13</sup>

Other researches have shown that patients are less depressed and less uncertain when they are properly informed by their physicians.<sup>16</sup> Information about the treatment and its side effects appears to be especially important.<sup>17</sup> From our study it appears that communication may benefit from specialists and GPs working together, and are linked in a communication chain of messages in the triangle of patient, specialist and GP. Therefore, it seems essential to examine and introduce new ways and means for the communication between care providers and patients (e.g. by electronic communication),<sup>6</sup> and to delineate better and define the tasks of GPs and specialists.

## Acknowledgements

We gratefully acknowledge the support of the participating GPs in the Zwolle Region. We also thank the colleagues C Hartman, SM Schot and HEP Bosveld for their contributions to the study.

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