Models of integrated cancer care: A critique of the literature

Bev O'Connell, Linda Kristjanson and Angelica Orb

Bev O'Connell is an Associate Professor in the School of Nursing, Deakin University. Linda Kristjanson is a Professor, School of Nursing and Public Health, Edith Cowan University. Angelica Orb is a Senior Lecturer in the School of Nursing, Curtin University of Technology.

Abstract

A number of models that integrate care across the hospital–community interface have been developed. Consumers and health care providers who are considering adopting this approach to service delivery need to consider which model is most suitable for implementation in their setting. A comprehensive review of the literature was conducted to identify and describe integrated care delivery models. This article defines five integrated models of care, provides a critical analysis of each model, and evaluates the extent to which claims about the models are supported by clinical reports and empirical findings. Finally, recommendations are made regarding implementation.

Introduction

Medical practitioners face increasing pressure to implement integrated models of cancer care and provide a seamless continuum of care across the community–hospital interface. Some of these pressures arise in response to governments' agendas to improve quality and lower the costs of health care by providing more community-based care. In addition, many patients and families have expressed a need to receive cancer treatment closer to their homes (Jamrozik & Sadler 1997). They also report dissatisfaction with the current models of cancer care; in particular, communication and coordination difficulties and a sense of isolation within the treatment system.

Health care providers who are considering the implementation of an integrated cancer care model may be frustrated by the jargon associated with this literature and the lack of clarity about which model to select. Questions may also arise regarding the applicability of models of care developed in other countries to the Australian health care system. This article defines five integrated models of care, provides a critical analysis of each model and evaluates the extent to which claims about the models are supported by clinical reports and empirical findings. Finally, the article concludes with recommendations regarding implementation.

Method

An extensive literature search of the Cinhal and Medline computer databases was conducted to identify literature on integrated models of care. Most literature described clinical accounts and personal opinions or evaluated integrated models of care using quality assurance principles. The few research articles found were critiqued by the authors and rated as either methodologically 'good' or 'fair' (see Tables 1 and 2).

Findings

A comprehensive review of the literature revealed five types of integrated models of cancer care:

- shared care
- case management/managed care
- home care
- collaborative practice clinics, and
- cancer centres.

Shared care

The concept of shared care has been defined in a number of ways across different settings (Harris, Fisher & Knowlden 1993). In a broad sense, shared care involves the sharing of responsibilities between a variety of health care professionals, specifically, specialist medical staff and general practitioners, nurses, patients and patients' families (Buchanan 1992; Dunning, Moscattini & Ward 1993; Kirkhart 1995; Booth et al. 1996). The basic principles that underpin shared care include:

- involvement of more than one health care professional in the management of patients longitudinally
- involvement of health care professionals across the hospital/community interface
- identification of personnel with defined roles and responsibilities
- use of specific communication pathways, treatment guidelines and documentation.

According to Homewood and Harley (1997), there are many benefits associated with using a shared care approach to treatment and care of oncology patients. For example, greater use of general practitioners for routine check-ups decreases the burden of care in hospitals. This shift in primary care provider means the patient receives more convenient, accessible and personalised care.

The Calman-Hine report describes how different agencies and disciplines in the United Kingdom collaborate in a network approach to improve the provision of cancer services (Closs, Ferguson & Thompson 1996). In Australia, several models of shared care are currently being used involving general practitioners in the delivery of patient care (Harris, Fisher & Knowlden 1993). However, an issue that needs to be considered in many parts of Australia is the widespread geographic distribution of patient populations and associated problems of patients' extended hospital stays away from families and difficulties experienced in accessing specialist treatment. In Tasmania, a palliative care service has been established to give terminally ill patients a community-based consultancy service with a primary function of coordinating all care resources outside a hospital environment (Boyes 1997). It was found that by employing this form of care for terminally ill patients, factors such as geographic isolation, physical, social and emotional issues were much easier to define and manage. Along with use of general practitioners and volunteers, extensive use of nursing personnel was a prominent indicator of the success of this program. One of the major benefits of this program included decreased costs through reduced number of hospital bed-days without reducing quality of care.

There were 22 positive outcomes identified in the literature that were attributed to the implementation of the shared care model. Of these, the most frequently cited were:

- cost reductions
- improved communication and continuity of care
- increased patient satisfaction, and
- a reduction in patient waiting times.

Ten negative outcomes were identified. Of these, the most frequently cited were:

- increased workload for health disciplines through poor organisation and role overlap
- emotional strain for health carers, and
- funding difficulties.

Day, Humphries and Alban-Davis (1987) noted that lack of organisation led to an increased workload. This appeared to stem from the lack of time that general practitioners had to deal with these patients and recommendations were made to allocate a nurse practitioner to aid in routine check-ups. This enabled general practitioners to achieve some 'protected time' to perform other professional activities that assist them in providing a high standard of care, such as being able to attend professional education forums and communicate with other health care professionals (Day, Humphries and Alban-Davis 1987).

Case management/managed care

The case management model is also described as the managed care model. This model involves a prospective payment system whereby an identified person is assigned to individual patients to manage their care from admission into hospital through to discharge into the community (MacCallum 1997). This case manager has been described in the literature as a specialist nurse or a general practitioner (Fitzgerald et al. 1994; Emanuel & Neveloff-Dubler 1995; Micheels, Wheeler & Hays 1995). The role includes educating patients, identifying and meeting physical and psychosocial needs, and facilitating and coordinating care and resources.

A variety of case management/managed care models have been used in practice and are described in the literature. The Agency for Health Care Policy and Research in the United States has evaluated managed care and has highlighted cost reductions from reduced length of hospital stay and lower hospitalisation rates for patients receiving managed care. There have been suggestions that preventative care is more effective using the managed care model rather than using other delivery models (Agency for Health Care Policy and Research 1997). The literature reveals 12 positive outcomes attributed to this model. The most frequently cited positive outcomes associated with managed care were:

- cost reduction
- improved communication and continuity of care
- earlier discharge, and
- patient satisfaction.

Eight negative outcomes were identified. Of these, lack of expertise was identified as the most common problem. Because this model focused on one health care professional determining care and did not discuss multidisciplinary involvement in care, its use may be restrictive within the Australian context. However, according to MacCallum (1997), there is merit in having a central person coordinating care as this enhances the quality of care.

Home care

The expansion of services for patients discharged from hospital is known as home care (Hall & McHugh, 1995). In this model, patients are managed by a team of health care personnel (Smith & Yuen 1994). Home teams may be based in the community or the hospital. When based in the hospital, staff have been rotated from hospital to community (Stacey, Martin & Underwood 1997; Stair & Hackman 1997). This approach includes shared responsibilities and has been used effectively for the delivery of palliative care.

The literature suggests that patients perceive home care as the preferred model of care. McDowell, Barniskis and Wright (1990) describe the results of a telephone survey by the Wisconsin Department of Health and Social Services in which 6000 households in the United States were given several scenarios related to their health and asked 'If you had a terminal illness, such as cancer, where would you prefer to be treated?' Seventy-four per cent of respondents indicated a preference for staying at home rather than going into hospital or a nursing home.

There was no primary research reported on the home care model although the advantages of this type of care have been suggested from a secondary research perspective (Sach 1997). Clinical accounts of home care have described 12 positive outcomes. Of these, improved communication and continuity of care as well as satisfaction of patients and health care personnel have been most frequently cited. Two negative outcomes have been identified: problems with transition from hospital and communication problems between health disciplines.

However critical analyses of the home care model highlight concerns that this form of care is labour-intensive for the family. Specifically, when family members care for the patient in the home, some consideration must be given to the carers' needs and the time they require to devote to other family members, regular household chores and their own wellbeing. In a study on a palliative care service (North West Tasmania Palliative Care Service) it was found that during periods where patients needed intensive care, the primary carer in the home (usually the family) was in need of assistance and support (Boyes 1997; New South Wales Department of Health 1997). To provide the necessary assistance during these times when the patient required 24-hour care, as many as three night nurses and several volunteers were necessary. This type of back-up assistance may be difficult to achieve in practice.

Collaborative practice clinics

Collaborative practice clinics are comprised of groups of health care personnel who work together in community or outpatient clinics. Different roles or responsibilities (particularly in the case of a nurse) usually characterise this model. Collaborative practice provides an 'opportunity for each partner to freely use his/her skills, expertise, and clinical judgement when planning health care for patients' (Martin & Coniglio 1996). As noted by Hall and McHugh (1995, p 271):

> *Our model had several defining characteristics, chief among them the idea that we would follow clients in both inpatient and clinic settings – providing continuity of care and comprehensive client health management…including equal admitting privileges for the nurse practitioner members of the team, equally shared on-call responsibilities, mutual consultations among and between providers, [sic] and mutual respect for each other's diverse specialty expertise.*

Only one study was found that evaluated collaborative practice clinics. Thirteen positive outcomes were attributed to this model. Of these, the most frequently cited were:

- saving time for patients
- cost reduction
- satisfaction of patients
- satisfaction of health care personnel, and
- increased support for patients/family.

Five negative outcomes were identified. Of these, only communication problems between disciplines were described by two authors. Various articles detailing personal experiences of different health professionals have highlighted the difficulties associated with sharing roles and responsibilities. More specifically, the different backgrounds, cultures and ideologies of health professionals may cause difficulties. Additionally, funding problems have been identified (Stewart 1996). However, mutual recognition and valuing the skills of other professionals assists the collaborative partnership (Rodgers & Fry 1994).

Cancer centres

Schipper (1994) refers to cancer centres as a central location where cancer care is integrated within the health service structure. Centres specialising in cancer care incorporate support and coordination of resources including a directory of local cancer support groups and other voluntary organisations, research and evaluation, prevention, early diagnosis, treatment and palliative care (Bradburn 1992; Schipper 1994).

Bradburn (1992) describes how a cancer support and information centre was established to provide a directory of resources for cancer patients. The centre provides telephone help lines, hospital and home visiting, sources of information, support meetings, speakers on health topics, practical help, complementary therapies, transport and counselling. Patients are thought to be more empowered by this provision of services and information. Schipper (1994) proposes that cancer centres be established to support, coordinate, research and evaluate cancer treatment and prevention. In the United Kingdom the Calman-Hine report proposed the development of cancer centres or cancer units for the delivery and coordination of cancer care. Specifically, the authors recommended that cancer centres should provide concentrated expertise and education in the care of common and rare cancers. It was also recommended that hospitals which meet specified criteria for excellence in the provision of care for both common and rare cancers be assessed and accredited as cancer centres (Closs, Ferguson & Thompson 1996). Such centres would improve communication and continuity of care, as well as increase research activity. No research was identified that evaluated the usefulness of cancer centres.

Discussion

A critical analysis of the delivery models of care was limited due to the multiple interpretations of each model described in the literature, as well as the lack of research-based evidence to support the use of any particular model. The cancer centre model, for example, was particularly limited by a lack of literature; however, a central facility that coordinated cancer care could play a vital role in managing cancer care and it should not be disregarded merely on a lack of evidence.

Close examination of the models provided insights into the usefulness of certain elements/strategies of each model. Some strategies appeared important throughout the models; others were peculiar to a particular model. A recommendation arising from this analysis is that an integrated model of care in Australia should incorporate strategies that result in similar positive outcomes identified from the delivery models analysed. In particular, a delivery model should aim to reduce costs, while enhancing quality of care, communication, continuity and patient satisfaction. Strategies should be incorporated in any model adopted to avoid the negative outcomes identified from the delivery models described. Patterns of negative outcomes varied between individual models. However, the following should be avoided:

- increased workload for health disciplines due to a lack of coordination
- emotional strain for health carer
- funding difficulties
- role overlap
- lack of expertise
- problems with transition from hospital, and
- communication problems among health disciplines.

Based on the information listed above and analysis summarised in Tables 1 and 2, the shared care model was selected as the preferred model as it has the potential to provide a more continuous and integrated form of care.

Prior to the implementation of any integrated model of care, five issues need to be considered:

- professional education
- communication
- coordination
- cost, and
- quality of care.

All models emphasise increased involvement of general practitioners and nurses in cancer care and effective communication pathways across disciplines. Educational preparation for general practitioners and nurses is essential to successful implementation

of an integrated model of care, as is ongoing support from specialists. If general practitioners are to assume a more active and central role in cancer care, attention must be given to adequate financial remuneration for this group of health professionals.

The literature revealed some essential strategies helpful in addressing these issues. They include:

- developing a role of coordinator/liaison person
- developing more effective communication strategies between disciplines
- implementing communication technologies (including telephone, facsimile and Telehealth facilities)
- introducing patient-held record systems that supplement the existing record systems
- applying consistent treatment guidelines, clinical pathways and plans of care
- protecting general practitioners' time to perform necessary duties such as communicating with other disciplines, and
- developing and implementing educational programs on cancer care.

In summary, this analysis has confirmed that there is a compelling case for use of an integrated model of cancer care which potentially will allow more effective use of resources while achieving a higher standard of care. Health practitioners considering implementation of an integrated cancer care model must consider advantages and disadvantages of the various models within the unique contexts of their practice settings. Additionally, practitioners must remain alert to advances in technology and changes in ways of delivering health care that may affect model implementation. The dynamic nature of health care practice requires that implementation of any model should include monitoring, ongoing evaluation and continuous refinement.

Table 1: List of positive outcomes with references

	Reference indicating clinical support	Reference indicating research support and level of research
Cost reduction		
Shared care	Buchanan 1992; Heard 1996; Dunning, Moscattini & Ward 1993; Homewood & Harley 1997; Orton 1994	McGhee et al. 1994 (fair)
Managed care	Emanuel & Neveloff-Dubler 1995; Ragaisis 1996; Walter & Robinson 1994; Wood 1995; Zwanaiger et al. 1996	Micheels, Wheeler & Hays 1995(fair); Sohl-Kreiger, Lagaard & Scherrer 1996 (fair)
Home care	Stair & Hackman 1997	
Collaborative practice clinics	Given & Stover 1995; Guerrero 1994; Martin & Coniglio 1996	
Decreased readmissions		
Shared care	Buchanan 1992; Dunning, Moscattini & Ward 1993	
Managed care	Zwanaiger et al. 1996	
Home care	Stair & Hackman 1997	
Collaborative practice clinics	Martin & Coniglio 1996	
Saves time for health professionals		
Shared care	Buchanan 1992; Heard 1996	
Managed care	Fountain 1993; Wood 1995	
Easier transition from hospital		
Shared care	Buchanan 1992	
Increased independence		
Shared care	Buchanan 1992; Orton 1994	
Collaborative practice clinics	Given & Stover 1995	
Satisfaction of health care personnel		
Shared care	Heard 1996; Dunning, Moscattini & Ward 1993	
Managed care	Fountain 1993; Wood 1995	
Home care	Hall & McHugh 1995; Stair & Hackman 1997	
Collaborative practice clinics	Dontje, Sparks & Given 1996; Guerrero 1994; Martin & Coniglio 1996	Booth et al. 1996

Note: No literature available for cancer clinics

Table 1: List of positive outcomes with references – *continued*

	Reference indicating clinical support	Reference indicating research support and level of research
Improved communication		
Shared care	Heard 1996; Dunning, Moscattini & Ward 1993	Van Damme et al. 1994
Managed care	Emanuel & Neveloff-Dubler 1995; Fountain 1993; Ragaisis 1996; Walter & Robinson 1994; Wood 1995	Sherman & Johnson 1994 (good); Sohl-Kreiger, Lagaard & Scherrer 1996 (fair)
Home care	Hall & McHugh 1995; Stacey, Martin & Underwood 1997; Stair & Hackman 1997	
Collaborative practice clinics	Martin & Coniglio 1996	Booth et al. 1996 (fair)
Less duplication		
Shared care	Dunning, Moscattini & Ward 1993	
Managed care	Zwanaiger et al. 1996	
Easier management of complex patients		
Shared care	Dunning, Moscattini & Ward 1993	
Home care	Hall & McHugh 1995	
Satisfaction of patients		
Shared care	Heard 1996; Homewood & Harley 1997	Booth et al. 1996
Managed care	Emanuel & Neveloff-Dubler 1995	Sherman & Johnson 1994 (good)
Home care	Smith & Yuen 1994; Stair & Hackman 1997	
Collaborative practice clinics	Dontje, Sparks & Given 1996; Guerrero 1994; Martin & Coniglio 1996	
Increased quality of life		
Home care	Homewood & Harley 1997	
Less patient distress		
Shared care	Heard 1996; Homewood & Harley 1997	
Saves time for patients		
Shared care	Heard 1996; Homewood & Harley 1997	Van Damme et al. 1994
Home care	Stacey, Martin & Underwood 1997	
Collaborative practice clinics	Dontje, Sparks & Given 1996; Guerrero 1994; Martin & Coniglio 1996	Booth et al. 1996 (fair)
Improved continuity of care		
Shared care	Heard 1996; Homewood & Harley 1997	Van Damme et al. 1994 (fair); McGhee et al. 1994 (fair)
Managed care	Emanuel & Neveloff-Dubler 1995; Fountain 1993; Ragaisis 1996; Walter & Robinson 1994; Wood 1995	Sherman & Johnson 1994 (good)
Home care	Hall & McHugh 1995; Stacey, Martin & Underwood 1997; Stair & Hackman 1997	
Improved coordination		
Managed care		Sherman & Johnson 1994 (good)

Note: No literature available for cancer clinics

Table 1: List of positive outcomes with references – *continued*

	Reference indicating clinical support	Reference indicating research support and level of research
Increased support for patients/family		
Shared care	Homewood & Harley 1997	
Managed care	Zwanaiger et al. 1996	
Home care	Stacey, Martin & Underwood 1997	
Collaborative practice clinics	Guerrero 1994; Martin & Coniglio 1996; Sagebiel 1996	
Earlier discharge		
Shared care	Heard 1996	
Managed care	Ragaisis 1996	Micheels, Wheeler & Hays 1995 (fair)
Home care	Stair & Hackman 1997	
Better accessibility for patients		
Shared care	Heard 1996	
Collaborative practice clinics	Guerrero 1994	
Easier identification of complications		
Shared care	Day, Humphreys & Alban-Davies 1987	
Improved quality of care		
Shared care		Van Damme et al. 1994 (fair)
Collaborative practice clinics	Dontje, Sparks & Given 1996	
Better follow-up of patients		
Shared care		McGhee et al. 1994 (fair)
More convenience for patients/medical staff		
Shared care		McGhee et al. 1994 (fair)
Reduced workload of general practitioners and specialists		
Shared care		Booth et al. 1996 (fair)
Improved liaison between general practitioners and specialists		
Shared care		Booth et al. 1996 (fair)
Increased research		
Managed care	Fountain 1993	
Collaborative practice clinics	Given & Stover 1995; Martin & Coniglio 1996; Sagebiel 1996	
Increased compliance		
Home care	Stair & Hackman 1997	
Collaborative practice clinics	Martin & Coniglio 1996	

Note: No literature available for cancer clinics

Table 2: List of negative outcomes with references

	Reference indicating clinical support	Reference indicating research support and level of research
Role overlap		
Shared care	Heard 1996; Dunning, Moscattini & Ward 1993	
Managed care	Fountain 1993	
Problems with transition from hospital		
Home care	Hall & McHugh 1995	
Potential to increase workload through lack of organisation		
Shared care	Day, Humphreys & Alban-Davies 1987; Homewood & Harley 1997; Orton 1994	Van Damme et al. 1994 (fair)
Increase workload for health care personnel		
Managed care	Emanuel & Neveloff-Dubler 1995	
Collaborative practice clinics	Sagebiel 1996	
Increased patient time		
Shared care	Homewood & Harley 1997	
Lack of continuity		
Managed care	Emanuel & Neveloff-Dubler 1995	
Emotional strain for health carer		
Shared care	Heard 1996; Homewood & Harley 1997; Orton 1994	
Patient/family dissatisfaction		
Collaborative practice clinics	Sagebiel 1996	
Communication problems among health disciplines		
Shared care	Heard 1996	
Managed care	Fountain 1993	
Home care	Smith & Yuen 1994	
Collaborative practice clinics	Dontje, Sparks & Given 1996; Martin & Coniglio 1996	

Note: No literature available for cancer clinics

Table 2: List of negative outcomes with references – *continued*

	Reference indicating clinical support	Reference indicating research support and level of research
Funding difficulties		
Shared care	Heard 1996	Harris, Fisher & Knowlden 1993 (fair)
Managed care	Fountain 1993	
Documentation problems		
Shared care	Heard 1996	
Lack of expertise		
Shared care	Heard 1996	
Managed care	Emanuel & Neveloff-Dubler 1995; Zwanaiger et al. 1996	
Lack of individualised care		
Shared care	Day, Humphreys & Alban-Davies 1987	
Decreased patient independence		
Shared care		Van Damme et al. 1994 (fair)
Hospital competition		
Managed care	Fountain 1993	
Lack of trust between health disciplines		
Collaborative practice clinics	Martin & Coniglio 1996	
Staff dissatisfaction		
Collaborative practice clinics	Homewood & Harley 1997	
Staff recruitment difficulties		
Managed care	Fountain 1993	

Note: No literature available for cancer clinics

References

Agency for Health Care Policy and Research 1997, <http://www.ahcpr.gov/> (accessed 16/12/97).

Booth CM, Chaudry A, Smith K & Griffiths K 1996, 'The benefits of a shared-care prostate clinic', *British Journal of Urology*, vol 77, no 6, pp 830–5.

Boyes S 1997, 'North-west Tasmanian palliative care service annual report 1996–1997', *AHA Key Issues Paper*, October, vol 3, no 2.

Bradburn J 1992, 'Linking hospital and community support groups', *Journal of Cancer Care*, vol 1, no 3, pp 179–81.

Buchanan DB 1992, 'Shared care: Implementing the concept from a nurse's perspective', *Canadian Journal of Rehabilitation*, vol 6, no 2, pp 105–10.

Closs SJ, Ferguson A & Thompson D 1996, 'Collaborating on the integrations of cancer nursing services', *Nursing Standards*, vol 10, no 50, pp 37–40.

Day JL, Humphreys H & Alban-Davies H 1987, 'Problems of comprehensive shared diabetes care', *British Medical Journal*, vol 294, 20 June, pp 1590–2.

Dontje KJ, Sparks B & Given B 1996, 'Establishing a collaborative practice in a comprehensive breast clinic', *Clinical Nurse Specialist*, vol 10, no 2, pp 95–101.

Dunning P, Moscattini G & Ward G 1993, 'Diabetes shared care: A model', *Australian Family Physician*, vol 22, no 9, pp 1601–8.

Emanuel EJ & Neveloff-Dubler N 1995, 'Preserving the physician–patient relationship in the era of managed care', *JAMA*, vol 273, no 4, pp 323–9.

Fitzgerald JF, Smith D, Martin D, Freedman J & Katz B 1994, 'A case manager intervention to reduce readmissions', *Archived International Medicine*, vol 154, 8 August, pp 1721–9.

Fountain MJ 1993, 'Key roles and issues of the multidisciplinary team', *Seminars in Oncology Nursing*, vol 9, no 1, pp 25–31.

Given BA & Stover D 1995, 'Nurse managed clinics: Linking specialty cancer care to rural areas', *Michigan Nurse*, vol 68, no 3, pp 11–2.

Guerrero D 1994, 'A nurse led service', *Nursing Standards*, vol 9, no 6, pp 21–3.

Hall EK & McHugh M 1995, 'Family practice health care: Making collaborative practice a reality', *N&HC: Perspectives on Community*, vol 16, no 5, pp 270–5.

Harris MF, Fisher R & Knowlden S 1993, 'Improving general practitioner involvement in urban hospitals', *The Medical Journal of Australia*, vol 58, 1 March, pp 304–7.

Heard G (ed) 1996, *Literature Review, General Practice Integration*, Centre for General Practice Integration Studies, School of Community Medicine, University of New South Wales.

Homewood M & Harley D 1997, 'Shared care in oncology', *Oncology Shared Care Project* (unpublished), General Practice Division, Geelong, p 54.

Jamrozik K & Sadler S 1997, *Medical and Other Care in Western Australia for Patients with Cancer*, Department of Public Health, Perth.

Kearney M & Reznick R 1988, 'The relationship between GPs and community health centres', *Australian Family Physician*, vol 17, no 5, pp 353–8.

Kirkhart DG 1995, 'Shared care: Improving health care, reducing costs', *Nursing Management*, vol 26, no 6, pp 26–30.

Martin B & Coniglio JU 1996, 'The acute care nurse practitioner in collaborative practice', *AACN Clinical Issues*, vol 7, no 2, pp 309–14.

McDowell D, Barniskis L & Wright S 1990, 'The Wisconsin community options program: Planning and packaging long-term support for individuals', *in* A Howe, E Ozane & C Smith (eds), *Community Care Policy and Practice – New Directions in Australia,* Monash University Press, Melbourne, pp 28–45.

McGhee SM, McInnies GT, Hedley AJ, Murray TS & Reid JL 1994, 'Coordinating and standardising long-term care: Evaluation of the west of Scotland shared care', *British Journal of General Practice*, vol 44, October, pp 441–5.

Micheels TA, Wheeler LM & Hays B 1995, 'Linking quality and cost effectiveness: Case management by an advanced practice nurse', *Clinical Nurse Specialist,* vol 9, no 2, pp 107–11.

New South Wales Department of Health 1997, *Optimising Cancer Management Project – Cancer Care Model for New South Wales*, vol 1, December, New South Wales Department of Health, Sydney.

Orton P 1994, 'Shared care', *The Lancet*, vol 344, 19 November, pp 1413–5.

Peter MacCallum Cancer Institute 1997, Literature review (unpublished), Peter MacCallum Cancer Institute, Melbourne, 21 May.

Ragaisis KM 1996, 'The psychiatric consultation-liaison nurse and medical family therapy', *Clinical Nurse Specialist*, vol 10, no 1, pp 50–5.

Rodgers J & Fry N 1994, 'Collaboration among health professionals', *Nursing Standard*, vol 9, no 6, pp 25–6.

Sach J 1997, 'Issues for palliative care in rural Australia', *Collegian*, vol 4, no 3, pp 22–7.

Sagebiel RW 1996, 'The multidisciplinary melanoma centre', *Surgical Clinics of North America*, vol 76, no 6, pp 1433–9.

Schipper H 1994, 'Whither cancer centres?', *The Lancet*, vol 344, 30 July, pp 281–2.

Sherman JJ & Johnson PK 1994, 'CNS as a unit-based case manager', *Clinical Nurse Specialist*, vol 8, no 2, pp 76–80.

Smith M & Yuen K 1994, 'Palliative care in the home: The GP/home hospice team', *Australian Family Physician*, vol 23, no 7, pp 1260–5.

Sohl-Kreiger MS, Lagaard MW & Scherrer J 1996, 'Nursing case management: Relationships as a strategy to improve care', *Clinical Nurse Specialist*, vol 10, no 2, pp 107–13.

Stacey B, Martin K & Underwood RA 1997, 'Continuum of palliative care services: Reflections on an Australian model of care', *Journal of Palliative Care*, vol 13, no 2, pp 45–9.

Stair J & Hackman A 1997, 'Going home: The next forefront for oncology programs', *Oncology Issues*, vol 12, no 5, pp 14–8, <http://www.medscape.com> (accessed 6/11/97).

Stewart J 1996, 'Prepare for more collaboration with other professionals, Manitoba FPs told', *Canadian Medical Association Journal*, vol 155, no 1, pp 98–100.

Van Damme R, Drummond N, Beattie J & Douglas G 1994, 'Integrated care for patients with asthma: Views of general practitioners', *British Journal of General Practice*, January, pp 9–13.

Walter JM & Robinson SH 1994, 'Nursing care delivery models in ambulatory oncology', *Seminars in Oncology Nursing*, vol 10, no 4, pp 237–44.

Wood HA 1995, 'Collaborative practice model in a community hospital', *Nursing Management*, vol 26, no 12, pp 57–9.

Zwanaiger P, Peterson R, Lethlean H, Hernke D, Finlay J, DeGroot L & Busman C 1996, 'Expanding the CNS role to the community', *Clinical Nurse Specialist*, vol 10, no 4, pp 199–202.