What the specific tools of geriatrics and oncology can tell us about the role and status of geriatricians in a pilot geriatric oncology program

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Background: Pilot Oncogeriatric Coordination Units (UPCOGs) were created by the French National Cancer Institute (INCA) in order to implement routine geriatric assessment of all cancer patients over 75 years of age. This article examines the role of geriatric and oncologic tools in the organization of medical oncogeriatric activities, focusing on the role and place of geriatricians.

Methods: We conducted a qualitative sociological survey in the West Paris Oncogeriatric Program (POGOP), one of the Pilot Oncogeriatric Coordination Units (UPCOGs) recently created in France. Various qualitative methods were used including a review of the literature, participative observational surveys, and semidirective interviews with medical staff managing elderly cancer patients.

Results: The results show that the way in which geriatric assessment procedures are implemented confirms the role of the geriatrician in the diagnosis and prevention of vulnerabilities and fragility at the time of initial diagnosis and medical decision making. Nevertheless, the articulation of these different working methods gives rise to various organizational configurations.

Conclusions: The POGOP has largely contributed to clarifying medical activity in oncogeriatrics: identification of physicians, definition of shared goals, initiation, and structuring of new partnerships. Nevertheless, the geriatrician’s tools, expertise, and know-how are often perceived ambiguously.

Key words: coordination, negotiation, oncogeriatrics, organization, role, working instrument

introduction

Pilot Oncogeriatric Coordination Units (UPCOGs) were created by the French National Cancer Institute (INCA) in order to implement routine geriatric assessment of all cancer patients over 75 years of age. In general, these pilot units are intended to resolve various problems, such as late diagnosis [1] and late management of elderly patients, incomplete investigations [2], poorer prognosis and less intensive treatment than in younger populations (with possible inequalities in access to treatment) [3], the lack of clinical trials [4], and specific treatment complications. Management of elderly cancer patients raises not only professional and organizational problems but also political, economic, and moral issues. Indeed, population aging has had an impact on hospital organization in both the public and the private sectors, particularly during the last decade. The International Society of Geriatric Oncology has underlined the current and future challenges faced by this sector [5], as well as national differences in the organization of the medical profession and in the general functioning of the healthcare system, which give rise to different practical interpretations [6].

These French pilot units are intended to provide multiple responses to these challenges. The solution is not to create a new medical specialty but rather, a new coordination of medical activity based on new partnerships with geriatricians. We focus on the articulation [7, 8] of the different organizational procedures of medical work (working instruments or tools). Multidisciplinary consulting meetings (MCM) are now obligatory for therapeutic decision making on all newly diagnosed cancer patients; medical decision making is organized through exchanges and discussions between the different oncologic professions, centered on the individual patient’s medical file. Geriatric assessment procedures serve as a reference for increasing awareness of oncogeriatrics in the international medical literature. These procedures are all designed to evaluate the elderly patient’s general condition.
(vulnerability or very fragility) and to orient the search for signs of dependency or geriatric syndromes. These evaluations allow the different cancer specialists (organ specialists, surgeons, radiotherapists, and medical oncologists) to assess and to adapt and tailor patient management. This article focuses on cancer specialists’ and geriatricians’ view of these procedures during the management of elderly cancer patients.

**Methods**

A qualitative sociological survey was conducted in a UPCOG belonging to the West Paris Oncogeriatric Program (POGOP), which is composed of the Curie Institute, a Cancer Center (CRLCC), and several academic hospitals. The survey was based on several sources, including relevant documents and regulatory texts, the medical literature, and POGOP internal documents. We also conducted a participative observational survey and semidirective interviews, which are two complementary methods for collecting qualitative information on physicians’ views of oncogeriatrics, to understand the role of working procedures. This survey has already given rise to a publication focusing on the impact of physicians' perceptions of this activity on its development [9]. This latter analysis demonstrated the importance of not analyzing the organization of oncogeriatrics solely from the point of view of the professional relationship between oncologists and geriatricians, and the wide range of perceptions of medical work on the management of elderly people with cancer, a source of barriers, and professional disputes in the workplace.

This was an inductive survey based on grounded theory [10, 11], and the analytical framework was interactionist sociology [7, 8]. The choice of interviewees was strictly confidential. We initially considered all surgical and medical professionals involved in patient management: organ specialists, surgeons, anesthetists, radiotherapists, medical oncologists, and geriatricians. On the basis of these interviews, we then added other professionals such as palliative care physicians and emergency (ER) physicians because they have emerged as key players in previous interviews to highlight the limits of the organization of the follow-up and monitoring. No restrictions based on age, sex, status, or place of practice were applied. The aim was to identify physicians with positive or negative experiences of this coordinating activity and thus to identify other physicians in order to understand the local structuring of this activity and the implicit negotiations. We also interviewed actors of the INCA in order to determine the challenges of this activity and institutional expectations. Semidirective interviews, transcribed verbatim, were subjected to three coding procedures: (i) open coding (categories, attributes, and properties), (ii) axial coding (relationship of categories, subcategories, attributes, and properties with analytical categories), and (iii) selective coding (articulation of categories within a structured framework) [10].

Forty-three clinicians were contacted by e-mail and telephone, and 32 semidirective interviews were conducted, 29 of which were recorded and transcribed verbatim. Three interviewees asked not to be recorded. The interviews lasted between 90 min and 4 h. Four interviewees (two oncologists, a surgeon, and a geriatrician) asked to be interviewed several times and thus became ‘key informants’ in ethnographic terms [12, 13]. These key informants allow the observational data and data analysis to be placed in context. Eleven requests for interviews were refused, for a lack of time, a lack of interest in the survey, or little involvement in medical oncogeriatrics. None of the medical oncologists we approached refused to participate. The interviewees included five surgeons specializing in cancer or organ systems (men aged between 40 and 55 years), five radiotherapists (three women and two men aged from 42 to 58 years), five oncologists (four women and one man aged from 33 to 55 years), and six geriatricians (four men and two women aged from 32 to 60 years). Two female palliative care physicians, two ER physicians, and two anesthetists were interviewed as well as two members of the INCA.

**Results**

**Overall situation: two organizational rules to articulate the working instruments**

In theory, the organization of oncogeriatric medical activity is based on two distinct organizational rules to articulate medical work in oncogeriatrics. The first corresponds to an age criterion – 75 years – that must translate into the adoption of an identical line of conduct by cancer specialists: the patient should be referred to a geriatrician for geriatric assessment before the patient’s case is discussed by the MCM. The second is the discussion by the MCM of the patient’s dossier, which is supposed to include the geriatrician’s findings and opinion. The geriatrician may be an integral part of the MCM or be specifically invited to attend. Thus, the organization of elderly cancer patient management resembles the organization of classical cancer patient management, except that the medical decision-making process integrates the geriatric technical, scientific, and medical know-how. In practice, these rules, in the absence of any conception of the articulation of the medical work in oncology and geriatrics, were mechanically inapplicable to local organizations. They nevertheless served as reference points for invention and daily professional negotiations that gave rise to a variety of organizational configurations. This coordinating medical activity generated various local professional and organizational arrangements.

**The age criterion and geriatric assessment procedure: the basis of organizational and professional negotiations**

As a rule, the way in which geriatric assessment procedures were implemented largely confirmed the role of the geriatrician in diagnosing and preventing vulnerabilities and fragilities in elderly cancer patients at the time of initial diagnosis and medical decision making. This role was appreciated by cancer specialists. The assessment procedures were perceived as relevant and complementary for medical decision making based on other criteria: autonomy, physiological reserves, cognitive capacity, etc. It is through these working procedures that other clinicians became aware of the geriatrician’s specific expertise and know-how. Cancer specialists started to perceive the geriatrician’s interventions as a means of improving the management of elderly cancer patients, but only in situations in which they considered it necessary. Indeed, the age criterion was controversial. Cancer specialists considered it undermined their independence in decision making. In practice, this criterion became an action marker rather than an invariable rule. For other reasons, the geriatricians themselves were not satisfied with the age criterion. Other factors therefore influenced geriatrician interventions and the use of geriatric tools. These included the demographics of the healthcare institution’s catchment area, the state of professional relationships structured by the local history, internal organization, that may...
facilitate or hinder the planning of geriatric interventions (mobile geriatrics teams, geriatric departments), and interinstitutional cooperation on oncogeriatrics. In the last configuration, interinstitutional cooperation obliged physicians to specify the timing of interventions by the different specialists, thus clarifying the activity and organization of patient management. The age criterion and geriatric assessment procedures thus provide a framework for local negotiations.

**emerging complementary roles: doubt to diagnose and prevent and to tailor treatment**

Cancer specialists have so far used geriatricians’ expertise in two ways: upstream and/or downstream of the MCM, leading to the same view of the complementarity of cancer specialists and geriatricians. The role of the former is to ‘doubt’ the health of the elderly patient (a doubt usually justified by the unreliability of the patient’s physical appearance), while the role of the latter is to ‘prevent’ and ‘screen’. This distribution of roles, which is usually implicit, gives rise to variable organizational configurations that nonetheless all tend to make the geriatrician dependent on the cancer specialist. To this was added an informal structure that placed the medical oncologist at the borderline between oncology and geriatrics; organ specialists, surgeons, and radiotherapists sought the medical oncologist’s opinion before referring the patient to the geriatrician. By this means, medical oncologists attempted to persuade their colleagues and continually negotiated with them.

The organization of the complementarity of roles was assisted by the creation of an oncogeriatric consultation and/or by the identification of geriatricians who conduct geriatric assessments during geriatric consultations. The organization of the complementarity of roles depended on how the geriatric practice was organized. This diversity of geriatric care, together with the diversity subtending oncologic care, contributed to the diversity of organizations required to take the local professional and organizational situation into account: in other words, to make the activity possible.

**variable configurations: diverse articulations of working procedures**

The resulting organizational configurations are variable, giving the geriatrician a more or less important place. In theory, MCMs have become places of multidisciplinary patient management decision making where specialists are always present. In practice, geriatricians rarely participated in the MCMs during the survey, except in large institutions with MCMs specifically dedicated to oncogeriatric medicine. Geriatrician participation in MCMs depends on the local organization of the institution, cancer specialists’ opinions of oncogeriatrics, and also geriatricians’ interest in cancer care. MCMs are extremely frequent and it is not always easy for geriatricians to participate for various reasons. First, not all institutions or departmental heads perceive the value of an oncogeriatric MCM. Secondly, for geriatricians to participate, the physicians must agree beforehand, and this requires a good deal of planning (time, date, periodicity of MCMs, etc.). Furthermore, the presence of geriatricians at these meetings was not (with rare exceptions) welcomed by cancer specialists. In their view, geriatricians do not have the know-how required to participate directly in treatment decision making, even when they are trained in oncology. They consider that such training gives geriatricians a common language with cancer specialists, but not shared know-how.

Two main situations were identified. The first is a ‘consultative’ position in which a cancer specialist addresses a patient to a geriatrician for diagnosis. In this case, the geriatrician’s work is juxtaposed to that of the oncologist. The geriatrician’s work thus depends on the cancer specialist. If geriatricians wish to participate more actively, they have to negotiate their place and find a way, e.g. to attend the MCM at which the patient’s case is discussed. Depending on the configuration, and the state of professional relations, these situations contributed to various local professional arrangements for different types of cancer. These arrangements were precarious and always negotiated. At this stage, oncogeriatric activity takes place in random manner.

Sometimes, however, geriatricians were invited to meetings in relatively precise situations. Cancer specialists and geriatricians described a similar situation from their respective angles, namely that of the elderly patient with a poor prognosis and cognitive disorders or dementia. The aim of such meetings was generally to ask the geriatrician to endorse the decision to give palliative treatment and possibly to accept to manage the patient on his or her own ward. In the same situation, some specialists decided not to accept the geriatrician’s opinion but consulted the palliative care physician directly, placing the two professions in competition. They expected the geriatrician to predict the curative potential of treatment, placing him or her in an unfamiliar situation. From their viewpoint, these teams fulfill the role that they expect the geriatrician to play and allow them to control the time(s) at which the geriatrician intervenes and, thus, the patient’s management. With the exception of those wishing to specialize in the management of elderly cancer patients, geriatricians seemed to be satisfied with this position, despite feeling that their expertise and know-how were depreciated. In contrast, these teams, being frequently called upon, sometimes placed geriatricians in a favorable negotiating position, e.g. when they judged it necessary to ‘push for treatment’ as they put it, or on the contrary ‘to envisage a different management approach’.

The second situation was rarer and difficult to organize. It corresponded to ‘concentration’: organized and structured participation of the geriatrician in the MCM (whether oncogeriatric or not), including full integration of the geriatrician in the oncologic activities of the institution or cancer department. This generally translated into the presence of a geriatrician, full- or part-time, in the cancer department, and/or the regular presence a geriatrician in the MCM. This organization requires support from the hospital management team. In this situation, cancer specialists and geriatricians come together to discuss and solve a clinical problem. The geriatrician gradually becomes a full member of the medical team and discovers the implicit hierarchy of the various oncologic specialties. The geriatrician ‘makes’ his or her place and participates in the patient’s entire management. For cancer specialists, the routine presence of a geriatrician helps them to understand their viewpoint and specificities and sometimes to share their professional values.
Geriatricians have, until now, rarely been involved in patient follow-up and monitoring. However, for the geriatrician, it is crucial to re-assess the patient’s status regularly throughout treatment. Cancer specialists described situations in which they used geriatricians as they would the palliative care physician, the psychologist, or the social worker, for so-called ‘maintenance of quality of life at home’ and ‘social readaptation’. Geriatricians were sometimes considered to be in competition with other medical and nonmedical specialties. They were seen as go-betweens with other institutions, except when the geriatrician was fully part of the oncology team. Patient management in oncology, as in geriatrics, is increasingly being reorganized toward home care and ambulatory treatment. Cancer specialists tend to negotiate with the geriatrician the discharge of a patient from their ward in order to free a bed. Geriatricians, depending on their working conditions, are more or less comfortable with such negotiations, especially as geriatric medicine is also increasingly ambulatory. The work needed to organize the entire course of patient management and its specificities in different types of cancer has not yet been properly identified. From what the interviewees said, and from observing their daily practice, it seems that the introduction of ‘tarification per procedure’ has introduced a notion of profitability that implicitly perturbs professional dialogue.

**discussion**

Even within oncogeriatric programs, medical activities develop from local conditions that structure negotiations. Geriatricians seem to have trouble finding their place throughout the management process and also a coherent role, i.e. one that is not dependent on upstream decisions by cancer specialists, which mean that they sometimes intervene too late or in a more or less random manner. Geriatricians consider that they are reduced to making simple assessments, their opinions and proposals being ignored, with the exception of situations in which they are an integral part of the cancer team. Situations in which the power struggle appears to be well balanced are rare. Nevertheless, the geriatrician’s specific tools have largely contributed to awareness of the complementarity of their techniques and know-how.

It is difficult to appreciate the efficiency of local structures. POGOP member physicians negotiate with their colleagues and management on a daily basis in order to convince them of the benefits of structuring oncogeriatric activity. This is a way of indicating the various levels of coexistence of organizational and professional negotiations [9]. Physicians learn to know each other to understand their different techniques and approaches. Routine practice, and the negotiations it provokes, contributes to clarifying the expectations of the different actors and to adapting the organization of medical decision making, and the resulting management, to local circumstances. Finally, the situation in which the hospital creates a position for a geriatrician in a cancer department may appear ideal, as it promote the sharing of know-how. However, in practice, it is mainly the medical oncologist and the geriatrician who work in concert. Such institutionalization might serve as an alibi or a ‘window’ for all those who have not yet considered the questions posed by population aging. The ONCODAGE project, which is designed to validate a geriatric screening tool for use in oncology, has raised both institutional and professional expectations [14]. Thanks to this tool, screening should be done routinely, thus allowing the geriatrician’s interventions to be better organized. Nevertheless, a qualitative study has shown that this tool alone cannot resolve all organizational issues. Assessment of the elderly patient must not take place solely at the time of initial diagnosis. Working instruments are symbolic of the work exchange but cannot alone structure professional relationships, especially as these relationships are not always chosen or desired. Evaluation and screening procedures carry meaningful information but do not mechanically define professional roles.

**conclusions**

The POGOP has largely contributed to clarifying medical activity in oncogeriatrics: identification of physicians, definition of shared goals, initiation, and structuring of new partnerships. Nevertheless, the geriatrician’s tools, expertise, and know-how are often perceived ambivalently. The geriatrician’s role seems to be confined mostly to the periphery of cancer treatment organization. While regulations and the medical literature in no way oppose such cooperation, in practice, geriatricians have little autonomy when it comes to determining their place and role, outside of local professional negotiations, which they use to increase their influence and field of action. It is currently difficult to determine the exact status of this oncogeriatric program, considering the variability of local configurations, and organizational unknowns in the care trajectory and professional relationships. In addition, this is a very recent concept. It seems that without a clear representation of oncogeriatrics, i.e. integrating all specialists in oncology, the influence of this pilot group may be limited, even if it has clearly contributed to the gradual integration of geriatricians in medical decision making and initial patient management, and to greater awareness of the impact of aging on the organization of medical oncology.

**acknowledgements**

We are grateful to all the physicians who accepted to be interviewed and for the time they devoted to us. We appreciate their trust and candidness and hope that the results of this study will contribute to their ongoing reflection. We thank David Young for editorial assistance.

**disclosure**

We have no conflicts of interest to report.

**references**


