



## Head and Neck Cancer: Otorhinolaryngologists Remain in Charge

The Cancer Program launched 3 years ago by the French government involves a number of measures whose implementation has generated considerable activity throughout the country. The program rests on the use of a multidisciplinary approach in all healthcare facilities, in order to ensure that treatment options are selected rationally irrespective of whether the patient is first seen by a surgeon, a radiotherapist, or a chemotherapist. Multidisciplinary management is now compulsory. There is widespread agreement that this measure has served to generalize an approach that was already used in most facilities. Continuity of care and complementarity of providers working in healthcare networks are other important aspects that can be expected to improve cancer management practices throughout France. Facilities providing care to patients with cancer must be part of an oncology network. To comply with new laws, healthcare facilities will need to obtain accreditation for delivering radiation therapy, chemotherapy and – this is an entirely new concept – surgery for cancer. Accreditations will be delivered based on caseload criteria. **Although viewed with reticence by surgeons who treat cancer patients, caseload criteria were imposed by the authorities as a means of ensuring high-quality care.** Caseload ranges were then determined during in-depth discussions between the National Cancer Institute (INCa) and learned societies of surgeons. The Regional Hospitalization Agency will deny accreditation to facilities whose caseloads are considerably lower than the required range. These facilities will have to stop offering surgery to patients with cancer, and their cancer surgeons will have to transfer to accredited facilities. Facilities whose caseloads are near the required range will be allowed time to increase their caseloads, for instance by hiring additional cancer surgeons working in the relevant field. The greatest changes can be expected to occur in the fields of breast cancer and gastrointestinal cancer. In addition, recommendations will be issued with the goal of improving the quality of surgical and nonsurgical cancer management.

Otorhinolaryngologists, together with their colleagues in other surgical specialties, will have to comply with the new caseload and organizational requirements. Multidisciplinary discussions will have to be set up in facilities where they do not yet exist. Otorhinolaryngologists, radiotherapists, medical oncologists, radiologists, and pathologists will participate in these discussions, which will offer surgeons the opportunity to exchange views with colleagues in their field in order to ensure that the best surgical strategies are chosen. A key objective is that otorhinolaryngologists make their voices heard in these discussions. Patients should no longer be treated only by radiotherapists without a previous multidisciplinary discussion involving an otorhinolaryngologist and a head-and-neck surgeon.

A number of hurdles will have to be cleared. In particular, difficulties related to remunerating physicians for the time spent in multidisciplinary discussions have been pointed out by surgeons and nonsurgeons working over the entire spectrum of medical specialties, in private and public facilities throughout France. An additional difficulty for specialties such as otorhinolaryngology, gynecology, and urology is that cancer contributes only a portion of the overall caseload. This might lead some practitioners to stop seeing patients with cancer. Should this occur, accredited facilities for common cancers such as those of the upper aerodigestive tract may be so sparsely distributed that patients must travel considerable distances to receive care. Neither otorhinolaryngologists nor the healthcare authorities are in favor of treating cancer patients exclusively in oncology centers (teaching hospitals or Cancer Control Centers), which are few in number and extremely specialized. Head and neck cancer should be managed by otorhinolaryngologists who have the necessary skill and experience. A consistent objective has been to ensure that facilities providing high-quality management of head and neck cancers are available throughout the country.

To achieve this objective, specific measures have been taken that both encourage a multidisciplinary approach aimed at improving the quality of care and take into account the demographic constraints present in the field of otorhinolaryngology. For instance, a reasonable number of cancer cases at each multidisciplinary discussion is considered to indicate a sufficient caseload in the field of otorhinolaryngology, since surgery is not consistently required. In addition, physicians who work in private practice may be allowed to create federations that organize multidisciplinary discussions. This would ensure that the number of cases discussed reaches the required threshold and that other participants, such as oncologists, participate effectively without having to attend an excessively large number of discussions. This format would be particularly useful in areas that are remote from teaching hospitals and Cancer Control Centers.

Otorhinolaryngologists must work on defining the best modalities for oncology training and continuing medical education, as well as the material and organizational requirements for their facilities. We should be encouraged by the new measures included in the Cancer Program: they leave otorhinolaryngologists in charge, as surgeons and as oncologists, and they can be expected to induce valuable improvements throughout the country. We must strive to be watchful participants in the changes to come.

Jean Lacau St Guily  
Otorhinolaryngologist, Tenon Teaching Hospital, Paris, France