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Recent developments in cancer care in France Competition or coordinated care?

Patrick Castel¹

Patrice Pinell (2002) has analysed the birth of a national policy to fight against cancer in France at the beginning of the 20th century and how this policy came to be articulated around a restricted number of hospitals specialised in cancer care. In those times, their characteristics were innovative, since these hospitals should manage research activities and treat patients at the same time while defending a multidisciplinary approach to cancer care. This meant that each medical speciality was to participate in the therapeutic decision process. The defence and promotion of radiotherapy as an emerging technique beside the dominant surgery methods was a major concern for the founders of these cancer centres.

From their creation to the 1970s, these Cancer Centres were the main organisations in charge of cancer patients in France. In 1965, the French government entrusted them with organising consultations for patients in other hospitals in their regions. Until 1972, physicians appointed to the National Commission in charge of advising the government to define a national cancer policy were exclusively drawn from the Cancer Centres, as well.

But from then on, things changed. Cancer Centres have faced increasing competition (by Teaching Hospitals and general healthcare organisations) and their legitimacy has been challenged by other healthcare actors and organisations (especially by organ specialists who contested their pathology-oriented and multidisciplinary approach). In this paper, I will sketch out two reform projects which greatly contributed to reinstate cancer centres as cornerstones in the French oncology sector. This movement shared two important characteristics with other past reforms (see P. Pinell):

- it was a centralised, national impetus;
- it aimed at normalising medical practices and the organisation of cancer care.

As we will see, this reform program clearly leaned on previous achievements as well as on some of the CC's organisational and cultural characteristics. But it was specific in two main ways:

- it aimed at defending and promoting medical oncology as an emerging speciality inside and outside cancer centres whereas radiotherapy and surgery had been the dominant specialities until then;
- normalisation was to be achieved through randomised clinical trials and (evidence-based) practice guidelines.

I focused my paper on three dimensions of this reform, so that it may facilitate discussions and international comparisons during the workshop:

- reasons why this reform was launched;
- conditions that might have facilitated its implementation;
- some current characteristics of the organisation of cancer care in France².

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² I am well aware that every topic deserves further developments and, most of all, that the logical link between the three should be explicated.

Reasons underlying normalisation

At the beginning of the 1990s, a group of 5 physicians at the head of cancer centres launched a reform program with the goal of normalising medical practices inside and outside cancer centres. They argued that the National Federation of Cancer Centres, an employers' association which was created in 1964 and whose board was composed of the 20 directors of CCs, should develop evidence-based guidelines and sponsor clinical trials. The reasons vary why they decided to design this reform.

Common interest and similar career paths

The CCs' reformers shared a number of distinctive features and a personal adherence to the evidence-based medicine program. They belonged to what Marks (1997) would have called therapeutic reformers: they believed in the necessity to improve efficiency and reduce the heterogeneity of medical practices through the development of rational methods.

First, their medical specialisation contrasted with those of the previous directors in the centre in which they were nominated. Three of them were the first medical oncologists to be nominated at the head of a Cancer Centre while the fourth was the first radiotherapist following three surgeons and a pathologist: in other words, they shared a disciplinary interest in the face of surgery as another, still dominant treatment technique.

Secondly, they had been actively involved in (international) research activities, a fact which strongly contrasted with other directors of the National Federation's board. In particular, the three medical oncologists had been appointed as research fellows in some of the most famous American institutions who developed new medical treatments through experimental research and multicentre clinical trials³.

As concerns the guidelines project, its instigator, a paediatric oncologist, could not abide by the heterogeneity among treatments which were prescribed by physicians in his centre, since they could imply inequalities among patients. He was all the more sensitive to this issue in that the international community of paediatric oncologists had been involved for many years in the question of the harmonisation of their practices (Castel and Dalgarrondo, 2005).

Normalisation for legitimacy

But the normalisation program was also based on more utilitarian grounds: it aimed at reinstating cancer centres as leaders in the French oncology sector. Indeed, from the 1980s on, these centres had faced increasing criticisms by regulatory bodies and other healthcare actors and organisations. If they were to survive, they had to prove that they were still useful.

First, general (for-profit and non-profit) hospitals had greatly increased their participation in cancer care. Cancer Centres possessed only 22 percent of the French radiotherapy equipment by the end of the 1970s, while they had heavily based their development on this technique. Moreover, the emergence of chemotherapy allowed new categories of physicians, who were not specialised in radiotherapy or surgery, to enter the field of cancer care⁴. As a consequence, the number of new cancer patients treated in the CCs stagnated during the 1980s whereas the

³ Two of them, who later were to assume the leadership of national scientific projects, had been research fellows at the Fred Hutchinson Cancer Research in Seattle. This institution specialised in haematology and in particular in bone marrow transplantation which was a new technique intended to allow the prescription of higher doses of chemotherapy to patients. When they came back to France, they both became director of a bone marrow transplant service in their respective centres, founded the French association of bone marrow transplantation and became advisers for the Ministry of Health in this area. Later on, they spent some months in the NCI laboratories of Prof. Steven Rosenberg, who was a much reputed specialist of Interleukin 2.

⁴ In France, oncologists are not the only physicians allowed to prescribe chemotherapy.

total number of cancer patients grew. Furthermore, the number of hospitals relying on CCs' physicians for cancer consultations stagnated to around 150 during the 1980s.

Secondly, some healthcare organisations promoted an alternative medical model that challenged the CCs'. They were organised around physicians specialised in the treatment of specific organs (gynaecologists, urologists, gastro-enterologists, etc.), cancer being only one among many other pathologies they treated, whereas Cancer Centres claimed that only physicians specialised in the knowledge of the pathology as a whole (oncologists) were able to propose the appropriate treatments. The Teaching Hospitals, created in 1958 (i.e. after the CCs), were particularly threatening for CCs. Having become the keystone of the French healthcare system, since they were perceived as offering the best and most advanced treatments, to train physicians and to conduct medical research for all pathologies, they began to claim from the 1980s on that Cancer Centres were no longer useful and argued that their physicians, specialised in organ treatments and at the forefront of clinical research, were thus more qualified to treat cancer.

In this competitive context, several public reports raised the question of maintaining these atypical hospitals: they were costly and did not show any evidence of their added value.

The normalisation program was conceived as an answer to all these challenges.

First, it was expected that the sponsorship of (multicentre) clinical trials and the elaboration of guidelines by CCs would contribute to prove the pre-eminence of their physicians and of their pathology-oriented and multidisciplinary approach in the oncology sector. For instance, through the guidelines project, they came up to regulatory bodies' expectations which tried to promote a quality approach in the French healthcare sector in order to curb expenditures (Setbon, 2000; Kerleau, 1998). Furthermore, homogeneity of practices inside CCs was expected to reinforce their professional legitimacy⁵.

Secondly, both activities – guidelines' elaboration and clinical research – could help to differentiate these centres and their physicians from other healthcare organisations. They were intended to make clear the “added value” of cancer centres in the French oncology sector. At that time, there was not any national cancer guideline in France although, given the increasing number of randomised controlled trials, reformers were convinced that professionals would welcome some help to stay well informed on current treatments. As concerns clinical research, objectives were twofold. On the one hand, an increasing participation of CCs' physicians in clinical trials could differentiate them from “rank-and-file” practitioners who only treated individual patients. On the other hand, the NFCC should (and indeed would) become the main public sponsor of clinical trials in France and thus differentiate CCs from Teaching Hospitals – since the latter had not developed such a co-ordinated activity at the national level.

Last but not least, the guidelines project was seen by the directors as a way to set the rules in the oncology sector. In particular, it was a tool to defend 1) the usefulness of radiotherapy and medical treatments besides surgery and 2) the medical approach and organisation of cancer care which CCs' physicians have developed (Pinell, 2002). Thus, one of the first guidelines elaborated by the CCs was entitled “*Standards, Options and Recommendations concerning good practices in the multidisciplinary organisation of cancer care*” (Chardot, Fervers et al., 1995).

⁵ By the end of the 1980s, the instigator of the guidelines project (recently appointed as director of his centre), analysed that heterogeneity of practices inside his centre was indeed an obstacle to the regional legitimacy of his centre. Because of this heterogeneity, physicians of other hospitals explicitly cast in doubt the quality of the advice that CC's physicians offered them.

Favourable conditions and social skilfulness

The reformers of Cancer Centres can be defined in Fligstein's words as "socially skilled actors" (2001). On the one hand, they succeeded in making sense of the situation that directors and physicians of Cancer Centres were encountering and in redefining their collective interests and identity. On the other hand, they were pragmatic enough to use the resources at hand and induce co-operation among actors.

Collective identity as a resource for change

While pushing for drastic reform along the lines which they sketched out, the group of reformers argued that their program was in line with, and therefore able to protect and to enhance, the founding project of Cancer Centres (Pinell, 2002) of which directors and physicians are very proud. They underlined that the two distinctive organisational features of Cancer Centres (their specialisation around the pathology and their multidisciplinary organisation), were seriously threatened by other medical approaches. They also recalled that the initial missions of Cancer Centres were not only to treat patients but also to have an influence on general cancer care : their proposal to produce medical guidelines and to develop research were presented as a way to regain scientific legitimacy and leadership.

The insistence on multi-disciplinarity, on collegiality and on a pathology-centred approach to cancer care was capitalising on the specific competence and skills (Selznick, 1957) of Cancer Centres, which was their historical identity. Indeed, this identity was used as a basis and as a tool of mobilisation in favour of change. And this model did in fact provide peculiar resources to push along other important dimensions of the reform. For instance, thanks to their multidisciplinary organisation, physicians in Cancer Centres had grown accustomed to showing their patients' records to each other and to discuss with each other the best therapeutic strategy, it transpired that they were ready to understand the utility of guidelines as a co-ordinating mechanism. These meetings would also prove to be a resource to enrol patients in NFCC's trials: since many cases were collegially discussed, medical oncologists had the opportunity to screen patients more easily and remind their colleagues that these patients could be enrolled in federal trials.

Federal resources

Reformers capitalised on other existing collective patterns to implement their program. Not to mention that the unified classification of tumours which was formalised years ago was a *sine qua non* condition to develop clinical trials and guidelines. Reformers also involved physicians who had been active in inter-centre scientific groups. These groups had conducted smaller clinical trials and had organised "open" collective reflection on some scientific topics since the 1970s. For instance, at the beginning of the guidelines' project, 26 out of 28 federal task groups were animated by a physician who had previous responsibilities in these inter-centre groups. These groups constituted a valuable resource for this project since physicians who had participated in them had learnt how to collaborate with each other and were interested in harmonising practices. Furthermore, their leaders had acquired a kind of legitimacy inside the CC's professional community. Last but not least, the traditional close relationships between CCs and the National League Against Cancer certainly facilitated that this association of patients accepted funding these federal projects.

Centralisation, informal hierarchy and "medical oncologisation"

A more centralised and unified organisational field

Traditionally, the federation was an employers' organisation with weak prerogatives. While there were of course differences in the influence of individual directors, the organisational

model seemed more like a confederation of highly autonomous centres than like a unified organisation. The situation today is quite different. By the end of the 1990s, the National Federation has grown bigger, stronger and more influential: 1) it has gained a significant increase in resources (see Annex 1), 2) its legitimacy to initiate and lead collective projects for the 20 Cancer Centres has been acknowledged and enacted, and 3) strategic orientations of Cancer Centres are congruent with the federal reform. The Federation also defines the clinical trials which are to be developed, decides when a trial needs to be ended earlier than expected because of too small accrual, while also monitoring these trials – thus intervening in medical practices.

Furthermore, the Federation is more influential. Cancer Centres' strategic plans are very similar to each other and congruent with the reform. Each strategic plan emphasises that the Cancer Centre intends henceforth to be a centre for assistance and expertise for other healthcare organisations in their particular region rather than their competitor. And the development of research activities and the improvement of the quality of care through treatment protocols and patients' participation are identified as priorities in every Cancer Centre, even in the centres which had been focused previously only on care.

Nowadays, this trend toward centralisation continues with the creation of a national cancer institute in 2004. This new public agency intends to regulate the organisation of cancer care and research. It is the result of a longstanding initiative by NFCC's reformers, which allied with some others opinion leaders who worked in Teaching Hospitals. It therefore comes as no surprise if this institute carries on former major projects of the NFCC and intends to generalise the creation of multidisciplinary staffs. Furthermore, it is now presided by the former director of the NFCC's project for clinical research. This represents an adoption of CCs' medical model which they have defended and promoted all along the reform.

A regional reorganisation of cancer care

At the regional level, CCs' physicians play a leading role in the creation of co-operative networks for the elaboration and implementation of regional treatment protocols adapted to the characteristics and resources of the local healthcare system in order to be relevant and accessible for everyday practice⁶. Local networks for the implementation of guidelines became the organisational infra-structure for exchange around difficult cases and the *de facto* grading of regional cancer-care: the "normal" cases for small non-profit and for-profit hospitals, the difficult cases for the Cancer Centres and the Teaching Hospital(s). 55% of CCs' patients are recruited outside their nearby territory, reflecting their role of support for the other organisations. Even when they do not treat patients, CCs' physicians do participate very often in the treatment decisions. In 2000, Cancer Centres' physicians were invited to 200 hospitals to discuss medical cases of local patients. This shows an increase in comparison to the 1980s (see above). Furthermore, between 1995 and 2000, the number of medical records which have been seen by CCs' physicians during these meetings has grown up from 33.000 to 50.000.

Evolution of physicians' work and intra-professional legitimacy

Decision in the medical field is becoming more and more a collective process. Not only are physicians expected to conform to guidelines, but they have to participate in multidisciplinary staffs where therapeutic decisions for their own patients are collegially discussed. Even when no available guideline fits with specific cases, physicians have to justify therapeutic decisions using scientific references (and especially the results of clinical trials).

⁶ This entails two activities. First, it means initiating and monitoring the discussion process at the regional level through which federal review monographs are transformed into decision algorithms and into specific recommendations of one among several scientifically appropriate treatments.

This is not a “pure” de-professionalisation process, since:

- only physicians participate (for example, patients and economists are excluded from guidelines’ elaboration);
- they can refuse to participate in clinical trials;
- medical audits are very rare and do not lead to sanctions (so far).

This has more to do with a “lateral control regime” (Laszega, 2000), consisting in increasing informal and horizontal control among peers. However, one may notice that medical oncologists are becoming more and more central in the organisation of cancer care in France, although at the same time nobody denies that surgery remains the most efficient treatment for most cancers. This will require further (comparative) analyses but one may argue that this is much due to the normalisation process. First, medical oncologists are the most involved specialists in clinical research. Secondly, and consequently, since specific therapeutic decisions and guidelines have to be grounded on the results of clinical research, medical oncologists are more likely to intervene in, and master, processes of collective deliberation. Thirdly, the development of multidisciplinary staffs allows medical oncologist to intervene earlier in patients’ trajectories, whereas they were more dependent on surgeons’ decisions before.

Conclusion: some perspectives of comparison

It cannot be denied that institutional conditions favoured the emergence and the relative easy acceptance of this reform by other CCs’ actors. First, as we wrote above, the emphasis on the development of clinical research in Cancer Centres as well as the commitment to producing guidelines corresponds to a major trend in modern medicine (Marks 1997; Timmermans and Berg 2003; Daly, 2005). Secondly, it corresponds to the rise of medical oncology as a speciality strongly linked with clinical research (Löwy, 1996; Cambrosio, 2005). For instance, in the middle of the 1980s, medical oncologists became the dominant speciality at the NFCC’s board (see Annex 2) – even if their colleagues had a far smaller experience in (international) clinical research than the reformers. Thirdly, it was in line with growing considerations for quality by regulation bodies, which facilitated their (financial and political) support.

International comparisons should allow us to weigh the impact of these broad factors on the social phenomena that we described. To what extent can we observe convergent changes on an international scale? Comparisons should address the following dimensions:

- 1) categories of actors and organisations who (possibly) gave the initial impulse to changes in the organisation of cancer care;
- 2) initial content of the projects for change and reasons why they are thus designed;
- 3) processes of implementation;
- 4) evolution in cancer care.

One may first hypothesise that the relative development of cancer treatment modalities in different countries (Pickstone, 2007) impacts the change process. In the same vein, can the relative development of cancer hospitals in different countries and their characteristics be related to organisational changes? Indeed, we saw that some of the historical characteristics of cancer centres seemed to facilitate the emergence and the diffusion of the reform inside CCs. To what extent is this true? Other differences may depend on the organisation and funding of the respective healthcare systems. In France, on the one hand, the competition between Teaching Hospitals and Cancer Centres and, on the other hand, the informal hierarchical

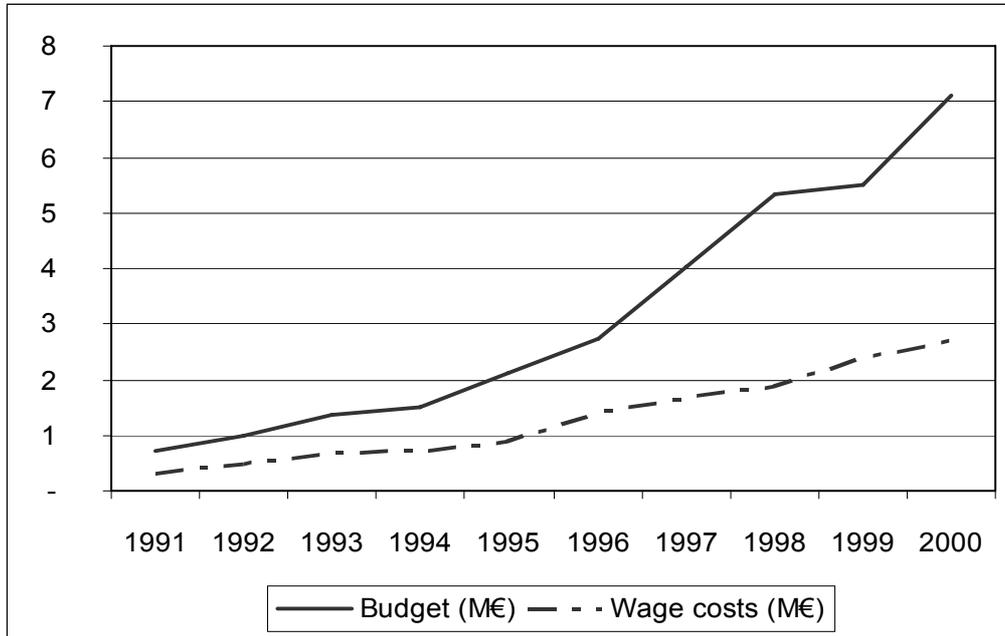
relationships between hospitals may explain the dynamics of the reform. For instance, French oncology networks should not be confused with American HMO or English trusts. These peculiarities may impact change processes in the different countries.

References

- Cambrosio A.** (2005). « Rationalisation et médecine des preuves en oncologie : quelques remarques à propos des pratiques biomédicales (Commentaire). » *Sciences Sociales et Santé*, 23 (4) : 41-48.
- Castel P. and S. Dalgalarondo**, 2005. « Les dimensions politiques de la rationalisation des pratiques médicales. », *Sciences Sociales et Santé*, 23 (4) : 5-40.
- Daly J.** (2005). *Evidence-Based Medicine and the Search for a Science of Clinical Care*. Berkeley, CA: University of California Press.
- Fligstein N.** (2001). “Social Skill and the Theory of Fields.” *Sociological Theory*, 19 (2): 105-125.
- Kerleau M.** (1998). « L'hétérogénéité des pratiques médicales, enjeu des politiques de maîtrise des dépenses de santé. » *Sciences sociales et santé*, 16 (4): 5-34.
- Lazega E.**, 2000. “Rule Enforcement Among Peers: A Lateral Control Regime.” *Organization Studies*, 21 (1): 193-214.
- Löwy I.** (1996). *Between Bench and Bedside*. Cambridge, Mass.: Harvard University Press.
- Marks H.** (1997). *The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900-1990*. Cambridge, Mass.: Cambridge University Press.
- Pickstone J.**, 2007. “Contested Cumulations: Configurations of Cancer Treatments through the Twentieth Century”. *Bulletin of the History of Medicine*, 81: 164-196.
- Pinell P.** (2002). *The birth of a scourge: the anti-cancer war in France 1890-1940*. London-New York: Routledge.
- Selznick P.** (1957). *Leadership in administration*. New York: Harper and Row.
- Setbon M.** (2000). « La qualité des soins, nouveau paradigme de l'action collective ? » *Sociologie du Travail*, 42 (1): 51-68.
- Timmermans S. and M. Berg** (2003). *The gold standard*. Philadelphia, PA: Temple University Press

ANNEX 1

Evolution of the budget of the Federation



ANNEX 2

