What I gained from the SIOG advanced course and why you should consider attending too.

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Why did I decide to apply and attend?

Geriatric Oncology found me, more than I found it. My schedule is filled with patients in their mid 70's – 90 years old. I did not feel well prepared to assess or advise them properly. Which patient benefits from standard therapy? Which patient needs palliative care? Which patient needs something "in between". This was something I had never encountered in my training. It was personally frustrating to do my best for patients, then see that they became more ill from treatment than from their cancer with no clear benefit of treatment. I was moved to learn more and improve my practice.

What was the course like for me?

This course was better than I had even hoped. The instructors are passionate about their teaching. I constantly asked questions, they were gracious in giving me answers. I did not learn everything I needed to know, but left with a good basic understanding of geriatrics. The framework I left with, has helped me direct my reading to expand my own knowledge. I am inspired by the instructors to expand the practice of geriatrics in the radiation oncology setting; by both improving my own work, and collaborating more with geriatricians.

What is the format of the course?

Prior to the course, readings were sent ahead, mostly published papers that addressed treatment strategies for different cancer types. This was in preparation for the group sessions. In the mornings, the geriatricians had oncology classes on topics such as chemotherapy and radiation therapy. As a radiation oncologist, I had geriatric classes. Topics included the concept of frailty, polypharmacy, pain control, cognitive impairment and depression in the elderly. Afternoons were spent in smaller groups, working as a tumor board of sorts. Answering questions about a case, with both geriatric and oncology input. It was helpful for me to hear how the geriatricians approached a patient, they worried more about delirium and falls than I usually do. They worried less about chronic illnesses that were well managed. I appreciated their input and learned a lot from them.

Is there opportunity for networking?

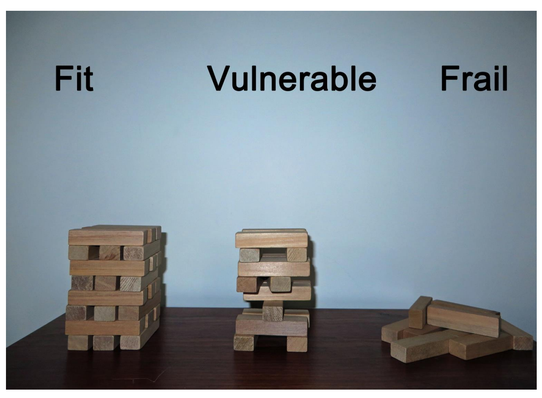
YES! This was one of the best parts of the course. There were ample coffee breaks and lunches, with a closing dinner at the end of the course. As you can see from our picture, we had a fun group to learn with. The international character of this course greatly enhanced my learning. There were attendees from all over the world, with different training and healthcare systems. It helped me gain perspective on the world and different ideas about how to do things. For instance, in France, patients can get IV hydration at home. I never thought of this. I think it is very appealing for patients, and I have applied for a grant to study how this can be implemented at my institution.

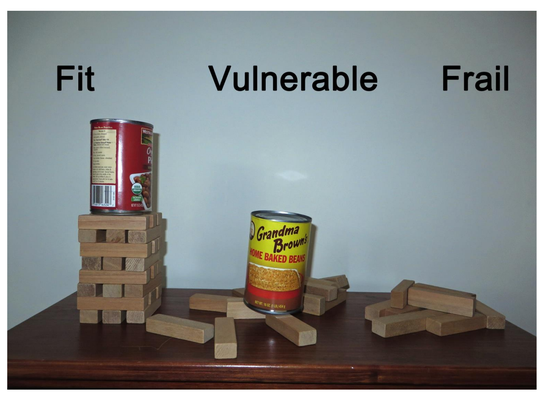
What has improved at my institution since I attended?

The first improvement is my own clinical practice. I have a better sense of how to evaluate patients who are older. I am not a geriatrician, however I am learning how they think, what they evaluate. The G8 screening tool is now part of my initial consultation for patients over seventy years old, or those who appear to be more vulnerable or frail, even if they are a bit younger. With experience, it is easier to use, enhancing discussions I have with patients. I am asking questions and getting answers I never used to think about, exactly what I wanted to learn. I am also starting to use more of the concepts that were taught in discussing patients with my colleagues. In turn, they also want to learn to use screening tools for better initial assessments when making therapeutic plans. As a group, the physicians in my department are learning about measuring quality in care and part of our work will be implementing geriatric screening into clinical practice.

How am I sharing what I learned?

The physicians I work with are interested in learning more about geriatrics. To help, I am creating 5-10 minute presentations to illustrate various concepts I find most useful clinically. I try to make them short, to the point and memorable. The first one is the concepts of fit, vulnerable and frail using a popular block stacking game and a can. With no stress on them, fit and vulnerable patients can look the same, but with stress (heavy cans) the vulnerable patients can become quite ill (the brick tower falls down). The block tower was something Dr. Marije Hamaker used in her slide set during the course, and helped me learn the concept so well.





How do I plan to develop links between oncology and geriatrics?

I would like to add geriatric sessions at local and national radiation oncology meetings such as ASTRO in the US. Within my institution, my goal is to hire a geriatrician for our cancer center. I would like their presence at tumor boards, in clinic evaluating patients, and potentially rounding with the inpatient teams to advise on best practice for managing geriatric patients. I would also like to grow a culture within my institution that considers geriatrics part of standard oncology care and practice. To do this, I am more vocal in tumor boards asking questions, and pointing out important aspects of history to highlight the role of geriatrics in everyday practice. I am gradually gaining support from surgeons, medical oncologists, and radiation oncologists for this.

What are my research plans?

I practice in a rural setting, with a sparse population over a large land area. At my institution, we have a developing telemedicine program. I am hoping that this may be a way for us to expand access to geriatric assessments. In person visits are ideal, but not always possible. My hypothesis is that a telemedicine visit would be better than nothing at all, especially if local oncologists knew what to look for in physical exam, such as grip strength and walking speed.