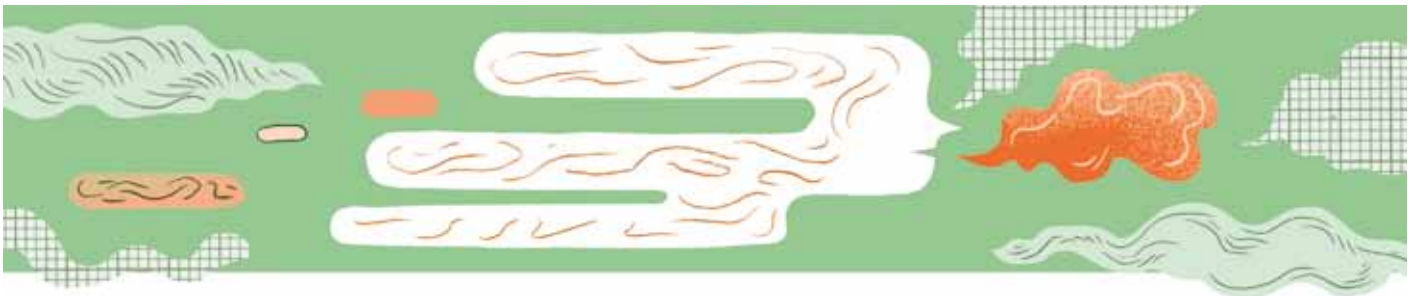

Helen Boyle: putting personalised care into practice

Whether the patient in front of her is old and frail, young and trying to keep their life on track, or simply struggling to come to terms with a terminal diagnosis, Helen Boyle goes the extra mile to ensure each one gets the care that is right for them. Doing all this at a time of rapid change in how, where and by whom care is delivered, keeps this specialist in genitourinary cancers very busy, as **Marc Beishon** found out.

Young medical oncologists can end up thrown in at the deep end early in their careers. That certainly was the experience of Helen Boyle, who specialises in genitourinary (GU) cancers – a field where many of the patients have metastatic disease with a poor outlook. It was not long after taking up her first oncologist post at the Léon Bérard cancer centre in Lyon, France, that she found herself having to conduct those most tough conversations with patients about their prognosis.

"It is very difficult to break bad news and give some hope and perspective on what you can do to help a patient," she says. "As a GU oncologist I often see patients after they have had a diagnosis by our urologists, and they will have been given information about metastasis, but sometimes they don't fully understand what it means. I also give adjuvant chemotherapy, and if a patient relapses, it's me that gives this information, and that there may be no options left and the disease is progressing."

Boyle had learned about communicating bad news as a medical student and then as a resident. But nothing had prepared her for the reality. "When you are really responsible for the patients it is different," she says. "When they break down in front of you, you need to know how to get past that and help them to accept treatment that could be of benefit."

Observing how other oncologists conduct these conversations is one way of learning – and Boyle has benefited from working with some of France's best medical oncologists at Léon Bérard. But she feels that more attention should be paid to teaching communications skills both at medical school and during training. "We do courses on psychology and social science, and watch films, but it is mostly theoretical." Things are beginning to improve, at least at Léon Bérard, she notes, where one of her colleagues is developing a course for medical students on breaking bad news, involving a number of doctors, "to help with this learning curve".

As with many medics who choose to specialise in medical oncology, the challenge of caring for people with a disease that is difficult to go through was a key factor behind Boyle's choice of specialism – that and "all the knowledge, the biology and translational research that are leading to new treatments," she says. The true scale of challenges though is hard to appreciate until that first metastatic patient is in front of you, she adds.

Pros, cons and consequences

For Boyle, the question of what motivates someone to choose medical oncology has been more than just a personal issue. At the time she did her training, more than 10 years ago, the French Association of Residents in Oncology (AERIO) was aware of only 61 medical oncology residents, which represented a "dramatic decrease" at a time when cancer incidence and prevalence was – and continues to be – on an upwards trend. Boyle co-authored a paper for AERIO on why students chose medical oncology as their training speciality.

The paper looked at results from a 2007 survey, which revealed that exposure to medical oncology as a medical student and in graduate training was an important factor. Most respondents felt, however, that they had not been given enough information about what training and a career would be like. Feedback on training was mostly good, there was interest in research and, encouragingly, most who replied said that public service rather than private practice was their aim (*Ann Oncol* 2010, 21:161–5).

Fast forward to 2013 and another, larger, survey of young oncologists in training in France was sent to 505 people, 105 of whom were taking a medical oncology option. That meant the numbers were rising again, in line with the situation in several European countries, according to the findings of a survey conducted by the European Society for Medical Oncology (ESMO) around that time. The findings of the 2013 survey were not all good news, however. Responses showed that many young oncologists were concerned about their professional future, due to the shortage of openings, the workload and the lack of work–life balance.

Many young oncologists were concerned about the shortage of openings, the workload, and the lack of work–life balance

Boyle recognises workloads as a continuing concern, not least because it constrains her from playing a full part in multidisciplinary activities. "For example, there are important decisions for patients with early prostate cancer that do not involve medical oncology – but I can give them a neutral opinion on say the merits of surgery versus radiotherapy, as we've seen studies that patients are influenced by seeing one or the other specialist first. But I just don't have much time for this with my clinic full of patients with advanced disease." Finding time for research and international society activities is also a challenge, she adds.

Why GU cancers?

Boyle's own path to her current job was first at medical school at the University of Lyon, and then extending her stay at the university by completing five years of medical oncology training before being awarded her MD in 2009. Placements during training included medical oncology itself at Léon Bérard, but also haematology, internal medicine, intensive care and pathology at several Lyon institutes. Her MD thesis was on managing brain metastases in germ cell tumours, and she also completed a one-year masters in genetics and cell biology. But even before this training, Boyle had been on several electives, including a student fellowship at the National Cancer Institute in the US.

It was during her medical oncology placement at Léon Bérard in 2004–2005 that Boyle came under the supervision of Jean-Pierre Droz, who was to prove instrumental in encouraging her interests in GU cancers, and especially the needs of older patients. Droz, who was profiled in *Cancer World* almost ten years ago ('We can do better for our older patients', January 2009), and is now retired from clinical practice, is a pioneer in geriatric oncology and remains active in guidelines and overseas development work, including in International Society of Geriatric Oncology (SIOG) taskforces. Boyle is now co-moderator with Droz of SIOG's prostate cancer taskforce, and she is also on the writing committee for SIOG's bladder cancer guidelines.

Joining Léon Bérard full time in 2009, Boyle spent a couple of years as an assistant medical oncologist, before moving to the GU team. "When I started in GU there was a feeling that this was a relatively dull cancer speciality compared with some others – there just weren't as many new medical treatment options. But we've seen a rapid expansion of treatments in the past few years for prostate, kidney, and even in bladder cancer, which has been a difficult cancer to treat," she says. These include a number of targeted drugs and immunotherapies, although many are still in trial stage.

Chemotherapies remain as standard treatments, but GU oncologists have a lot more to offer now, especially in advanced kidney and prostate cancer, and Boyle and colleagues are participants in several current trials. But even in France, often seen as ahead in oncology in Europe, not all new approved drugs are reimbursed, says Boyle, and like all countries, France is facing tough decisions on whether to fund expensive drugs that currently benefit only a small number of patients. "But in bladder cancer we now have patients whose metastatic disease we have controlled for three years or so with immunotherapies." The director of Léon Bérard, Jean-Yves Blay, is one of Europe's leading medical oncologists (and also a previous *Cancer World* profile, 'Integrating translational and clinical research', May 2011), who has voiced strong concerns about drug access, and is certainly key to maintaining Léon Bérard as a major trial centre.

Focusing on older patients

There is a natural fit between GU cancers and geriatric oncology, as so many patients are in the older age groups. There is a steep gradient after age 60 in bladder cancer, and about 75% of prostate cancer diagnoses in Europe are in men over 65. The poor outlook for advanced cancers in older people, and the presence of comorbidities, makes this a large and challenging patient group, and the integration of geriatric screening and assessment into medical oncology is crucial, Boyle argues. She says a lot of progress has been made since *Cancer World* interviewed Droz in 2009, when he described multiple shortcomings in assessing physical and mental status, a lack of guidelines, and just a general lack of interest, as only a few countries had geriatric oncology programmes at that time, meaning that older people were often undertreated or not appropriately cared for.

"We are much better at managing older patients now," says Boyle. "Here we screen all those over 70 with the G8 tool, and aim to have the information at tumour board meetings. We can then decide whether to send patients to a geriatrician." Geriatric assessment is not needed for all people – and the G8 tool has become a preferred tool for screening the health status of older cancer patients to then decide on whether a basic or comprehensive geriatric assessment should be carried out, according to the severity of co-morbid conditions, and activity and nutritional status. The Mini-Cog tool is also now widely used for screening for cognitive impairment, and both it and the G8 take only about five minutes each to carry out.

As Boyle adds, the starting point is that, in those who are physically fit, there is often no reason not to treat as with younger patients, and for others it can be about adapting treatments. "Can we get them through chemotherapy without major complications? It is a difficult balance to find even with a geriatric assessment," she says. In a paper Boyle co-authored, 'Role of geriatric oncologists in optimising care of urological oncology patients' (*Eur Urol Focus* 2017, 3:385–94), the point is made about challenging oncologists who feel they can make clinical judgements without geriatric input – who may think that because they know about treating this cancer type they also know how to treat it in older

patients, or who may assume that the patient is just too sick or old to treat, or – "most disturbing" – that a patient is too old, and will die anyway, so why prolong their suffering?

As is often the case in oncology, this is not only about effective multidisciplinary working – and building awareness that, as SIOG stresses, "all oncologists are also geriatric oncologists". It is also about enabling the care team to have the tools, guidelines and pathways available for each member to play their part in ensuring older patients get evidence-based, individualised care.

Boyle says that there is much better international representation in SIOG now, indicating an increased international interest in improving cancer care for older patients. There is also greater buy-in from other oncology professional groups – the society has been successful in getting its prostate recommendations co-endorsed by the European Association of Urology and also ESTRO, Europe's radiation oncology society. Boyle is now working on an update of the prostate guideline and also on SIOG's first bladder cancer guideline, which is urgently needed. As the SIOG taskforce notes, once there is progression to muscle invasion, such cases are "clearly undertreated in senior adults. If left untreated, the local evolution is devastating, leading to intractable pain, major bleeding, and death in very poor clinical conditions."

"Can we get them through chemotherapy without major complications? It's a difficult balance to find"

Léon Bérard is a regional oncogeriatric centre – a designation from INCa, France's national cancer institute – and has been running a geriatric oncology programme for 20 years, but as Boyle notes there is still much to do in researching how effective interventions are. She mentions a French randomised clinical trial comparing 'usual care' against 'case management' (assessment of the patient by the nurse and the geriatrician with interventions as prescribed by the geriatrician) over 12 months in a geriatric patient population. "It's called the PREPARE trial, and is looking for improved survival and quality of life as primary outcomes."

Colleagues at Léon Bérard have also just published a paper on the experience of geriatric assessment at the centre (*J Geriatr Oncol* 2018, doi.org/10.1016/j.jgo.2018.05.008, published online 14 June).

Focusing on younger patients

INCa has also established a programme of centres that look after the needs of adolescents and young adults (AYAs) with cancer. In response to the INCa call, Léon Bérard set up an AYA multidisciplinary team, with Boyle in charge – as if geriatric oncology wasn't enough of a special interest. More recently, an opportunity opened up to create a small AYA ward. It's a joint initiative of Léon Bérard and Lyon's Paediatric Haematology and Oncology Institute, and is one of the few units in France that is certified to carry out early-stage trials with this patient group.

Boyle points to two key aspects of the team. One is the complex interface between paediatric and adult oncology, and the need for multidisciplinary working to arrive at protocols and age limits for various treatments, as there is no clear cut-off between the groups. The other regards the particular social problems this group faces: "Some have started work or university, and are at risk of dropping out. Adherence to treatments can be a challenge in this population – it's a very difficult time for them. Here they see a psychologist and social worker to identify what the problems are from the start – what active life they can return to."

Oncology practice is also changing. More patients are seen and treated in day-care facilities and in the community, and more treatments are taken orally. Léon Bérard has built a new outpatient building, which can mean more logistical issues in arranging rooms and times to see patients, says Boyle. All centres are also facing a drop in revenue due to less hospital-based work. Supervising patients needs new approaches.

"We now have a clinical pharmacist who starts the patients on oral drugs and who communicates with community pharmacists to liaise on side-effects and drug interactions. We have recruited a nurse who calls patients to learn about adverse events, and we run MDT meetings with specialists such as endocrinologists and internal medicine doctors on managing patients on drugs such as immunotherapies."

It all points to a pivotal role for medical oncologists as they become increasingly involved with all aspects of patient journeys, including many of the latest major advances in treatments, and the psychosocial side of helping often vulnerable groups. For Boyle, who also does some teaching of residents and medical students, there are more interesting challenges to communicate about oncology than ever – but there is no disguising the heavy workload that results.

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