Report of the Clinical Leadership Workshop, September 2022, Paris following ESMO (European Society of Medical Oncology) Congress 2022

Introduction

Historically, the first groups to act to defend patients' rights emerged in the 1950s in America, among them the American Cancer Society representing cancer patients, at the dawn of cancer research and treatments [1]. Subsequently, during the 1960s, patient rights advocates and citizen organisations began to propose self-help and self-care movements in the early 1970s. The 1970s and 1980s saw the emergence of the concept of the conscious, informed patient with activists in the field to ensure the importance of patient rights over profits [2,3]. Over time, patient associations have evolved into patient advocacy practioners, because in addition to supporting their members, they are concerned with being a liaison with clinicians, institutions, and the political world, to put the person who has a disease, and their family, at the centre of the pathway of treatment and social and health care. Patient advocacy has come to refer to the activities that affect all aspects of the patient's life: from research to the choice of treatments to be made, from the assessment of needs to their identification to the planning of a strategy to find adequate answers and the evaluation of the latter.

The International Kidney Cancer Coalition (IKCC), a federation of over 50 affiliated patient organisations plays an active role in reducing the global burden of kidney cancer, estimated to be the 7th most common cancer [4]. The IKCC is a patient-driven organisation, which aims to identify and address unmet needs in kidney cancer patients globally, implementing an evidence-based approach. In an attempt to accelerate the recognition of the importance of partnerships between clinicians and patient advocates, IKCC held a pilot Clinical Leadership Workshop for clinicians already recognised as experts in kidney cancer care. This is a report of the resources and tools developed for the workshop designed to encourage clinicians to work with patient advocates to expedite and prioritise cancer research that improves patient outcomes.

Workshop objective

The inaugural IKCC Clinical Leadership Workshop was held over a total of 8 hours at the end of a major clinical oncology meeting, the European Society of Medical Oncology (ESMO) Congress on September 2022 which many participants (n=22) were already attending. The participants were clinicians from 16 countries distributed globally from 5 continents (Fig 1). It consisted of 9 sessions in which 14 speakers (7 additional faculty) presented different aspects of patient advocacy and facilitated Q&A interactivity.
The workshop aimed to foster a better understanding of the role of clinicians in promoting patient advocacy and enable participants to accelerate patient engagement with the specific objectives of:

- Helping to foster new national patient groups or improve the organisational impact and effectiveness of existing ones in different countries and regions;
- Helping further develop advocacy and leadership skills to understand better the role and benefits of patient engagement among colleagues;
- Fostering a desire to educate trainees to understand better the role and benefits of patient engagement, which should include engaging them in activities of the IKCC, e.g., providing expertise for new infographics, contributing to meeting highlights reports, contributing to possible initiatives in contributing Journal Highlights or other potential projects of IKCC;
- Encourage mentorship of clinical colleagues in different countries and regions to understand best patient advocacy and engagement practices.

Importance of patient advocacy

The pathway through which patient advocacy can take on new roles in decisions affecting research and care processes is only just beginning. However, the experiences have proven that such functions are effective and add value to research and care, creating new knowledge previously unavailable or providing new perspectives for decision-making [3,4].
The workshop highlighted the need to increase the areas clinicians and patient advocates can meet. In particular, a survey about survivorship care specific to genitourinary cancer shows that clinicians refer patients to a patient organisation only 10% of the time [7].
The opportunities for patient involvement are numerous and affect all phases of research, from prioritisation, design and planning to operational management, dissemination and communication of research in its post-authorisation phase [6,7]. Speakers and participants in the workshop discussed key activities in which patient organisations can cooperate in research. They concern the following areas:

- **Research funding** - patients' associations can contribute to small or large grant support, both public and private;
- **Research support tools** - this category includes animal and cellular models, disease registries, biobanks, Patient Reported Outcomes (PROs) and all initiatives created by the patient community to stimulate research;
- **Data** - patients are repositories of information that is useful and often necessary for the transfer of research to the clinical phase, enabling knowledge about the natural history of the disease and the limitations of available treatments;
- **Experience and perspective** - the patients' perspective is essential to identify the actual needs to be met by the research, design a clinical trial, identify endpoints and evaluation parameters, select the most appropriate patient population, optimise the protocol and interpret the trial results in the best possible way;
- **Dialogue with regulatory agencies** - patients can cooperate with academia and the pharmaceutical industry in highlighting and supporting the rationale for approval and reimbursement of a therapy or clinical guidelines development;
- **Communication** - associations can facilitate the dialogue between academic research, industry, institutions and their community. Expert patients can communicate research results to health professionals at scientific conferences according to their perspectives.

Determining research priorities

The applicability and reliability of the research conducted significantly impact how well it is translated into practice. Therefore, the collaboration between clinicians and patient advocate is critical to ensure the significance of the research produced to patients and their caregivers [10]. For this reason, several organisations have developed strategies for setting research priorities. During the workshop, two different priority-setting methods were described: the James Lind Alliance (JLA) adopted by the IKCC and the systematic mapping approach adopted by the Melanoma Patient Network Europe (MPNE).
The JLA method identifies treatment uncertainties and categorises uncertainty as a situation in which neither the uncertainty nor the effects of treatments have been the subject of any current or trustworthy systematic reviews of the available research evidence (or significant definitive trials). It begins with creating a steering committee, which guides the overall process. The steering committee's formation is crucial because it directs and participates in all phases of the procedure. Each level of the procedure requires commitment from the steering group members, including publicising the initiative to potential partners, participating in the initial awareness meeting, developing and distributing information and forms to gather uncertainties, collecting and checking uncertainties against existing systematic reviews, managing interim priority setting, publicising and participating in the final priority setting exercise [11]. Following this method, in 2017, the Kidney Cancer Research Network of Canada, in collaboration with the JLA, Kidney Cancer Canada

and the Kidney Foundation of Canada, identified the 10 research priorities shared by patients, caregivers, and clinicians [12].
Within the MPNE, a systematic mapping approach is adopted to identify key research areas to be improved. At every annual meeting, the patient pathway is mapped on a line. Every patient, caregiver or clinician points out issues at every step, along with different specialists and emotions involved. All the topics are finally classified based on who should address that problem, whether research, the management or external parties. Repeating the process every year allows to mirror the actual situation and explore dead corners.

Measuring the quality of life

Setting up the right research priorities and improved treatments for cancer led to higher survival rates, and it is expected to increase in further years [13]. However, with enhanced survival, more people would have to live with advanced disease and uncertainty [14]. This condition can create a stress condition that can persist over time and negatively impact psychological well-being and quality of life, thus resulting in increased utilisation of healthcare resources [15]. It is why the importance of the health-related quality of life (HRQoL) has shifted towards its maximisation, and the measure is included in clinical trials as a secondary endpoint. However, HRQoL is a multidimensional concept which is difficult to characterise and has, therefore, been associated with various definitions in the medical literature [16]. The complexity of the HRQoL brings the problem of its quantification, which is why patient-reported outcome measures (PROMs) have been validated. PROMs are defined as measures directly reported by patients without interpretation by a health care professional. They refer to the method in which HRQoL is assessed rather than the content itself [17]. The PROMs development requires 4 phases:

1. Literature search and interviews with patients and clinicians (open-ended interviews about HRQoL issues);
2. Operationalisation of HRQoL issues into questionnaire items (no study participants involved);
3. Pre-testing of questionnaire items and preliminary psychometric testing (administration of questionnaire to patients with short debriefing interviews);
4. Psychometric validation of the questionnaire module (administration of questionnaires to the patient).

The data provided by PROMs are then used in clinical trials, and selecting the right PROMs can be complicated. For this reason, the PROTEUS-trials consortium helps researchers generate PROM to enable investigators, regulators, and policy-makers to consider patient perspectives when conducting research and making decisions. Furthermore, it helps patients understand treatment options and make treatment decisions [18].

Patient decision aids

Research advances have improved survival rates and brought a growing number of treatments. Furthermore, many health treatments and screening decisions have no single "best" choice. For example, for localised kidney cancer, the most used treatment options are surgery, ablation, and active surveillance, which have a diverse range of morbidities to consider, ranging from the risk of anaesthetic to the psychological morbidity of surveillance [19]. Patient decision aids (PDAs) are evidence-based tools designed to help patients make specific and deliberated choices among healthcare options [20]. In general, PDAs aim to [21]:

1. explicitly state the decision that needs to be considered;
2. provide evidence-based information about a health condition, the options, associated benefits, harms, probabilities, and scientific uncertainties;
3. help patients recognise the values-sensitive nature of the decision and clarify, either implicitly or explicitly, the value they place on the benefits and harms.

The National Institute for Health and Care Excellence (NICE) established standards to assist people who use PDAs in determining the usefulness and quality of a PDA. It consists of 2 sets of essentials and enhanced standards. Essential standards are the fundamental requirement for a PDA, without which it cannot be considered as such. At the same time, enhanced standards are additions and indicate that the PDA aims for its highest quality [22].

Overall, people exposed to PDAs feel more knowledgeable, better informed, and more explicit about their values when compared to usual care in a wide range of decision contexts. In addition, they are likely to play a more active role in decision-making and have more accurate risk perceptions [21].

Patient involvement in clinical practice guidelines

Clinical practice guidelines are recommendations based on a systematic literature review and assessment of benefits and harms to optimise patient care and outcomes. Their implementation can improve outcomes and reduce resource utilisation, but there are significant gaps in understanding optimal implementation strategies [23]. As such, patient involvement proved essential to address patient needs and preferences and include information to support patient participation in decision-making [24].

The main barriers recognised in this cooperation are perception barriers – clinicians perceive patient involvement as disturbing the scientific discussion – and capacity barriers – patients believe that they have insufficient information, for example, on terminology or content, and are unwilling to contribute if they do not feel adequately educated [23,24]. However, a multidisciplinary approach can empower and informs consumers in healthcare decisions and lead to trustworthy guidelines. Patients can contribute at each stage of clinical guidelines development. EURORDIS Rare Diseases Europe developed an overview of the potential patient role at every step (Table 1) [27].

Conclusions

Patients with chronic conditions will define their unmet needs very differently than those with a life-limiting disease. For example, how medicines fit into daily life is critical for long-term conditions, including reduced side effects. In contrast, if you are facing a terminal illness, you may value life extension above all else, while others may prioritise pain relief. It underlines the need to ensure that a broad range of stakeholders, particularly the patients' voices, is included in any process to have a large diversity of unmet medical and care needs. The pathway through which the patient can take on new roles in decisions affecting research and care processes is just beginning.

The experiences to date have proven that such roles are practical and add value to research and care, creating new knowledge previously unavailable or providing new perspectives for decision-making [28]. This evolution goes very closely with the digital transformation of research and healthcare processes and is both a cause and a consequence.

Therefore, the promotion of broad adoption of information technologies, the development of discussion and data collection platforms, social media discussion and others by patient organisations is an important enabling condition.

The role of clinicians in fostering this evolution and how industry, patient organisations and individual patients collaborate in research and communication is critical [5]. The clinician and patient partnership must be based on trust and collaborative purposes.

This requires a different awareness of cancer and working to reduce its stigma, lifestyle and environmental risk factors. To guide this development appropriately and correctly is a task in which the institutions, academia, industry and above all, the patient and his organisations are called upon to use all the available tools.

The IKCC has plans to conduct further Workshops as well as publish further reports about this initiative.

Michael A.S. Jewett, IKCC Board Chair
Eric Jonasch, IKCC MAB Chair
Sara MacLennan, (University of Aberdeen, Scotland, UK)
Rachel Giles, IKCC CEO

Acknowledgements
This project was supported by equal independent grants from (alphabetically listed): BMS, Eisai, Exelixis, and Ipsen. Sponsors had no influence in the content of the workshop or report.

References

[1] G. Ana Rita, 'Patient Advocacy History, Evolution and Impact on Health', *Juniper Online J. Public Health*, vol. 3, no. 3, Apr. 2018, doi: 10.19080/JOJPH.2018.03.555615.

[2] Institute of Medicine (US) Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st century*. Washington (DC): National Academies Press (US), 2001. Accessed: Oct. 07, 2022. [Online]. Available: http://www.ncbi.nlm.nih.gov/books/NBK222274/

[3] L. Levit *et al.*, *Delivering High-Quality Cancer Care*. National Academies Press (US), 2013. doi: 10.17226/18359.

[4] R. Giles *et al.*, 'Patient-reported Experience of Diagnosis, Management, and Burden of Renal Cell Carcinomas: Results from a Global Patient Survey in 43 Countries', *Eur. Urol. Open Sci.*, vol. 37, pp. 3–6, Mar. 2022, doi: 10.1016/j.euros.2021.12.003.

[5] H. Stires *et al.*, 'Improving the odds together: a framework for breast cancer research scientists to include patient advocates in their research', *Npj Breast Cancer*, vol. 8, no. 1, Art. no. 1, Jun. 2022, doi: 10.1038/s41523-022-00440-y.

[6] D. E. Collyar and L. J. Gautier, 'The importance and value of engaging patients in cancer research', *Future Oncol.*, vol. 17, no. 28, pp. 3663–3666, Oct. 2021, doi: 10.2217/fon-2021-0856.

[7] A. Almatar *et al.*, 'Practice patterns and perceptions of survivorship care in Canadian genitourinary oncology: A multidisciplinary perspective', *Can. Urol. Assoc. J.*, vol. 8, no. 11–12, pp. 409–417, 2014, doi: 10.5489/cuaj.2279.

[8] M. Anderson and K. Kimberly McCleary, 'On the path to a science of patient input', *Sci. Transl. Med.*, vol. 8, no. 336, pp. 336ps11-336ps11, Apr. 2016, doi: 10.1126/scitranslmed.aaf6730.

[9] O. Zvonareva, C. Craveț, and D. P. Richards, 'Practices of patient engagement in drug development: a systematic scoping review', *Res. Involv. Engagem.*, vol. 8, no. 1, p. 29, Jun. 2022, doi: 10.1186/s40900-022-00364-8.

[10] S. H. Rossi, A. Fielding, C. Blick, C. Handforth, J. E. Brown, and G. D. Stewart, 'Setting Research Priorities in Partnership with Patients to Provide Patient-centred Urological Cancer Care', *Eur. Urol.*, vol. 75, no. 6, pp. 891–893, Jun. 2019, doi: 10.1016/j.eururo.2019.03.008.

[11] 'JLA Guidebook | James Lind Alliance'. https://www.jla.nihr.ac.uk/jla-guidebook/ (accessed Oct. 05, 2022).

[12] J. Jones *et al.*, 'The kidney cancer research priority-setting partnership: Identifying the top 10 research priorities as defined by patients, caregivers, and expert clinicians', *Can. Urol. Assoc. J.*, vol. 11, no. 12, pp. 379–387, Dec. 2017, doi: 10.5489/cuaj.4590.

[13] M. Arnold *et al.*, 'Progress in cancer survival, mortality, and incidence in seven high-income countries 1995–2014 (ICBP SURVMARK-2): a population-based study', *Lancet Oncol.*, vol. 20, no. 11, pp. 1493–1505, Nov. 2019, doi: 10.1016/S1470-2045(19)30456-5.

[14] B. Thewes *et al.*, 'Fear of Cancer Recurrence in an Era of Personalized Medicine', *J. Clin. Oncol. Off. J. Am. Soc. Clin. Oncol.*, vol. 35, no. 29, pp. 3275–3278, Oct. 2017, doi: 10.1200/JCO.2017.72.8212.

[15] S. Lebel, C. Tomei, A. Feldstain, S. Beattie, and M. McCallum, 'Does fear of cancer recurrence predict cancer survivors' health care use?', *Support. Care Cancer*, vol. 21, no. 3, pp. 901–906, Mar. 2013, doi: 10.1007/s00520-012-1685-3.

[16] T. Cai, P. Verze, and T. E. Bjerklund Johansen, 'The Quality of Life Definition: Where Are We Going?', *Uro*, vol. 1, no. 1, Art. no. 1, Mar. 2021, doi: 10.3390/uro1010003.

[17] D. L. Patrick *et al.*, 'Patient-Reported Outcomes to Support Medical Product Labeling Claims: FDA Perspective', *Value Health*, vol. 10, pp. S125–S137, Nov. 2007, doi: 10.1111/j.1524-4733.2007.00275.x.

[18] C. Snyder *et al.*, 'The PROTEUS-Trials Consortium: Optimising the use of patient-reported outcomes in clinical trials', *Clin. Trials Lond. Engl.*, vol. 19, no. 3, pp. 277–284, Jun. 2022, doi: 10.1177/17407745221077691.

[19] K. Beyer, R. Barod, L. Fox, M. Van Hemelrijck, and N. Kinsella, 'The Current Evidence for Factors that Influence Treatment Decision Making in Localised Kidney Cancer: A Mixed Methods Systematic Review', *J. Urol.*, vol. 206, no. 4, pp. 827–839, Oct. 2021, doi: 10.1097/JU.0000000000001901.

[20] R. J. Volk and A. Coulter, 'Advancing the Science of Patient Decision Aids through Reporting Guidelines', *BMJ Qual. Saf.*, vol. 27, no. 5, pp. 337–339, May 2018, doi: 10.1136/bmjqs-2017-007657.

[21] D. Stacey *et al.*, 'Decision aids for people facing health treatment or screening decisions', *Cochrane Database Syst. Rev.*, vol. 2017, no. 4, p. CD001431, Apr. 2017, doi: 10.1002/14651858.CD001431.pub5.

[22] 'Background and context | Standards framework for shared-decision-making support tools, including patient decision aids | Guidance | NICE'. https://www.nice.org.uk/corporate/ecd8/chapter/background-and-context (accessed Oct. 06, 2022).

[23] M. J. Armstrong, C. D. Mullins, G. S. Gronseth, and A. R. Gagliardi, 'Impact of patient involvement on clinical practice guideline development: a parallel group study', *Implement. Sci.*, vol. 13, no. 1, p. 55, Apr. 2018, doi: 10.1186/s13012-018-0745-6.

[24] A. R. Gagliardi, M. C. Brouwers, V. A. Palda, L. Lemieux-Charles, and J. M. Grimshaw, 'How can we improve guideline use? A conceptual framework of implementability', *Implement. Sci.*, vol. 6, no. 1, p. 26, Mar. 2011, doi: 10.1186/1748-5908-6-26.

[25] J. D. Chalmers *et al.*, 'Patient participation in ERS guidelines and research projects: the EMBARC experience', *Breathe*, vol. 13, no. 3, pp. 194–207, Sep. 2017, doi: 10.1183/20734735.009517.

[26] M. J. Armstrong, C. D. Mullins, G. S. Gronseth, and A. R. Gagliardi, 'Recommendations for patient engagement in guideline development panels: A qualitative focus group study of guideline-naïve patients', *PloS One*, vol. 12, no. 3, p. e0174329, 2017, doi: 10.1371/journal.pone.0174329.

[27] 'Guide for Patient involvement in the development of clinical practice guidelines & clinical decision support tools', *eurordis.org*. https://www.eurordis.org/it/publications/guide-for-patient-involvement-in-the-development-of-clinical-practice-guidelines-clinical-decision-support-tools/ (accessed Oct. 06, 2022).

[28] J. M. Salamone *et al.*, 'Promoting Scientist–Advocate Collaborations in Cancer Research: Why and How', *Cancer Res.*, vol. 78, no. 20, pp. 5723–5728, Oct. 2018, doi: 10.1158/0008-5472.CAN-18-1600.

	1. PREPARATION	2. RESEARCH	3. WRITING	4. IMPLEMENTATION
Main steps in each stage	• Support & training for patients and clinicians involved in the process • Topic prioritisation/ selection • Team assembly • External Consultation on topic • Determining CPG Scope • Formulate PICO Questions	• Literature Search (search, screening and selecting relevant papers) • Evidence extraction and revision: (i) when there is robust evidence, data extraction for systematic review using GRADE; ii) when evidence is less abundant summarise Key Evidence using modified GRADE; iii) if evidence is very limited or lacking proceed to develop a **Consensus Statement*** • Consensus-Building	• Translating evidence into recommendations • Formulate Recommendations • Writing CPG • Peer review • Co-author CPG	• Set up the implementation working group • Develop lay versions • Raise awareness of and disseminate the CPGs
Potential role of patient representatives	Early patient **input is critical** to ensure an agreement on when and how to collect and integrate patient input. Patients can help **identify areas** where a CPG is needed in their disease area, e.g. a clinical trial has shown a new treatment to be effective and an update to the treatment CPG is needed. Patients should integrate the **Guideline Development Group**. Additionally, a **Patient Advisory group** can be set up to ensure patient early and continued CPG input. Patients suggest **aspects important to them**, e.g. **PICO** questions (**P**opulation, **I**ntervention, **C**omparison, **O**utcome). Patients **identify outcomes which matter** and rank them for importance, e.g. *number of flare ups, hospitalisations, quality of life, etc.*	Patient **role is limited** in scientific literature review, particularly in grading evidence. Patient perspectives may be sought via **review of patient experiences via published qualitative literature,** e.g. ***focus groups, interviews*** *about experience of diagnosis.* Patients may be consulted when using GRADE by **weighing the benefits and harms,** burdens, and cost of a treatment, raise questions about the **practicality of a particular treatment approach and help to ensure that patients will support outcomes** of the CPG. Patients may identify **evidence gaps** in areas they consider important, e.g. *discomfort.*	Patients play a **vital role** in developing the recommendations by providing their **input during 'evidence to decision' meetings.** Patients **review draft publication,** ensure patient views are included and acknowledged.	Patients should integrate in the multidisciplinary **implementation working group** (responsible for creating and enforcing the implementation plan) Patients play an important role in developing **lay language** CPG versions and other products. Patients may help **raise awareness of and disseminate** CPGs, namely through patient organisations and ERN communication channels, e.g. newsletters, social media channels. Patients can co-develop **'patient-professional perspective' articles.**