The Royal
Australian and
New Zealand
College of
Radiologists

Faculty of
Radiation
Oncology

Senator Gavin Marshall
Chair
Community Affairs References Committee
Department of the Senate
Parliament House
Canberra ACT 2600
community.affairs.sen@aph.gov.au

Dear Senator Marshall

Please find attached a submission for the Inquiry into services and treatment options for persons with cancer from the Faculty of Radiation Oncology.

If we can provide any further information or assistance, please contact our Executive Officer, Fiona Pacey on (02) 9268 9709.

Yours sincerely

A/Prof Roger Allison
Dean

18 March 2005

Level 9, 51 Druitt Street
Sydney NSW 2000, Australia

Telephone 61 2 9268 9777
Facsimile 61 2 9268 9799

Email ranzcr@ranzcr.edu.au

ABN 37 000 029 863

Introduction

The Faculty of Radiation Oncology of the Royal Australian and New Zealand College of Radiologists is the professional organisation which supports the practice of Radiation Oncology in Australia and New Zealand. The College is responsible for the conduct of both speciality training and continuing professional development programs. It is accredited by the Australian Medical Council in regard to these activities.

Radiation Oncologists are medical specialists in oncology whose primary treatment tool is ionising radiation, through external beam therapy (delivered by a linear accelerator) or brachytherapy, which involves the insertion of radioactive seeds near the tumour site.

There is evidence that more than 50% of all patients with new cancer diagnoses would benefit from receiving radiotherapy treatment. It is used for curative treatments as well as for palliation of cancer symptoms.

There are ongoing concerns about the availability of access to timely radiotherapy treatment which is the subject of a number of reviews either funded or conducted by the Australian Government. Recently, this has included the National Strategic Plan for Radiotherapy in Australia; the Baume Inquiry – "A Vision for Radiotherapy' which reported in June 2002; and the Final Report of the Radiation Oncology Jurisdictional Implementation Group which provided its report to the Australian Health Ministers' Conference and the Australian Health Ministers' Advisory Council in 2003.

One of the major challenges to the future delivery of co-ordinated cancer services are the current funding arrangements which are not patient centred or geared, but rather reflect jurisdictional, health service and hospital divisions.

The comments contained within this submission are general, and the Faculty would be pleased to assist the Committee in providing any further information sought, or to assist in identifying any of our Members who would be able to provide more detailed or technical advice.

The Faculty appreciates the opportunity to contribute to the Committee's deliberations and to assist them in their endeavours to review and recommend improvements to the treatment and services available and accessible to patients with cancer.

(a) The delivery of services and options for persons diagnosed with cancer

The Faculty of Radiation Oncology is a strong supporter of the development and practice of multi-disciplinary care and treatment.

The 'Optimising Cancer Care in Australia' report published in 2003 and prepared by the Clinical Oncological Society of Australia, The Cancer Council Australia and the National Cancer Control Initiative. This report highlights that Australia is not delivering the type of co-ordinated care, which consumers want and clinicians know would be valuable.

It proposes the development of an integrated multidisciplinary care model which is centred around ensuring that people with cancer receive optimal evidence based care.

The Faculty has endorsed the principles contained in the report, and we would strongly recommend that the Committee give its recommendations full consideration .

(i) the efficacy of a multi-disciplinary approach to cancer treatment

Multidisciplinary clinics for persons diagnosed with cancer emerged in the late 1960's in the treatment of head and neck and gynaecological cancers. In the early days, involvement was limited to a few types of medical specialists.

The early 1970's saw the creation of the Clinical Oncological Society (COSA) to stimulate and promote the multidisciplinary treatment of patients with various forms of cancer.

Following the House of Representatives report into Breast Cancer in 1995 the National Breast Cancer Centre was instituted and has subsequently become a further champion of Multidisciplinary Care mainly in Breast Cancer but more latterly in Ovarian Cancer and as part of its work has undertaken from 2000 – 2002 a National Multidisciplinary Care Demonstration Project and recently published in 2005 a further report on the sustainability of Multidisciplinary Cancer Care. Members of Faculty have been strong supporters of the National Breast Cancer Centre and the Multidisciplinary approach to breast and ovarian cancers.

Multidisciplinary clinics today include a wide range of medical specialists such as surgeons, radiation oncologists, medical oncologists, radiologists, pathologists and potentially palliative care physicians.

Most cancer treatments are non selective and therefore have what is called a "low therapeutic ratio". This means that the beneficial effect of any particular treatment maybe accompanied by a series of side-effects both acute and late. These may be difficult to manage at the time and reduce the quality of life following the treatment and potentially cause ongoing problems for patients who have been cured of their cancer.

The aims of Multidisciplinary Clinics are firstly, to select patients for particular treatments so that the most appropriate treatment is given. Secondly, to try to enhance the chances of cure by combining treatments and thirdly, if it is felt that no further enhancement of cure can be offered then a multidisciplinary approach may diminish the morbidity and side-effects of treatment.

Organisations such as the National Cancer Control Initiative and the National Breast Cancer Centre are integral to the development of a range of best practice clinical guidelines which are developed around tumour sites or specific aspects of patient care and are multidisciplinary in approach. The use of these guidelines as a base of consistency of care is most valuable.

(ii) the role and desirability of a case manager/case co-ordinator to assist patients and/or their primary care givers

The increasing complexity of modern cancer treatments and the considerable timeframe in which they are delivered has over the years led to the development of case managers and case coordinators to help patients and their carers. This development is strongly supported by the Faculty.

The concept is most highly developed in the field of Bone Marrow Transplantation and since the inception of the National Breast Cancer Centre the increasing role of Breast Cancer Nurses is also evident. There is clearly a role for Case Coordinators in many other complex cancer management systems so that the patient and their family can be guided through the often complex treatment protocols and the Faculty strongly supports the provision of case managers particularly for patients who have to travel away from their home base for treatment.

Patients with cancer are faced with considerable stresses at the initial diagnosis, during treatment and after treatment and most particularly if they develop secondary tumours or metastatic disease following initial treatment. These stresses affect not only the patient but also their families and carers and a wide circle of friends and work colleagues. The stresses are not only personal but financial and social.

(iii) differing models and best practice for addressing psycho/social factors in patient care,

These stresses, outlined above, can be alleviated somewhat by good communications between patients and their treatment team and the Faculty has been a keen supporter of communication skills training and has supported the National Breast Cancer Centre in its work in this.

The Faculty has also endorsed The National Guidelines for Psychosocial Care of adults with cancer developed by The National Cancer Control Initiative and the National Breast Cancer Centre, which have been approved by the National Health and Medical Research Council. Work is currently being undertaken to support the implementation of these guidelines.

Practical ways to alleviate psychosocial stress may include the provision of clinic consultant liaison psychiatry and social work and psychology support at various stages but particularly in the circumstance of newly diagnosed cancer. The Faculty fully supports the further development of these services.

(iv) differing models and best practice in delivering services and treatment options to regional Australia and Indigenous Australians,

In order to provide a safe skilled and expert service in radiation oncology centres for radiation treatment have tended to be in larger cities or towns which has necessitated patients and their families travelling to the centres for treatment. This is clearly a problem to those living in regional and remote areas.

Over the years many Faculty members have tried to overcome this by providing consultative outreach services for the purpose of seeing new patients and doing follow-up reviews for previously treated patients. This is both cost effective and provides a useful service for patients.

It does however rely upon appropriate referrals to the outreach clinics and this in itself may be a barrier for some patients and in particular Indigenous Australians. Indigenous Australians are particularly at risk from cervical cancer and smoking related cancers and therefore early referral is desirable. The provision of patient transport schemes and provision of accommodation for patients and carers is also vital to the success of treatment in major centres. This is particularly the case as inpatient hospital beds become more difficult to access and more treatment is carried out in an ambulatory setting.

Some trials of teleconferencing and video conferencing have certainly been helpful but physical clinical examination plays an integral role in the Radiation Oncology consultation and therefore the potential of remote electronic conferencing may remain limited although useful for other members of the Multidisciplinary team.

These difficulties were recognised in the Baume Report and deliberations are we understand ongoing in the Radiation Oncology Reform Implementation Committee.

(v) current barriers to the implementation of best practice in the above fields;

A great deal of work has been done by medical practitioners (including Radiation Oncologists), other health professionals, government, community and consumer representatives over the last 5 years in contributing to guidelines and service improvement frameworks, minimum datasets and other documents. A blueprint improving the excellence of our cancer service exists by way of a National Service Improvement Framework, developed under the auspices of the National Health Priority Action Council.

Problems do arise with implementation at all levels and this is often hampered by lack of availability of skilled personnel and funding for them. This is a significant problem in regard to some clinical oncology specialties, but also in respect of other health professionals included Radiation Therapists, Radiation Oncology Medical Physicists and Oncology Nurses.

There are significant structural and other challenges in achieving the standard of integrated multidisciplinary care as outlined in the Optimising Cancer Care in Australia report for all Australians, irrespective of where they receive treatment. It is hoped that ongoing commitment to addressing these issues through a body such as Cancer Australia will increase the speed at which this can be achieved.

(b) How less conventional and complementary cancer treatments can be assessed and judged

The Faculty would seek to draw distinction between those treatments which claim to have an anti cancer effect and those which may help to reduce the unwanted side-effects of treatment or in some other way improve patient’s quality of life. Broadly speaking if any form of treatment is found to have a predictable and valid anti cancer effect then it is incorporated in someway or other to standard oncological practice. Therefore as indicated above the multidisciplinary approach to cancer treatment incorporates surgery, radiation treatment, cytotoxic chemotherapy and hormonal therapy all of which over the years have evidence available for predictable and sustained efficacy.

(i) the extent to which less conventional and complementary treatments are researched, or are supported by research

In orthodox medicine, new anti-cancer drugs or other compounds are examined for activity in the laboratory (using cell cultures and experimental animals) and then tested in clinical trials with patients. This research is lengthy, time consuming and expensive but is clearly the way forward to provide effective and safe new anti cancer treatments for our patients.

Unfortunately, many cancer treatments which are promoted as alternatives to established treatments lack this scientific rigour. Most frequently, they are promoted on the basis of testimonials from patients who claim to have benefited from the treatment. Such evidence is highly biased and in the few cases where alternative treatments have been put to randomised trial, they have been found to be ineffective. Examples include a trial of high-dose Vitamin C and the US National Cancer Institute sponsored trial of Laetrile neither of which showed any evidence of anti-cancer activity for the agent to support the folk lore of efficacy.

(ii) the efficacy of common but less conventional approaches either as primary treatments or as adjuvant/complementary therapies,

Complementary treatments that do not claim an anti cancer effect but are designed to improve patients' wellbeing are welcomed by the Faculty provided there is some evidence of efficacy and that the treatments do not in themselves have significant side-effects or are prohibitively expensive. As discussed earlier most cancer treatments have a "low therapeutic ratio" and have considerable side effects and therefore any measures which can reduce these are welcomed. These will include dietary modification, rehabilitation of all sorts, physiotherapy, occupational therapy and other allied health interventions and experts in these fields are often members of the multidisciplinary team. In addition to psychology support, other approaches such as relaxation therapy, music therapy and hypnosis maybe helpful to some patients and improve their quality of life and the Faculty would clearly support such approaches provided they are seen to be helping the patient.

(iii) the legitimate role of government in the field of less conventional cancer treatment

The legitimate role of government in the field of less conventional cancer treatment is a difficult one and countries around the world have a varying approach. Again many distinguish between treatments which claim to have an anti cancer effect and those which are designed to support the patient. The Faculty is a strong supporter of clinical research and many Faculty members are also members of the Trans Tasman Radiation Oncology Group which has an impressive record in clinical research particularly in phase three randomised trials. It is however true that the proportion of patients involved in clinical studies is quite small. The reason for this is the practical difficulty of mounting investigator led research as participation in trials takes extra time for already busy oncology personnel and the provision of Data Manager support is difficult to fund in investigator led research which does not have the backing of large pharmaceutical companies. The Faculty would therefore welcome any proposals to increase the percentage of patients who are offered participation in clinical studies.