

Submission to the Inquiry into services and treatment options for persons with cancer

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Introduction

We write from the perspective of extensive clinical experience as a rural breast cancer nurse (Pammie Ellem) and a nurse researcher with a significant interest in rural women's issues in relation to living with breast cancer (Cath Rogers-Clark).

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

Models of care need to be developed in partnership with rural and remote communities. They **must** be sustainable (ie not short-term projects) and must be **developed with** the community, and not simply imposed on it.

We are very familiar with rural women's stories of having breast cancer, and a common theme is the current fragmentation of care, with limited referral and significant gaps in the provision of ongoing supportive care. The specialist breast care nurse model is particularly relevant to regional Australia and Indigenous Australians in this regard, and has been evaluated very positively (see National Breast Cancer (NBCC) website). Specialist breast cancer nurses provide holistic care and support to women with breast cancer and their families. Their role is as a coordinator of care, and they provide consistency of care. This is especially appropriate for Indigenous Australians who, in our experience, will prefer to see a nurse in the first instance.

It was concerning to us that, from the nationally funded *Strengthening Support for Women with Breast Cancer*, specialist breast care nurses funded in Queensland were only placed along the Eastern seaboard with the most rural placement being in Toowoomba. However this has not been the case in other states, where a number of rural placements were made. Evaluations of the effectiveness of those placements have been consistently strong. Reports on the state projects are available as public documents.

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

As we have noted, coordinated care is notable for its absence for women with breast cancer in rural Australia. It is our experience that current best practice guidelines are not universally implemented in rural and regional Australia. For example, there is a lack of willingness to refer to specialists in the field. We are aware of many instances where rural GPs are reluctant to refer their patients for specialist medical care, and prefer to do biopsies on suspected breast carcinomas rather than sending on to a specialist in the first place. Sadly, we are also aware of a number of instances where this stance had significant detrimental effects for the women concerned.

There are also major difficulties in relation to communication between specialist services, for example referral from metropolitan specialists to rural practitioners within the allied health team and community nurses. Generally the only referral which is made is back to the GP. If the GP does not provide referral to other health services in the area (which in our experience is often the case), then the resources available within areas such as community health are not available to the woman and her family. Discharge planning tools could be easily developed to overcome this problem.