MONASH MEDICAL CENTRE – GYNAECOLOGICAL ONCOLOGY UNIT - SUBMISSION REGARDING GYNAECOLOGICAL CANCER CARE IN AUSTRALIA 2006 TO THE SENATE ENQUIRY

PROPOSED GYNAECOLOGICAL CANCER CENTRE FOR AUSTRALIA:

In regard to this proposal, ideally a Gynaecological Cancer Centre should be based in a location that is readily accessible to all Gynaecological Oncology Units in Australia. Discussion regarding location should involve all Units within Australia and the location should be decided prior to inception of the Centre. The proposed Gynaecological Cancer Centre should have its own full time staff, including an appropriate executive that would report to a formal Board of Directors. These directors should be certified Gynaecological Oncologists and preferably should be broad representatives of the members of the sub-speciality throughout the country. For practical purposes, this could potentially constitute the executive of the Australian Society of Gynaecological Oncologists. Their responsibilities would, and should, include directing research funding and co-ordinating clinical trials. In addition the Centre could also be responsible for the training of new Gynaecological Oncologists. This function currently rests with the RANZCOG but could, and perhaps more appropriately, be run through this autonomous body. The Board of the Gynaecological Cancer Centre should comprise a consumer representative, members of the business and legal professions and at least one independent scientific advisor. The

responsibilities and duration of appointments to the Board should be determined prior to its inception.

B. MONASH MEDICAL CENTRE GYNAECOLOGICAL ONCOLOGY UNIT

SERVICE REQUIREMENTS

Serious deficiencies, due to a lack of funding, exist in our current service. These relate to the three areas of Gynaecological cancer care, namely:

1. Service provision
2. Education and awareness
3. Research: both Clinical and Basic science

1. SERVICE PROVISION

A. Provision of a full time, fully funded Gynaecological oncology Fellow-In-Training

Currently our funding for a Fellow is on an ad hoc basis at best. In the past the Fellow has been only partly funded by the hospital with the shortfall in their income being provided by a) our Ovarian Cancer Research Foundation an b) operating assisting fees in the private sector. As our three Consultants are employed on a sessional basis only, it is important that the Unit have the benefit of a securely funded Fellow to continuity of care and to maintain the high standard of patient care provided by the Unit.

B. Provision of a fully funded Data Manager

One of the most glaring deficiencies within Australia and in particular, in the Gynaecological Oncology Unit at Monash is a complete lack of a co-ordinated data management system. We have no funded Data Manager and a rudimentary database at best. It is impossible to co-ordinate our clinical research and audit our Unit as we are unable to adequately enter or retrieve data on a routine basis. At best we have our weekly, multidisciplinary Tumour Board meetings that allow a co-ordinated approach to clinical care but no real audit facility. Each Gynaecological Oncology Unit within Australia should have a fully funded Data manager, ideally with a national database to facilitate collaborative studies and exchange of information between units. Standardization of the databases between Units would be advantageous in this respect and further foster collaboration between Units. Development of a database and the appointment of a Data Manager would greatly facilitate our ability to further contribute to clinical research. Currently the Unit relies upon a part-time Unit Secretary to co-ordinate our Clinical trials and manage our data. Provision of appropriate computer hardware and software would also be required, as would be the provision of adequate office space for the Unit.

C. Ambulatory Care:

1. **Provision of a dedicated lymphoedema service for our patients**

Currently in our Institution there is only provision for upper limb lymphoedema management under the auspices of Breast Care. A significant proportion of our Gynaecological cancer patients suffer from lower limb lymphoedema and they do **not** have access to the current service and are thus severely disadvantaged by this glaring

deficiency. Provision of easy access to a fully effective and co-ordinated lymphoedema management service should be a major priority and would benefit Gynaecological cancer patients throughout the state.

2. Improved Outpatient facilities

The Gynaecological Oncology Outpatient Clinic is at present poorly equipped. In particular there is a deficiency in the colposcopy equipment. We do not have access to a modern, electric examination couch, which makes colposcopic examination difficult, and uncomfortable for our patients, especially our elderly women for whom access to the current couch is a physically demanding exercise and a potential safely risk. In addition we only have the one colposcope and couch between three consultants, the Fellow, Registrar and Resident. This is both inefficient and frustrating. Major improvements in this regard in the standard of care in our Outpatient clinic are needed but would require a substantial injection of funds. Access to an additional outpatient session would also facilitate the provision of better care due to the large number of patients seen in our multidisciplinary weekly clinic.

2. Colposcopy and Dysplasia Service for Southern Health

The current Colposcopy and Dysplasia Service provided is inadequate for the demands of the area with a population in excess of 1.5 million. Currently we have two consultant gynaecologists providing the equivalent of two and a half sessions of colposcopy outpatient services per week. Our current waiting time for a new patient to be seen with a severe dysplasia is in the order of ten weeks and a review appointment has a waiting time

of approximately eight months. The other two Units at The Royal Women's Hospital and The Mercy Hospital for Women have considerably more support and thus provide a far more efficient service. Despite repeated attempts to secure additional funding and service provisions from Southern health we have had no success. Provision of a colposcopy and dysplasia service is an integral part of a Gynaecological Oncology service and is an area of considerable 'need' within our service.

3. Hospital in the home

A Nurse Co-ordinator would enhance the ability to run this program effectively and would be a major step forward in linking the domiciliary care and inpatient care.

4. Psychological, psychosexual and social support services

Despite the NH&MRC publication, in 2003, of Clinical Practice Guidelines for the psychosocial care of adults with cancer we currently have no psychological service provision for our cancer patients and only limited access to liaison psychiatry services. Many of our patients are under considerable psychological stress at the time of admission to our unit, usually with a new diagnosis or potential diagnosis of cancer and we have no professional support to offer them at this time or in the following period, which again often involves further adjuvant treatment such a chemotherapy or radiotherapy, both with their attendant psychological stresses. This situation is not unique to our Unit and is standard in most Units around the country. Given the psychological impact of Gynaecological cancer on women and the report produced two years ago it is a glaring omission that we have no funding for a psychologist and appropriate psychological

support for our women. This would also be an area where clinical research would be of considerable value in defining better patient management.

5. **Ward facilities**

A significant proportion of our patient are from rural areas and many are elderly and often frail thus the policy of Day of Surgery admission puts considerable strain on the majority of our patients and again decreases the opportunity for counselling and discussion with the women and their families. This situation is not unique to our unit as all the Units in Australia have the similar geographical and demographical profiles. Ideally better funding that can allow for the provision of admission prior to surgery would be an important step to addressing some of these inadequacies. Alternatively the provision of a Medihotel facility on site would be of benefit. Such a facility would potentially benefit other areas such as Radiation Oncology, Chemotherapy and other cancer treating Units in our facility.

C. Education and Awareness

The Unit does not presently have good facilities for the provision of patient education material. We do not have a website, which in this era of the Internet, is a way many women seek information about Gynaecological cancer and its management. Again this is the direct result of a lack of funding. A one-off grant to establish a site would be of considerable value. In addition we lack access to adequate facilities allowing us to run appropriate public lectures and educational courses for nurses, general practitioners, the general public and other medical professionals. This is currently done on an ad hoc basis

and could be improved significantly. Provision of up-to-date audiovisual equipment would be of value in facilitating this. In addition the Unit has been at the forefront of the implementation of Laparoscopic surgery in Gynaecological Oncology and has considerable expertise in this area. Our ability to pass on our skills to our trainee doctors is limited by our facilities. Provision of adequate teaching equipment, such as a laparoscopic training box would be of considerable value.

D. Research

1. **Clinical Research:**

As discussed above the ability to conduct adequate clinical research is compromised by the complete lack of adequate data management systems and needs to be addressed as an urgent priority. Our Unit has been a keen participant in a number of clinical trials and continues to participate but with considerable strain on our resources. The ability to offer our patients the opportunity to participate in clinical trials is a vital aspect to the provision of a high standard of care in Gynaecological Oncology. Provision of a research Nurse, a Data Manager and a full-time secretary should be a minimum requirement.

2. **Basic Science Research:**

We currently have an externally funded research facility in conjunction with Prince Henry's Medical Research Institute with the funding being provided by public donations and corporate sponsorship. We have received no government support in any way, shape or form. We have a well-run scientific program but there is an urgent need for far greater access to public funds for us, and other groups, to progress our research that currently

involves two main areas related to ovarian cancer, molecular biology and development of an early detection test for ovarian cancer. Our Research Foundation has funded the purchase of up to date equipment including a microarray reader, a laser dissecting microscope and a Seldi Mass Spectrometer. The ability to acquire such technology has given us a superb opportunity to advance our research goals, however, we do require on going support to maintain and build our research program.

The Monash Gynaecological Oncology Unit is committed to provision of a high standard of patient care, to participation in Clinical trials and basic scientific research. Provision of the additional support requested above would greatly enhance the services of the Unit and allow us to continue to be at the forefront of Gynaecological cancer care together with our colleagues in the other Units within Australia. Women with Gynaecological cancers within our region should have the advantage of the services requested as they would improve the quality of their care.