COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Services and treatment options for persons with cancer

THURSDAY, 12 MAY 2005

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Thursday, 12 May 2005

Members: Senator Marshall *(Chair)*, Senator Knowles *(Deputy Chair)*, Senators Humphries, Hutchins, Lees and Moore

Substitute members: Senator Cook to replace Senator Hutchins for the committee's inquiry into the delivery of services and treatment options for persons with cancer

Participating members: Senators Abetz, Allison, Barnett, Mark Bishop, George Campbell, Carr, Chapman, Colbeck, Coonan, Crossin, Denman, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Forshaw, Greig, Harradine, Lees, Lightfoot, Ludwig, Mackay, Mason, McGauran, McLucas, Murray, Nettle, O'Brien, Payne, Watson and Webber

Senators in attendance: Senators Humphries, Knowles, Lees, Marshall and Moore

Terms of reference for the inquiry:

To inquire into and report on:

(a) The delivery of services and options for treatment for persons diagnosed with cancer, with particular reference to:

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

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

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

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

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

(b) How less conventional and complementary cancer treatments can be assessed and judged, with particular reference to:

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

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

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

WITNESSES

Committee met at 8.40 am

ULMAN, Mr Douglas, Director of Survivorship, Lance Armstrong Foundation, Texas, United States of America

Evidence was taken via teleconference—

CHAIR—The Senate Community Affairs References Committee is continuing its inquiry into services and treatment options for persons with cancer. I welcome Mr Doug Ulman from the Lance Armstrong Foundation, who will be providing evidence to the committee via teleconference from the United States. Mr Ulman, I will just set the scene for you, because we are not going to have a lot of time for questions. I think in Australia there is an evolutionary process going on at the moment involving a very slow acceptance of complementary medicine and lip service being paid to what we call the multidisciplinary approach to the treatment of cancer. The committee would like to be able to map out a strategy that speeds up that evolutionary process and jumps over some of the hurdles that are in front of us, in order to get to the leading edge of treatment or care of patients with cancer without having to wait the long time for attitudes to change naturally. The committee is very interested in knowing where you in the United States are at, how you got there and the sort of resistance you may still be receiving to a broader approach or a more broad-minded approach to the treatment of cancer. That is where we are at. Could you generally talk to that. If we have got time for a few questions, we will try that.

Mr Ulman—Thank you again for the opportunity to speak with you today. I appreciate the time and also the energy that you are all putting into this issue. Let me talk real quickly about the Lance Armstrong Foundation and then I will speak to the broader landscape of the United States and where we are in terms of cancer survivorship. The foundation was founded in 1997 by Lance Armstrong. We exist to help people from the day they are diagnosed with cancer for the balance of their life, whether it is a year, five years, 10 years or, hopefully, 50 or 60 years. We believe that in your battle with cancer knowledge is power and attitude is everything. We really strive to not only inspire but also empower those people with cancer so that they have the tools and information they need to live with a very high quality of life. We focus our attention in four areas: education, advocacy, public health and research. We do that because we believe that all four of those areas are crucial to the issue that you spoke to earlier, which is how we change the mindset and create a societal shift that sees cancer as a chronic illness that needs to be managed in an ongoing capacity as opposed to simply a deadly disease that needs to be treated only by the medical community which lacks the understanding or the acknowledgement of what we call the practical and emotional aspects that a cancer diagnosis brings.

As background, there are more than 1.3 million people in the United States diagnosed with cancer each year, and there are currently more than 10.1 million cancer survivors alive in the United States. That is roughly four per cent of the United States population. If you factor in family members, friends and loved ones, it is a very significant population who are living with the disease, whether they are in active treatment or living with the long-term and late effects that cancer brings, most notably through the treatment of the disease.

Fortunately in the United States 60 per cent of adults will be alive five years from their diagnosis and more than 70 per cent of children will be alive five years from their diagnosis. One in three people in this country will be diagnosed with cancer in their lifetime. So again we are talking about a significant population. One of the issues we have faced here in United States is that cancer is an old disease. It has been around for a long time and has received attention for a long time. To a certain extent it has become a little bit stale in the minds of both the general public and the public policy arm of our country. So we really seek to elevate the issues of cancer and cancer survivorship so that we can impact change and, as you say, create a system where a multidisciplinary approach is not only valued but implemented—and implemented in a fashion that reaches those who need it most. As we say in this country, there are the haves and the have-nots. We want to be sure that we are not just reaching those who already have access to information and resources.

I will touch briefly on a survey that we did in November 2004. This was called the Live Strong survey. The intent was to go out and ask more than 1,000 cancer survivors across the United States what they were dealing with as a result of their cancer diagnosis. I will briefly highlight a couple of the responses that we got. One that I think is striking is that 49 per cent of these people interviewed said that their non-medical needs—that is, their emotional, practical and physical non-medical needs—were currently going unmet by the health care system. Of those individuals, 70 per cent said that their oncologist did not offer any support in dealing with the non-medical aspects of cancer—for example, infertility, depression and fear of recurrence, which are three very pertinent issues that we hear a lot from cancer survivors about. So on the one hand you have people acknowledging that these non-medical issues are very important to them and on the other hand there is not necessarily a health care professional or somebody in the health care system talking to them about how to access those resources.

I guess the other critical pieces of information were that more than half—53 per cent—of people surveyed said that they agreed that the practical and emotional consequences of dealing with cancer were harder than the medical issues. I think that says a lot about people with cancer. I think individuals who are diagnosed with cancer are extremely resilient. They are optimistic. They know that the reality of a cancer diagnosis can be devastating and treatment can be devastating, overwhelming and frustrating and yet they feel like the non-physical issues can be even more of a burden than the cancer treatment itself.

What does all this mean? I think what it means is that we as a foundation and we as a country in the United States need to continue to shift our mindset and understand that more and more individuals are going to be living with this disease. Living with cancer encompasses any number of issues on a physical, practical and emotional level. We cannot continue to just think about treating someone’s cancer; we need to think about how we treat that individual as a whole. I think if we do that we will shift to a situation where cancer is seen as a chronic disease—so people die with cancer as opposed to dying from it. I say that in the most genuine terms. We really sincerely hope that we can create a system that allows people to live a long time with a cancer history as opposed to dying from the disease.

One of the ways we have seen evidence of this is in funding. The government in the United States have increased their funding enormously over the last several years—funding specifically looking at what happens to people five, 10 or 15 years after they have had cancer. What other health issues do they have? In children we know that there are significant cardiac issues. We know that those women who were treated with radiation for Hodgkinson’s disease tend to have an increased risk of breast cancer. Years ago it used to be okay to say, ‘We’re going to cure you of your cancer,’ and that is all we asked of the medical community.

But now, as we learn more about what happens to these individuals, we know that is simply not enough. It is not enough for someone to get a second cancer as a result of their treatment. The example I would use is Lance Armstrong. When Lance was diagnosed he had the option of two different types of treatment. One type was the conventional, conservative route, and that would most likely have cured his cancer but would have scarred his lungs and he would never have been able to ride a bike again. For him, that would have been a huge quality of life decision. He would have never been able to pursue his profession. For someone else it might be a prosthetic, it might be a cardiac issue, it might be a memory or cognitive issue that causes them to have a reduced quality of life. Our goal is simply to ensure that everyone who is diagnosed with cancer has the ability to achieve not only the goals that they had prior to cancer but anything that the normative public would want to pursue.

So the shift between where we are today and even continuing towards seeing cancer as more of a chronic illness is important. To that end, we have partnered with the centres for disease control in the United States to create a national action plan that lays out a five-year vision for how we do this. Some of the issues that the plan highlights are how we make sure again that people are accessing the resources that are available, how we minimise the psychosocial distress and disability for people with cancer and how we ensure that people have the maximum number of years of healthy living once they have had cancer. So at a very large, high level we are partnering with the federal governmental agencies in the United States to ensure that this happens.

At a more granular level, we are offering a lot of funding to grassroots programs that are in communities throughout the United States that are really impacting people’s lives on a daily basis, because we feel that we need to continue to develop model programs that are helping people that can be replicated and taken to additional communities around the country. Those programs address any number of aspects of the kind of cancer continuum but they are focused on getting people back to their lives. Again, it is not how you live after cancer; it is how well you live.

The last thing that I will touch upon, and then I will be happy to answer questions, is that the foundation is very engaged in creating networks. One of those networks is what we call the Survivorship Centre Network. We want to create the ability for comprehensive cancer centres, as they are known in the United States, and community based cancer centres to work together to really define and determine how people with cancer get their care. Many people will travel long distances for their care. Others are not comfortable with that; many would rather be treated in their local community. The fact of the matter is that we do not fully understand yet all the reasons why that is. So we want to bring people together in networks to really try and impact the way that people receive their survivorship services, support and care. We think the best way to do that is to really have a very diverse group of entities working together to address some of those issues and some of those unanswered questions. We feel like that will serve as a model for the delivery of cancer care in the clinical setting. We are excited to be launching that later this year.

That was a kind of longwinded answer to what you mentioned earlier. I would be happy to answer any questions. Obviously, we would be happy to provide additional information as you guys move forward. We really appreciate the opportunity to participate.

CHAIR—Thank you very much for that and thank you for that offer. Senator Knowles has a question for you and we will probably only have time for one question, unfortunately.

Senator KNOWLES—One of the problems that we have here in Australia is that we seem to have a massive duplication of support groups. How have you honed the Lance Armstrong Foundation into such an extensive support group? Do you in reality compete with a whole lot of other support groups who are doing similar things?

Mr Ulman—That is a great question. I would venture to guess that the problem you reference in Australia is of the same magnitude in this country. In other words, we have many non-profit organisations providing support, education and information and, while the majority of them are begun with the best of intentions, sometimes they can be duplicitous in nature. We are in a unique situation where we both run and operate our own programs and fund other programs. I think the unique aspect that we bring is that we like to fund other organisations that are doing great work. We do not want to re-create what they are doing. So, by creating networks and by offering seed grants and funding, we hope not to be duplicitous. At the same time, when we did an environmental scan several years ago, we found that the majority of organisations were focused on the treatment aspect of cancer—how you help people get to the best doctor and get information about the type of cancer they are diagnosed with. We felt we could best impact on people’s lives by focusing on these non-medical, practical, emotional and physical issues that impact on individuals with cancer. We have great relationships and partnerships with many of the other organisations in our country and we strive to be a partner as opposed to a competitor.

Senator KNOWLES—How did you get to that stage, though, where you are so self-sufficient that you can, in fact, assist other organisations? Is that from Capitol Hill as much as from your own fundraising, or is it a combination of both?

Mr Ulman—We have been very fortunate. Because of Lance’s visibility, we have been able to raise a significant amount of dollars without necessarily having to compete for them. We have tried to wield some influence on Capitol Hill, and we will continue to do that, but for the most part it has been from fundraising and marketing an awareness of the foundation.

Senator COOK—Perhaps I could slip something in quickly that might be complementary to this question. Mr Ulman, do you have any particular insights to share with us about non-urban America, the country and regional areas, where services are thin on the ground? What have you been able to do in those areas?

Mr Ulman—This is very pertinent to the previous question. One of the efforts that we have under way is that we are working very closely with the American Indian and Native American populations in this country. When we did some research and looked at what was available currently, we found there was a lot of duplication. So one of the things we decided to fund was a consensus meeting, where we would bring in, free of charge to all the participants, individuals and representatives from all the organisations in the Native American and American Indian community and have them discuss openly what they do and how they could complement each other. We feel that is the first step to reaching those populations. That said, the realistic nature of reaching those populations takes incredible amounts of intensive resources, both human and financial. That is something that organisations and governmental agencies need to make a commitment to and understand fully the impact of. But we are entirely committed to making sure that everything that we develop and programs that we fund are accessible to those who are not typically at the forefront of health care programming.

CHAIR—Senator Cook, please proceed. We were told you were not on the line. Now we know you are, please keep going.

Senator COOK—I have been here all day. Mr Ulman, I go back to your initial presentation. You stated that 57 per cent, I think, of respondents to the Live Strong survey said that most of their problems were not about treatment and medical issues but about all the other issues. What were the main issues that they identified? In addition, if this is not stretching the question too far, can you tell us about integrated medicine or alternative or unorthodox treatments, as far as the foundation is concerned?

Mr Ulman—Sure. The first part of your question refers to issues that people felt were more important or had a bigger impact on their lives than the actual physical treatment of their cancer. One of the things we learned, which was very eye-opening for us, was that a significant portion of people experienced a large amount of financial debt as a result of their cancer experience. For the most part, these people have health insurance, so the debt may be a result of not working or ancillary costs that go along with being involved in the medical world for this experience. We do not know. We need to learn more about those issues.

Some people had issues about going back to work; other people had issues about relationships—how did they tell their kids; how did they provide support and education for their kids who were worried about their parent with cancer? Fertility is an enormous issue. How do you deal with the fact that someone may not be able to have kids as a result of their cancer experience? All of those things are what I think drive the number representing the kinds of decreased quality of life or changed expectations of what they envisioned prior to their cancer experience. Could you repeat the second part of your question?

Senator COOK—Do you have anything to say to us about what might be classified as alternative treatments?

Mr Ulman—Sure. At the foundation we try not to profess any specific type of alternative treatment, but we really stress the importance that individuals and families who are impacted by cancer need to learn as much as they can about all types of programming treatment et cetera that could be beneficial to them. Just as our National Cancer Institute has developed the Center for Alternative and Integrative Medicine, we are always encouraging and empowering people to seek out resources that may or may not be beneficial to them but are not always easily accessible or that physicians are not always referring people to.

Senator COOK—Is this part of your empowering of the individual with cancer?

Mr Ulman—Exactly. When people call the foundation we really try to empower them to learn the skills and find the tools to go about this process as opposed to just handing them something and saying, ‘Here’s how you do it.’

CHAIR—I am afraid we are going to have to wind up. I am sorry we had a late start; we would have had a lot more questions for you. The committee may take up your offer and be in contact with you again. Thank you for involving yourself in this process and making yourself available to the committee.

Mr Ulman—Thank you.

[9.05 am]

CASSILETH, Dr Barrie, Chief Integrative Medicine Service, Memorial Sloan-Kettering Cancer Centre, New York, United States of America

Evidence was taken via teleconference—

CHAIR—Welcome, Dr Cassileth. Thank you for making yourself available to the committee today.

Dr Cassileth—It is my pleasure.

CHAIR—I invite you to make an opening statement and then we will have some questions for you.

Dr Cassileth—I am delighted to have this opportunity to speak to you today as I have a long-time interest in promoting integrative modalities, complementary therapies, that are useful for the treatment of cancer—the symptoms as well as the disease itself. There are no viable alternatives, so we certainly do not promote those when we study them. But I am delighted that you all in Australia are thinking of dealing with this issue, which has been a sticky one. Our experience in the United States, and certainly the experience of the Memorial Sloan-Kettering, may be of use to you, and that would be my great pleasure and hope.

Senator COOK—What caused Memorial Sloan-Kettering and you as a medical practitioner to get into this field of integrative medicine?

Dr Cassileth—Primarily because in cancer medicine we frequently face problems that cannot be well addressed by mainstream intervention. There are many kinds of pain, side-effects of various kinds and symptoms associated with cancer and treatment that frequently cannot be comfortably met with available mainstream treatment. We know that there are many complementary modalities out there that have been studied, and some of them are currently under study, but they all have a great deal of promise particularly in alleviating the symptoms associated with the disease.

On the other hand, I must tell you that I spend about half of my time trying to disabuse patients and others of the idea that there are literal viable ‘alternatives’ to mainstream care—in other words, treatments that are as good as or better than surgery, chemotherapy and radiation for cancer—because that is not the case. There are no viable alternatives. If they were useful and beneficial, they would not be alternatives; we would all be using them in cancer practices. So I spend half of my time on that end of the continuum and the other half trying to promote high-quality science in the study of herbs and other botanicals and various complementary therapies such as massage, Tai Chi, meditation, acupuncture and so on.

Senator COOK—Does diet figure in there?

Dr Cassileth—Diet is very important. Diet does not cure disease, but diet keeps patients long enough to get through some very difficult treatments; it also creates a strong internal environment, which is very important. But no diet cures cancer.

Senator COOK—If I can just invoke some economic jargon, as far as the market is concerned, for treatment, are you in a position to sort of say from Memorial Sloan-Kettering's point of view or indeed from the broader US perspective what the market or demand is for, if you like, treatment complementary to the core treatment being received from the physician?

Dr Cassileth—Yes. The demand is very large. It is already a multibillion dollar business annually in terms of over-the-counter supplements, use of acupuncture, massage therapy and so on. There is a huge demand and it is better for patients to receive treatments from certified people in a controlled setting offered by people who are supervised by oncology professionals than it is for patients to go out and try to find something on their own.

Senator COOK—How do you separate the snake oil salesmen from those who have something usefully to add to the primary treatment?

Dr Cassileth—We are not supportive of bogus interventions. We are not supportive of quackery. As I said, I fight very hard against that and I do a lot of work for government in the United States to deal with people who make claims on the internet and in books that cannot be substantiated and that are, in fact, outrageous and unreal.

Senator COOK—One of the 'problems' for assessing the viability of alternative or less orthodox treatments is that there usually is not a scientifically based study about their efficacy—that the support for the particular therapy is anecdotal.

Dr Cassileth—Really? That is a surprise to me, since we have published and many people have published randomised clinical trials at the highest level of science on the merits of acupuncture, music therapy, yoga, Tai Chi, massage therapy and so on. I believe that you have many references in the materials that I have forwarded to you. You certainly can go onto Medline, which is the US government's selection of all articles published in the medical literature. If you put 'acupuncture' and 'cancer' in, you will find many articles that show with randomised clinical trials that acupuncture is very beneficial in treating pain, nausea and osteoarthritis. In our current studies that are under way now, we find that acupuncture has been very effective in treating hot flushes in breast cancer patients. Those patients have very serious hot flushes as a consequence of cancer treatments which bring them into premature menopause. They cannot be treated with hormones in many cases, and acupuncture seems to do the job quite nicely. We have under way a randomised clinical trial that we are doing with a thoracic surgery group to look at preoperative acupuncture as a way of reducing severe pain after a thoracotomy—that is, removal of a cancerous lung or lobe of lung. I could go on. We have many, many such trials open, and the literature is full of very exciting support for acupuncture. This is not anecdotal at all.

We can go on to any one of the other aspects of this, such as mind-body therapy, meditation, Tai Chi, yoga and music therapy—what am I leaving out?—and I can give you the same kind of information because there are a lot of very fine, high-quality publications on this.

The same thing holds for studies on herbs and other botanicals. Generally, the research that comes from Asia is not of the quality required in the Western world. However, for the last several years there has been increasing interest in studying herbs and other botanicals at a much higher scientific level and there are many groups round the world that are focused on that—as we from Kettering are. We just received a very large grant from the National Institute of Health in the US to become a botanical research centre in cancer. We are working closely in that endeavour with major world-class scientists at the Memorial Sloan-Kettering Cancer Centre for the laboratory and clinical work. We are also doing this in collaboration with the Chinese University of Hong Kong. They are experts in botanicals and in fact they have invented the genetic fingerprinting of herbs and other botanicals, so we now have a very good way to standardise these agents. Let me stop there. I am happy to go on but I do not take up more time on a particular subject than you wish.

Senator COOK—If this evidence is available, why isn't it more widely applied in the medical field?

Dr Cassileth—It is quite widely applied in the United States. I would say that probably 90 per cent of all cancer programs at cancer centres have some kind of complementary program. Our program at Sloan-Kettering was consciously established to be a prototypic program that others could learn from and pick up pieces of and plant them elsewhere. We have a consultation service for leaders of hospitals and hospital systems who have come to us from all over the world to learn how to put this kind of program in place with scientific backing.

Senator COOK—Thank you. I might want to see some of those studies.

CHAIR—I will hand over to Senator Humphries, who has a question, but we are very interested in the particular subject you were talking about then.

Senator HUMPHRIES—I am interested in how education of doctors and specialists in the United States deals with the issue of complementary and alternative medicines. You say there is a wide range of information available to people in the United States about the clinical effectiveness of particular alternative therapies—things like yoga, acupuncture, music therapy and so on. How well integrated is that knowledge into medical training in the United States? Are there a variety of outcomes in terms of the training of doctors? Is there some kind of central authority for providing accurate information to doctors and to laypeople across the United States about what is useful and what is not—the sort of equivalent of the Surgeon-General's recommendations about issues like smoking and drugs?

Dr Cassileth—There are a number of sources of information for practicing oncologists and other oncology professionals. The most important one is the medical literature that they read: the major journals and major textbooks. I can tell you that over the past five or six years—since I came to Sloan-Kettering—I have been asked by virtually every major oncology textbook editor to do a chapter on this topic. That is one thing. The second thing is that the medical journals read by oncologists have had increasing numbers of publications of good studies conducted in this area. That is really where physicians get a good part of their information from. Thirdly, there are medical conferences in oncology—like ASCO, if you are familiar with that. But there are many. There are national breast cancer conferences. There are international oncology conferences that focus in general on oncology but may focus on prostate cancer, lung cancer, breast cancer or colorectal cancer. All of these meetings now have people speaking about one aspect or another of complementary therapy or herbs and botanicals.

In addition, a couple of years ago we established a non-profit organisation called the Society for Integrative Oncology. We held our first international meeting this past November in New York City, in Times Square. Ray Lowenthal from Australia was one of our speakers. We had over 600 oncology professionals from all over the world, including seven or eight people from Australia. This is another very important source of information for a professional. This meeting will be annual. Our next one is going to be in the coming November. We hope, through this organisation, and its web site and its annual conferences, to keep people up to date. There are publications in the medical literature that come from this. So it all circles around and hopefully brings medical professionals up to par on what is available.

They do not have to be experts in offering it; they have to be experts in understanding its value, or sometimes its lack of value. What many hospitals do—not only cancer centres but also more general hospitals and cardiac centres—depending on the money that they have and whether they are just starting out or more experienced, is to bring someone in, like an acupuncturist, one day a week. It may be one massage therapist a half day a week. It could be a music therapist one evening, or whatever. They will start out that way. They will see how it goes. It usually goes very well because these are wonderfully helpful interventions that are pleasant, that patients are drawn to, that are very comforting and that, indeed, according to very good studies can play a very important role in the management of patient care.

Another source of education for both physicians and the general public are books written for them. Two hours ago, I finalised a book that is now in press. We are publishing it with BC Decker in Canada. This is a major oncology book publisher. This is a book for oncology professionals called *Integrated Oncology: Complementary Therapies in Cancer Care*. It details all the literature, the research that has been done, what has been shown to be useful for what and what is not useful. These are all standard ways of getting information across.

The National Institute of Health in the US also has two offices that are relevant to this discussion. One is called the National Centre for Complementary and Alternative Medicine. The other is the NCI, the National Cancer Institute, which has its own complementary and alternative medicine program. Both of those centres work very hard to promote bringing excellent science to the study of these interesting therapies and to alert people on their web site, in conferences and in many other ways, to the fact that there are some good modalities that can help with problems that there is no other way of treating.

Senator LEES—You were saying that 90 per cent of cancer patients across the US have ready access, without any issues such as affordability or problems in getting the support they want, to complementary medicine?

Dr Cassileth—I am saying that virtually all programs have something. It may be, as I said, just a miniscule portion of what we have at Memorial because our program is very fully developed. We have clinical services, research, education and training and our web site. Not everyone is in a position to implement complementary modalities—the study of them, the teaching of them and so on. But maybe they are able to bring one practitioner in to take care of a particular selection of problems. That practitioner might be a massage therapist or an acupuncturist. That is the way people usually start. They start out small, they see how it goes and they try to get financial support for it. And there are different ways to do that. When we provide our consultation services to other hospitals we try to explain to them what they might do to help themselves further the promise of these therapies.

Senator LEES—Do insurance companies cover the costs of complementary medicine?

Dr Cassileth—Only some insurance companies cover some costs. They cover the costs of an acupuncturist if the acupuncturist is the physician. That is unfortunate, but that is a political activity at this point. I think it will change in the future because some of the very best acupuncturists are not physicians. Some insurance companies are beginning to cover massage therapy. Right now we are waiting for that to happen in a fuller sense. Insurance companies for the most part do not cover these therapies. Patients go and seek them somewhere else. They might as well get them from a good hospital where there is some supervision, oversight and credentialling.

CHAIR—Senator Cook, did you want to finish up with a question?

Senator COOK—No, I am fine, Mr Chairman.

Senator HUMPHRIES—Just coming to that issue of useless or dangerous therapies, you say that you have spent a lot of time counselling people about that and providing to cancer sufferers wider information on these sorts of dangers. How is that conveyed, though? You as an individual have some persuasive power with other practitioners presumably, but is there a system whereby people might be more comprehensively warned about these things? Is there, say, an authoritative web site in the United States sanctioned by a federal government agency that gives people information about dangerous or useless therapies?

Dr Cassileth—There certainly are. You are absolutely correct; that is what we do have. I wish you would take a look at our web site. It is mskcc.org/aboutherbs. It is about herbs, vitamins, over-the-counter supplements and a lot of bogus therapies and a lot of things that are promoted as alternatives. These are the questionable, problematic, not viable interventions. We have a lot of information in there. Anyone can enter our web site as a member of the general public, a patient or an oncology professional, either through the professional route or through the public route, at no cost, and get all of this information. The two government agencies that I mentioned, the NCI and the National Center for Complementary and Alternative Medicine, both have web sites with similar information—not updated as often as ours is but it is there. Also there is an excellent web site called ‘quackwatch.org’ that is devoted entirely to bringing to light problematic activities.

We make a distinction between alternative and complementary therapies. Alternative therapy is when something is alternative not by what it is but by how it is promoted. Say something is promoted as a cancer treatment, as a cancer cure, as something that is as good as or better than surgery, chemotherapy and radiation, and we know that that is not viable, that it is bogus. We remind patients at every turn that this is the case, and so do all the other web sites I mentioned—and there are many, many more.

CHAIR—Thank you very much. You have contributed some very valuable information to our inquiry and we thank you very much for your participation with us today.

Dr Cassileth—You are very welcome. It is my pleasure and I hope you will call on me if I can be helpful in the future.

CHAIR—You can be assured of that. Thank you very much.

Committee adjourned at 9.28 a.m.