EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN PUBLIC HEALTH SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 16 OCTOBER 2002

SESSION TWO

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

SHEINER, MR HARRY
Surgeon, c/- Cancer Foundation,
examined:

ROONEY, MS SUSAN HANNAH
CEO, Cancer Foundation,
examined:

The CHAIRMAN: This committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as a contempt of Parliament. Have you completed the Details of Witness forms and do you understand the attached notes?

The Witnesses: Yes.

The CHAIRMAN: The committee has received your submission. Are there any points that you would like to raise?

Mr Sheiner: One of the most critical problems in cancer services is radiation therapy. Under the list provided by the committee, that involves Nos 5, 6, 7 and 9. We believe there is a very strong need to improve radiotherapy services, as they are currently stretched to the limit. Our medical oncology services are also being stretched. I assume the committee knows the difference between radiotherapy and medical oncology. They need to be addressed if we want to improve and increase cancer services in this State.

Ms Rooney: Some of the issues are the same as the national issues. Locally, there are other problems because we do not train radiation technicians in this State. That causes problems for us. People have to train outside the State and sometimes they do not return. It is sometimes quite hard to get people back.

A report has been prepared for the Department of Health. I am not sure whether the committee is aware of it.

The CHAIRMAN: What is the name of the report?

Ms Rooney: It is called "Radiation Oncology in Western Australia - Current Status".

Mr Sheiner: There is also a report on a proposal to train radiation technicians.

The CHAIRMAN: Are you able to table it?

Mr Sheiner: You can have this copy.

Ms Rooney: There is also a national report, of which I am sure you are aware. Some of the issues raised are similar to the issues raised in the other report.

Mr R.A. AINSWORTH: Is that the report that recommended the establishment of a national body?

Ms Rooney: Yes. Not all the issues are applicable but some certainly are.

The CHAIRMAN: You mentioned another report?

Ms Rooney: That was the one prepared recently by the Department of Health. It was prepared in March 2002.

Mr Sheiner: It is essentially a private report given to the Department of Health. It has not been widely circulated.

Ms Rooney: It is essentially an internal document but a lot of issues are outlined in the national document.

The CHAIRMAN: Where do people get training?

Mr Sheiner: There is a worldwide shortage of trained people. There has been a major attempt to recruit nine radiation therapy technicians - not doctors. We are hoping to get 10 or 12 new positions filled but I believe only two have been filled. There is still a desperate shortage. Various schemes have been tried; we have tried to train people interstate but there is such a shortage elsewhere that if people graduate, they do not often return.

Mr M.F. BOARD: In your opinion, why is there such a shortage?

Mr Sheiner: Radiation therapy is very expensive and there is a huge capital cost for equipment. I am not a radiation therapist but I am sure you are aware of the workforce issues. Much of the workforce is centralised and once a person has made a commitment to a centre it is hard to work out the optimum time to build a second centre or increase the centre. The number of treatments utilising radiotherapy is always increasing. More patients need more treatment. There is a tendency to just not have enough money to buy equipment and expand departments to meet the need. Because of the huge geographical area of Western Australia, services have to be centralised to provide a state service.

Mr M.F. BOARD: There is no capping of the number of people who can train?

Mr Sheiner: I do not know how popular it is as a specialty for doctors. As I understand it, there is no cap on numbers, only difficulties in attracting people.

Ms Rooney: One of the issues we have with radiation technicians is that we need sufficient numbers to run a training course locally. I do not know the exact details but the report goes into it. The Department of Health has to examine distance learning or postgraduate courses as options. An undergraduate course needs a minimum number of students to be viable. Those numbers do not exist here. The group looking at possible options is examining a postgraduate course, which would better suit the needs of the State. Margaret Stevens was involved in writing the report and led the group to look at those sorts of things. It is still being examined. Because of distance and numbers we need a more flexible way of addressing training needs rather than just having an undergraduate course.

Mr R.A. AINSWORTH: Is training readily available elsewhere in Australia? We obviously do not have enough numbers to do training here but if, for example, 10 people want training, would there be room for them in training facilities elsewhere or would only five be trained? If there is a shortage of training positions nationally, we could justify having a training institution established here and take trainees from other parts of the country rather than vice versa.

Ms Rooney: I am not sure.

Mr Sheiner: We used to try to get our trainees to go to South Australia and Victoria. I am sure there is a training institution in New South Wales and probably one in Queensland. I am not sure of the costs involved.

The CHAIRMAN: It is not just a matter of training; it is also a matter of recruitment to get the numbers up to justify running a course.

Mr Sheiner: Yes. If a tertiary institution is involved, it wants funding for student numbers.

Mr M.F. BOARD: This inquiry is looking at emerging trends and developing new occupations in health for a better outcome. We are examining emerging world models. Do you see the potential for any change in Australia? What would you recommend?

The CHAIRMAN: You gave an example regarding breast cancer screening.

Mr Sheiner: When you talk about change, we can no longer look at the specialty in isolation. Many cancer treatments are across several disciplines. The national report talks about a multi-disciplinary approach. Radiotherapy and medical oncology are key elements. A good example is what has happened despite a lot of resistance from a lot of quarters about breast cancer. More women are contracting breast cancer and there is automatically a multi-disciplinary approach. That is for the better; there is evidence to show it is for the better. If a multi-disciplinary approach is used in other areas such as colon-rectal cancer and head and neck cancer, it will have an impact on radiotherapy and other specialties. In my view, we should look in a major way at restructuring how we treat patients. People do not like me saying this - I am a bit of a lone voice - but we should restructure public hospitals because the present system cannot cope with the numbers or with the type of specialty services that are needed to provide optimum care.

Mr M.F. BOARD: What about the occupations themselves? Is there a need to develop occupations below that of a specialist? I am just opening the door to see how these issues can be resolved.

Mr Sheiner: There are more areas that were traditionally the role of doctors that are being picked up by other occupations. I am thinking particularly of counselling and support services. Doctors are not too good at that. There is a recognised need nationally for more services and training. Prevention and screening are the best ways to reduce the cancer burden. More of those services can be taken up by less qualified people. It is a political issue and requires a lot of debate and discussion with various professions. With screening for colon-rectal cancer, there is a need for colonoscopy services - looking into the large bowel. The United States has already tried and trained technicians under supervision, much as they do with anaesthetics. They have one anaesthetist supervising four technicians in different theatres. We may have to look at things like that.

The CHAIRMAN: Is it because of emerging technology that technicians are needed more?

Mr Sheiner: No, it is a cost-effective way of dealing with a large number of patients. One highly qualified person will supervise four others.

Mr M.F. BOARD: In looking at emerging trends, how do they deal with insurance issues in the United States?

Mr Sheiner: I do not know; the insurance issue is a huge problem. It is driving people away from medicine.

Mr M.F. BOARD: Emerging trends are stopped in this country because of the problem of responsibility, where it lies, and who is at the end of the litigation. It stops a lot of things happening around the world.

Mr P.W. ANDREWS: Our inquiry is into the role and interaction of health professionals. We want to inquire into the confusion over the role of oncologists and radiation therapists. Do you have any comments? Is there a confusion of roles?

Mr Sheiner: I would not use the word confusion. There is always a difference of opinion about how certain patients should be treated in particular cases or in difficult cases. There are areas of too much disagreement, which may create confusion. In my view, that could be solved with a multi-disciplinary approach to treatments in which such differences would have to be aired openly with different groups and commonsense would prevail. I am not sure whether that answers your question.

Mr R.A. AINSWORTH: You talk about the multi-disciplinary approach, which has been most effective with breast cancer. Given that the benefits have obviously justified using such an approach, has it resulted in additional costs as opposed to single disciplines? Is there a better outcome with no extra cost?

Mr Sheiner: I do not know whether it can be costed. I do not know whether anyone has tried to cost it. We do not know what the cost of cancer is in this country, let alone Western Australia. The budgets are not broken down like that.

Mr R.A. AINSWORTH: From a layman's point of view, if there is a cancer patient and one specialist attending as opposed to four specialist attending, having more specialists must increase the cost. That is presuming, of course, that they all spend the same amount of time.

Mr Sheiner: I would not necessarily agree with that because, for example, with breast cancer screening there is a difference between the private and public sectors in the multi-disciplinary principle. In the public sector, three or four specialists at a clinic would be consulted at one time and decisions made. The private sector would have three or four commissions not all at one sitting but in a series of visits. They would continue to get a multi-disciplinary opinion but that is at the mercy of the referring doctor who would decide individually what is necessary.

The CHAIRMAN: Do you think radiation therapists in Western Australia should be registered?

Mr Sheiner: Yes, I do.

The CHAIRMAN: Why are they not now?

Mr Sheiner: I presumed they were. They are not?

Ms Rooney: No, they are not.

Mr Sheiner: I did not know that.

Ms Rooney: One matter referred to earlier about the difference in roles and the multi-disciplinary approach is that some reports on radiation therapists have indicated that they could have a senior radiation therapist level and then assistants to deal with the less technical work. That is consistent with what occurs in a number of other allied health areas, but it does not occur in radiation therapy. One problem appears to be a lack of career path. The approach is not unique. For example, physiotherapy has senior physiotherapists, physiotherapists and assistants, as does occupational therapy. That type of model, which does not currently exist in radiation therapy, might be useful to develop a career path for people who are radiation therapists. It would also link into the multi-disciplinary team approach in that the more skilled person is more involved the multi-disciplinary team.

Mr M.F. BOARD: That would need to be a national project. Would you therefore support the establishment of a national body to examine work force, registration, career path and training issues?

Ms Rooney: Having a national body is useful to an extent, but you would have to ensure that it did not become focused on issues in the eastern States, which happens in other matters; there would have to be a balance. For example, it might suit New South Wales to have only undergraduate courses, but that might not suit WA in that if a national body made a decision based on the greater population, we would miss out on those sorts of things.

Mr Sheiner: Yes, flexibility.

Ms Rooney: Yes, so that there would be, for example, a level of national cooperation and national standards, but there would also be the ability to do those things flexibly at the local level.

Mr R.A. AINSWORTH: Are we talking about another variation of the nurse practitioner model?

Mr Sheiner: No.

Mr R.A. AINSWORTH: Is that at yet another level?

Mr Sheiner: It is entirely different. The technicians run the machines. They are skilled, but the doctor - the radiation therapist - determines the treatments and where those treatments will take place. The technicians set up the computerised machines, focus on various areas and ensure correct dosages. They are similar to the technicians who take X-rays in a radiology department who require a fair degree of education and understanding of what they are doing. They are not doctors, they are under the supervision of doctors, but in a sense they administer the treatments.

Mr M.F. BOARD: I am interested in the availability of screening and scanning and where it is conducted. Screening for breast cancer as a model has been a tremendous success and has diversified into a public campaign of community awareness that I have not seen with other forms of cancer, particularly those affecting men. Could we do that a lot better in the emerging occupations that promote and then deliver some primary health advice?

Mr Sheiner: I would be very cautious about doing that. I know I sound like a typical doctor now. However, breast cancer screening has been successful in the sense that it is up and running and all females over 50 years of age have access to screening. At the expense of upsetting just about every doctor involved in the screening program, I have to say that screening for breast cancer has been going 10 years and if you want successful outcomes screening must reduce the death rate. There is a suggestion that the death rate in WA is reducing but we cannot be confident about that. There is therefore a 10-year history of putting in enormous resources and funding in the hope of a benefit to the community. Overseas studies suggest we should be getting a benefit about now. However, we must continue to maintain a degree of cynicism to ensure that the death rate will fall. Many people say it is beginning to fall, and I accept that. In another year or two we can breathe a sigh of relief. With other screening modalities you must ensure that a very effective treatment is available if you are to detect an early cancer and you must be happy that in doing that you will reduce the death rate. I do not want to sound like a nihilistic doctor, but there is no point in detecting early cancers in the population if ultimately we do not reduce the death rate in our community; that is the bottom line.

The most promising screening modality that we should be concentrating on next is colo-rectal cancer. As the committee knows, the federal Government has introduced three pilot programs, not to see whether screening works, because that has probably been done elsewhere, but to examine the difficulties of establishing that in the Australian setting. We were disappointed that WA did not get one of the pilot programs because I believe this State has unique problems. It would be difficult to publicise any test for colo-rectal cancer screening in WA now unless we were sure that we had the infrastructure to deal with the estimated number of abnormal results that we would get. For example if someone had a positive faecal occult blood test for cancer, the next test he would need is a colonoscopy and in public hospitals there is a three-month waiting list for a colonoscopy. Until we solve that problem, we would be quite wrong to cause anxiety and confusion in the community with positive occult blood tests and then find that our existing services cannot cope with an increased demand. I am unsure of the reliability of tests for detecting early prostate cancer. They are not as reliable as are the tests for breast and other cancers. I am not convinced that we have the optimum treatments that will affect the overall death rate in the community and it is very hard for people to understand that because an individual might benefit. However, a benefit must be shown to the community when you consider screening thousands of people with the Government paying the bill. I would be cautious about embarking on too many screening programs until we are sure of the outcomes and sure of the infrastructure to deal with abnormal results. Would you agree with that?

Ms Rooney: Yes.

The CHAIRMAN: In your submission you referred to the importance of improving communication training for health professionals. Can you expand on the communication training that should be provided and at which professionals it should targeted?

Ms Rooney: There are draft clinical practice guidelines for the psychosocial care of adults with cancer. Those guidelines indicate that the wellbeing of people, how they respond to treatment and the information they retain is dependent on the communication skills of the practitioners who deal with them, such as clinicians, doctors, nurses and allied health people. Basically, the evidence in the guidelines indicates that when people are trained well in communication, information given to patients is retained better and they feel more comfortable and more involved. I am talking about training for example, for undergraduate medical students who have communication training now, but there is an issue about when that training occurs. It might be early on in their training, but it should be continued in the clinical setting. Communication training should also be given to people who deal specifically with people with cancer. There is anecdotal evidence that the people who participate in communication training are often those who have less need for it, and those who do not believe they need it are often most in need of the training. People working in public hospitals should at least participate in a communication-training course and have an ongoing program to make sure their skills are retained. People with cancer have given anecdotal evidence that the way in which they have been told about their diagnosis and prognosis was not very empathic and that they had no understanding of what was said to them. These national clinical practice guidelines, therefore, have identified that ongoing communication training for all people involved has better psychosocial outcomes for people with cancer.

Mr Sheiner: Another advantage of communication training, which gets back to the original point, is that the most common reason for litigation is the lack of communication with a patient. The more doctors are aware of that, the more we will sell them the idea of improving their communication skills.

Mr M.F. BOARD: I agree.

The CHAIRMAN: We appreciate your attendance at the committee. A copy of the Hansard transcript will be sent to you and I ask you to go through it carefully to make sure you are happy with the way your evidence has been recorded. If you need to change anything, would you do that and return it within 10 working days.

Proceedings suspended from 10.40 to 11.00 am