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 Cook, 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 6.01 p.m.

LERNER, Dr Michael, President, Commonweal, Bolinas, California

Evidence was taken via teleconference—

CHAIR—I welcome Dr Michael Lerner, President of Commonweal, a health and environmental research institute in Bolinas, California, who is providing evidence to the committee via teleconference from Oxford. We have a number of senators here. We have Senator Cook online as well.

Senator COOK—Yes, I am online at Melbourne airport. My plane is going in half an hour.

CHAIR—Dr Lerner, we invite you to make a presentation to the committee and then we will hand over to Senator Cook. He can then catch his plane at his leisure and we will take it from there.

Dr Lerner—Commonweal is a health and environmental research institute. I will be brief in my initial comments. I find that the question and answer format is often the best. Over the last 25 years I have studied alternative and adjunctive cancer therapies in the United States and Europe and to some degree around the world. For the last 20 years I have led week-long retreats at Commonweal for cancer patients. We have done about 130 of these weeks, which are educational programs that provide a combination of meditation, relaxation, yoga, massage, vegetarian diet and so forth. These are not medical treatments; these are educational programs. Finally, I am the author of a book, *Choices in Healing*: *Integrating the Best of Conventional and Complementary Approaches to Cancer* from MIT Press, which has been regarded as a key book in the field. It was the first book on integrative cancer therapies to be well reviewed in the scientific literature as well as in the lay press. I also serve on the CEO Advisory Board of the American Cancer Society and I was the chief consultant to the Office of Technology Assessment in the United States Congress for their landmark study, *Unconventional cancer treatments*. Those are my credentials.

In the course of studying complementary and alternative cancer therapies over the last 25 years I have reached a number of conclusions that I think have stood the test of time. The first is that I have seen no clear-cut cure for any form of cancer among the complementary and alternative cancer therapies in the sense of any treatment that reliably reverses any form of cancer. This is a very important statement, because there are many people in the field of these therapies who claim that there are cures out there that are being suppressed. I have never seen that phenomenon.

The second point is that, although I have seen no clear-cut cure for cancer, there is no question in my mind—and there is a very substantial research literature—that some of these therapies can enhance quality of life. This is well established in psychosocial therapies for cancer—meditation, support groups, relaxation and the like. There is no question whatsoever that they can enhance quality of life, which is a major accomplishment.

The third point is that, while there are no clear-cut cures for cancer and these therapies enhance quality of life, there is indirect evidence that these therapies may also extend life, so not cure cancer but extend life. The fourth point is that there are some very interesting new studies, specifically by Dr Dean Ornish, a leading American cardiologist who has been studying prostate cancer and very low fat diet, that in the case of prostate cancer specifically a low-fat diet with yoga, meditation and a support group lowers prostate specific antigen counts. It may extend life more systematically by actually controlling the development of the cancer, much in the way that one might be able to control diabetes to some degree with diet and the like.

So the bottom line for me is that, firstly, there is no clear-cut cure for cancer; secondly, there is the capacity to profoundly enhance quality of life; thirdly, there is the real possibility that there is life extension using some of these approaches; and, fourthly, there is emerging evidence on prostate cancer—and therefore potentially by inference on some of the other fat related cancers—that a very strong dietary approach and related psychosocial supportive intervention could make a difference in that way. I will stop right there and take some questions, unless you want me to go further into any specific point.

CHAIR—Thank you for that. I will hand over to Senator Cook for questions.

Senator COOK—Thank you, Michael. Taking a step back from all this and looking at the whole field in wide shot, do you feel comfortable making an observation about what direction cancer care in the United States is taking? Is it or is it not taking a tilt in this direction of alternative or complementary integrative therapies?

Dr Lerner—Yes, I would say that it is taking steps in that direction. If I look over the last couple of decades, I see that the growth of credibility of support groups for cancer patients—that kind of thing—in cancer centres has been tremendous. That is the case not only with support groups. Take the Memorial Sloan-Kettering Cancer Centre in New York, which is one of the great cancer centres in the world. It has a whole institute—led by Dr Barry Cassileth and funded by Lawrence Rockefeller before his death—for integrative cancer therapies that include support groups, massage, visualisation, imagery and all those kinds of things.

What has become respectable are the so-called ‘soft’ integrative therapies. By soft I mean they work on the psychological, the physical and the spiritual levels. A hard therapy would be an alternative pharmaceutical intervention, an alternative herbal intervention or something like that. The hard therapies are looked at with much more questioning—and with good reason, because the soft therapies intrinsically enhance quality of life. Any human being who starts taking care of themselves physically, mentally, emotionally and spiritually tends to become a healthier human being. That means you are a healthier human being with cancer. That means you have what oncologists call better functional status. Functional status in drug tests is reliably associated with longer survival, which is why they control for functional status when they test pharmaceuticals, otherwise they cannot figure out to what degree you are living longer because you are in good shape and to what degree you are living longer because of the new pharmaceutical.

So the soft therapies are, to me, kind of a slam dunk—they make sense and they are getting wider and wider distribution. The hard therapies—the alternative pharmaceuticals, herbals and things like that—really should be subjected to the same kinds of randomised control trials as any other pharmaceutical. They are in a different category. I am not saying that they will not ever demonstrate efficacy; that is an open scientific question. But the soft therapies do not require that kind of evaluation because they intrinsically enhance quality of life, and that is reasonably associated, to some degree, with life extension for some people with some cancers.

Senator COOK—We heard from Dr Barrie Cassileth earlier. To go back to my line of questioning: in the broad, is it a fair statement, in your view, to say that today's alternative treatments are most likely tomorrow's mainstream treatments?

Dr Lerner—I am sorry; could you say that again?

Senator COOK—Today's alternative therapies—or some of them—are likely to emerge as tomorrow's mainstream treatments.

Dr Lerner—Yes. I think the way I would say that to be more precise is that psychosocial therapies and approaches like massage, deep relaxation, exercise and healthy diet—what I call the vital quartet of spiritual, psychological, nutritional and physical approaches to cancer that intrinsically enhance health and quality of life—absolutely are very likely to emerge as tomorrow's mainstream therapies.

Senator COOK—What are the indicators that this is the way in which the American health system is tilting to treat cancer? You mentioned support groups. Is there any evidence that, for example, insurance companies providing health insurance are opening their premiums to some consideration about people who do this sort of treatment?

Dr Lerner—I will not be your best witness on that, simply because I do not know in detail about that. What I can say is that the evidence that they are becoming mainstream is that more and more cancer centres offer them. Just from a sheer economic point of view, treating cancer is, in many places in the American system, a profit centre for hospitals. They do reasonably well on treating cancer and they want to attract cancer patients with good private insurance. Many centres wanting well-insured women with breast cancer are offering support groups for breast cancer and especially for women's cancers because they know that this draws the clients they want towards their hospitals. Whether they are doing that because they are actually managing to get reimbursement or whether their profit margins on the treatment are such that it makes cost sense for them to do it is not clear to me. I think it is the latter. I think that they are absorbing the costs, which are relatively minor, of offering these therapies because they do reasonably well economically on other therapies. As to what degree insurance companies are beginning to reimburse for this, I am simply not your best witness.

Senator COOK—Can you make any observations about where the push to move in this direction is coming from? Is it led by the medical profession or is it the patients voting with their feet? Where is the pressure?

Dr Lerner—It has been led by the patient community, but there are also an increasing number of physicians interested in this. Let me give you a specific example. My colleague Dr Rachel Naomi Remen at Commonweal is nationally known for her work with transforming medicine, bringing medicine back to understanding its deep origins in patient care and the deepest reasons that people become physicians. Her program—The Healer's Art—is now offered in 38 medical schools across the United States.

There is a tremendous interest amongst younger physicians and also amongst older physicians in recovering the heart of medicine—the psychological and spiritual reasons why they went into medical practice—and moving away from the exclusively technological and biomedical base on which medicine is taught. I offer that as an indicator that there is a hunger in the medical community for responsible, integrative approaches, which is by no means limited to cancer. I think that hunger really reflects the fact that physicians are part of the culture as a whole and that the culture as a whole has a hunger for these integrative therapies. As you well know, Dr David Eisenberg from Harvard points out that a majority of Americans use these integrative therapies in one form or another. So it is patient led but, because the physicians are also part of the culture, many of them are interested, and the level of movement in this direction over the last few decades has been extraordinary.

Senator COOK—I am a politician, and the difference between perceptions of what is good for you and what is in fact good for you—the argument between perception and fact in politics—is a fairly interesting discussion. The patients perceive this to be of value but is there now any evidence that increasingly some of these therapies are being tested to justify them in a scientific way?

Dr Lerner—There is a huge body of literature on psycho-oncology, originally led by Dr Jimmie Holland at Memorial Sloan-Kettering Cancer Centre. She is the founder of the International Psycho-Oncology Society. Her handbook on psycho-oncology is a major mainstream handbook. So in that area it is huge. Dr Julia Rowland—whom you might want to testify—is the Director of the Office of Cancer Survivorship at the National Cancer Institute. She focuses on psychosocial approaches to cancer to enhance quality of life and on exercise. By the way, exercise has emerged as one of the areas most likely to be associated not only with quality of life but potentially also with life extension to some degree. So psychology and exercise are very high credibility areas.

Spiritual approaches are more contested, simply because there is a part of the community which legitimately has an exclusively secular framework and is uncomfortable with any religious or spiritual language. Nonetheless, obviously a very large percentage of Americans believe in the efficacy of prayer or spiritual approaches to illness. So while there is controversy in that area there is an awful lot of support.

Finally, nutritional approaches, like spiritual approaches, are more controversial than physical and psychological approaches. There is also a good deal of research being done in nutrition. I mentioned Dr Ornish’s groundbreaking studies on low-fat diet and prostate cancer. So the answer to your question is that in that vital quartet of spiritual, psychological, physical and nutritional approaches three of them at least—psychological, physical and nutritional—are being rigorously evaluated. But, in addition to that, because they are very low-cost and enhance quality of life they can be safely recommended to cancer patients without further testing, because they clearly help people. Whether or not they extend life, they clearly enhance quality of life.

Senator COOK—The Lance Armstrong Foundation said to us today that 70 per cent of people felt that their oncologist did not understand the need for alternative approaches. From the answer you have just given us we could expect that figure to change. If you want to make some reflections on that, please do. My final question is over the definition of terms. It is a basic point but we seem to be tripping over what we mean when we are talking about these terms. Is there any reference that is emerging as the universal touchstone for definitions and that we could look to to settle down the meaning of things such as ‘alternative’, ‘orthodox’, ‘integrative’, ‘multidisciplinary’ and those sorts of things?

Dr Lerner—Your first question was the one about the Lance Armstrong Foundation. I think it is true that a large proportion of oncologists—70 per cent sounds reasonable—are not enthusiastic when their patients talk to them about integrative therapies. I think that will change with time. I would say that 10 years ago that figure was probably closer to 90 per cent. As the culture changes and as these therapies move into the mainstream, I think that will change.

Terminology is a floating issue but I can offer the following rough guide. Alternative therapies tend to refer more to the hard therapies that I spoke of: alternative pharmaceuticals and things like that. Complementary therapies tend to refer to therapies that are used in combination with mainstream therapies. Integrative therapies means integrating the best of both conventional and complementary therapies. The term of art in the field these days is ‘CAM therapies’—complementary and alternative medicine. The other term of art, as I just mentioned, is ‘integrative therapies’. My book, *Choices in healing*, is pretty clear on this. The Office of Technology Assessment report, *Unconventional Cancer Treatments*, included some work on that. Both of those references are about seven or eight years old.

In terms of present term definitions, I do not know whether you have asked Jim Gordon to speak to you, but he is one of the leading people in the United States today on these therapies and he runs a very influential training program called Cancer Guides. He may have references. The references I just gave you are up to date. ‘CAM therapies’ is the term of art for the whole field. ‘Integrative therapies’ means the integration of the best of both conventional and complementary areas. ‘Alternative’ refers more to the hard left therapies and ‘complementary’ refers to those that integrate.

CHAIR—Dr Lerner, I think everyone we have heard from in our international inquiries has described an evolutionary process from very conservative approaches to cancer treatments to treatments that are much more accepting. In fact, the approach now nearly mainstreams complementary medicine and practices. We are also in an evolutionary process here in Australia but I suspect, from what we have heard, that we are several years behind where you are in the United States, and certainly where the UK is. I am wondering whether you can offer us any advice, knowing what you know now and from what you have experienced. If you were to go back five or 10 years, is there anything you would have put in place? Can you advise us on how to speed up that evolutionary process or enable us to leapfrog some of hurdles and obstacles so that we can get to the leading edge in cancer treatment management much faster than just waiting for it to develop naturally and waiting for oncologists to get themselves out of the very conservative circles that they are in now?

Dr Lerner—That is an excellent question. The first observation I will make is that, from my point of view, you have a remarkable resource person in Australia—a friend and colleague of mine, Ian Gawler, whom I am sure you know. I know he submitted materials to you. Can I assume that all the senators present are familiar with Ian Gawler’s work?

CHAIR—Yes, you can. He has appeared before the committee already.

Dr Lerner—Ian is a really remarkable example of somebody who reversed a metastatic, life-threatening cancer using very, very intensive complementary and alternative cancer therapies. He has been to our centre at Commonweal and lectured there; I have been down to his centre and spent time there. I regard his approach as ethical and of the highest quality. Where Ian and I have differed, in a respectful and positive way, is that, because he has had this experience of recovering from a metastatic cancer, his program encourages patients to believe that that is a possible outcome for them. He puts less emphasis on helping people with advanced cancer also prepare for the possibility that they may die—a least, that was true when I was there; I do not know if the program has changed.

In our program, because I have seen relatively few people recover as Ian did, we have more of a combination approach that says: ‘We support you in your effort to recover from this advanced cancer—but it is also possible, of course, that with this kind of cancer you may die.’ It is really a question of emphasis. We talk about living well with the cancer and doing absolutely the best you can, but also, if you cannot recover, how to deal with pain and suffering and how to deal with death. Ian, in turn, says to me: ‘Don’t you think that by this so-called more balanced approach you perhaps influence the patients away from making the most vigorous fight that they could make for their lives?’

I bring you the detail of that because I regard that as a creative, constructive, important dialogue between people who have dedicated large parts of their lives to this. Having said that, because that is the only area where there is a difference in nuance between us, I think that Ian’s work really is an important model for this kind of work. I think it has been done extremely ethically and well. I point to it because I do not know anybody in the United States who does a better job at what Ian does than he does. I think it is important to look to resources within Australia because Ian is deeply respected by his colleagues who have met him in the United States and at Commonweal. So I just wanted to start with that point. Is there anything you would like to ask about that before I move to your broader point?

CHAIR—I accept everything you say about Ian Gawler and his centre, but I just make the point that the evidence is that very few oncologists would ever refer their patients to him.

Dr Lerner—That is true, but is it not also true that a lot of people have sought him out?

CHAIR—Precisely, yes.

Dr Lerner—It seems to me that, if the patients are seeking him out, then that begins to suggest a strategy. In the United States many years ago Senator George McGovern’s Senate Select Committee on Nutrition and Human Needs produced a report that played a defining role in moving nutrition in a very positive direction in the United States—and it was simply a report. It seems to me that the thing that you as a Senate committee could most directly do would be to publish an authoritative report on integrative approaches to cancer that really took a careful look at the evidence and, in a balanced way, legitimised the clearly legitimate fact that there are ethical, well-founded, integrative approaches to cancer that unquestionably enhance quality of life and may contribute to life extension—but with the emphasis on the fact that they unquestionably enhance quality of life, because that is demonstrated.

If the case therefore is made that enhancing quality of life in the face of a life-threatening illness is a major social benefit which can be achieved at a very low cost, then it seems to me that simply by framing that as authoritative and urging and encouraging medical societies, hospitals, insurance companies and the like to recognise this, the report itself, if carefully framed, can play a decisive role in legitimising an important field. So that would be my first response: simply to emphasise the value of the report and to say that, in order to have that value, it has to be a very good report.

On the second point, about the specific ways to move forward, I would say—and I do not know how cancer research is set up in Australia—that, if it were possible to put in place low-cost research that tracked patients who elected integrative supportive therapies and those who did not in terms of outcomes, that would also be enormously beneficial—an ongoing research agenda. A friend of mine in England is proposing that one per cent of the research budget of the British health services be made available for evaluating therapies of this kind. If you look at the level of patient interest, how can anyone argue that Australian citizens would not support one per cent of the research budget going to evaluating these therapies?

Once you create a budgetary stream without increasing your research expenditure—simply saying, ‘Let’s put one per cent into this area’—then you begin to get the academics competing for those research dollars. Those academic competitions for those research dollars make it credible in cancer institutes to study these issues. When they are studied, the oncologists recognise that they are being studied and they are being studied by, obviously, the most credible people, since they want it to be done carefully, and so there is a cascade effect down through the system of beginning a research program. There are certainly a lot of people around the world who could support the already able researchers in Australia interested in those kinds of things.

The third area is the issue of reimbursement. That is the trickiest area of all because you really have to make the case that you are not going to increase costs and premiums in that way. There you have to be able to demonstrate that you are enhancing outcomes that the insurers care about. It is not always clear to me that they care about quality of life, even though they should. As I said at the outset, I am not sure that I am your best witness on the reimbursement issues. I think that on the report itself and the research issue those two interventions would help move the field rapidly.

The final point I would make is this. If you do this as well as I believe you can do this, I think Australia really could move to the forefront of this area quite rapidly, simply by the quality of your intention and by some sustained attention to it, not simply by a single report but by a coming back to the issue through the setting out of a national agenda and a coming back to the issue on some regular basis to see whether the metrics of progress that you have laid out in your report are in fact being met and what obstacles have developed and how you could surmount those obstacles.

Senator MOORE—I have two questions. One is about the integrated approach. One of the things that we have found here is that it is not just through the link between mainstream medicine and complementary therapies but also through the range of quasimedical professions that there needs to be joint understanding and cooperation. The stuff from your organisation that I have read does seem to cover the whole stream of medical support. Are the people involved in the various therapies trained in the same way using the different forms of support that are available?

Dr Lerner—That is an excellent question. One thing I would absolutely say, at least as to the United States and I imagine it may well be true internationally, is that the health professional communities that tend above all to be most interested in integrative approaches to cancer and integrative health care more broadly are nurses. There is a tremendous interest in nursing in integrative therapies. Partly this is built into the definition of the profession. Nursing is about patient care and it is about the wellbeing of the patient, so anything that enhances quality of life for patients is centrally interesting to nurses. A second group that have been enthusiastic about integrative therapies are psychotherapists and social workers, again people involved with psychological approaches and social support systems. So in the United States these three groups have been in the vanguard in the health professions.

In terms of training, there are very few systematic training programs in this area. Jim Gordon’s program, Cancer Guides, which I mentioned earlier, is one of the leading programs that are available to all of these groups. But I cannot tell you that in there, in health professional training and medical schools—schools of nursing and so on—there is any kind of systematic training, because there is not. This is mostly elective training that people do for continuing medical education or nursing education. Is that responsive to your question, Senator?

Senator MOORE—Yes, that is the kind of thing we are finding here: we have to have that complementary approach across all people involved in patient treatment. My second question is more from a personal interest. One of the things we have found out through our evidence is that a lot of the stimulus for moving forward with treatment and public awareness has come through the interest of the community in breast cancer issues. The community seems to have been turned on, been made aware and become more questioning around that area, and the other groups have come along behind. Using that as a model seems to be something that we are looking at. Is there a similar gap in the States between the support and knowledge and the money being spent on breast cancer, as opposed to the many other streams of cancer?

Dr Lerner—Absolutely. The breast cancer community has been in the vanguard of integrative therapies for a long time in the United States and the other cancer groups do lag behind. It is also interesting, may I add—and I know this is not central to this particular dialogue but I raise it because I think it is relevant—that breast cancer patients not only are concerned with treatment but also have been at the vanguard on prevention issues. They are particularly concerned that their daughters do not have to go through what they are going through.

Because of this interest in prevention, they have become active in a major way on another major area of my interest and concern, which is the contribution of toxic chemicals to the incidence of cancer, and specifically to the incidence of breast cancer. That would be a subject for a whole other hearing, but the reason I mention this is that the breast cancer community in the United States have produced some of the most effective organisations pressing for research on why we have an epidemic of breast cancer in our time. They do not want their daughters to develop this. I do not need to tell you that 100 years ago breast cancer was a rare disease, and now we have all these young women in their 30s and 40s—many of them with young children—with primary and metastatic breast cancer. I have spent 20 years of my life trying to help young women with metastatic breast cancer and young children figure out how to die. None of us want that to be the fate of our children.

So you are absolutely right about integrated therapies and I simply encourage you, in your collective wisdom, to consider that the issue of chemical contaminants and human health is a major breakthrough area, very closely related to integrative therapies because it is part of prevention, and prevention has always been a far more effective approach to human disease than treatment.

Senator MOORE—Thank you. It is certainly one of my passions.

CHAIR—If I could just finish off with this question, which is a little bit away from what we have been talking about. The medical professions in Australia are a very closed community. They really control their own destiny and qualifications and they are very conservative. I understand that in the United States and the United Kingdom there is much more openness about the performance of medical professionals and more information available about success rates, the types of treatment that they have experience in and the number of patients they treat. I understand that that openness and information has been around for a long time. It does not really exist in Australia. Consumers of cancer treatments sometimes do some of that research and try to publish it, but it is not done in an organised way with any government authorities keeping track of that sort of information. Do you see the openness and what follows from that openness—more accountability, I guess—impacting on best quality or best practice treatment of cancer?

Dr Lerner—That is a great and informed question. I am not sure I can do justice to the quality of the question. Let me just reflect on it. There are many levels to that question. The first point I would make is about access to information. There is a remarkable web site, the Association of Cancer Online Resources, acor.org. This is not about complementary therapies, it is about access to information primarily on mainstream therapies. It offers a whole set of list serves for patients and doctors who are afflicted with different kinds of cancers. It helps patients access information on mainstream therapies, which by the way are usually the most critical choices that patients face. Given that there is no clear-cut cure for cancer among the complementary and alternative therapies, the real life-and-death decisions are very often about mainstream therapies and it is hard to get good information on those. So acor.org is one of the best resources that I am familiar with on helping people get into online support communities where a remarkable array of information on treatment choice is available.

On your central point, do I see US and UK physician networks as being more open and does this transparency lead to greater access and more informed choices, I suppose in the very framing of the question the answer to that has to be yes. I do not have access to comparative data between, say, the United States, the UK and Australia on those outcomes. There is a remarkable book that I reference in my book by Lynn Payer called *Medicine and Culture*. It compares medical treatment in the United States and Europe and with some emphasis on cancer. In that book, which does not include Australia but includes the United States and Europe, the point is made that the big difference in cultures of cancer care is that American cancer therapy has been infinitely more aggressive than European cancer therapy. I spent time in Japan and that is also true for Japan. We use a great deal more chemotherapy, radiation and surgery than the Europeans do. That is based on exactly the same scientific literature, which leads to a very important conclusion, which is that medicine is not simply science based.

There is a cultural prism through which the science is viewed, and that cultural prism leads to very different therapy approaches. For example, with breast cancer, while in the United States we were doing radical mastectomies the Europeans were trying to do simple mastectomies. When we moved to mastectomies they were trying to do lumpectomies. When we started doing lumpectomies with chemotherapy and radiation they were trying to figure out whether you could do the lumpectomy without chemotherapy and radiation. The point is that throughout the European and American cultures there is a broad preference for less intrusive therapies in Europe with long historical background. I add that the Europeans are much more open in a systematic way to complementary and alternative medicine. In Europe you have homeopathy being sold in pharmaceutical stores broadly, which certainly was not the case until recently in the United States. There is a much broader openness to those therapies.

It interests me, now that I think about it, that, given Australia's historical link with the United Kingdom and the fact that Britain is relatively speaking more open to complementary therapies than the United States has been historically, this openness did not follow over into Australia. I have to correct myself in this sense: if my British friends were listening to me, I think they would contest my view that Britain is more open than the United States, but when I was beginning to look at how to set up a cancer educational program one of the key models for me was the Bristol Cancer Help Centre in Bristol, England, and the Lukas Clinic in Arlesheim, Switzerland. They were both European models. So I can say with some certainty that Germany, the United Kingdom and Switzerland had greater openness even 20 years ago than the United States. While there has been an explosion of interest in the United States, culturally we still have more aggressive mainstream therapies and less of a real cultural integration of complementary therapies. That does not do justice to your question, because I cannot really answer it, but those are reflections around the edges of a very important question.

CHAIR—Thank you. That has helped a lot. We have kept you longer than we planned. Could you give us a bit more background to the web site you referred to in your last answer? Is that a privately run and managed web site?

Dr Lerner—It is a private web site. It is a very interesting story. A young and very brilliant Frenchmen was living in New York with his wife. She developed breast cancer and went to a New York hospital and they told her that she needed to have—I forget what; I may have the details wrong—a radical mastectomy or something. They asked about other choices and they were told there were none. He went on the internet and asked if anybody could help and within an hour—and this was when the internet was very primitive—he discovered that there were hospitals across town that were doing very different therapies.

This was so striking to him that he set up a system for people to share information on what they were doing. When I met him in New York, I said to him, ‘What is the greatest single thing you have learned from these years of doing ACOR?’ He said, ‘The greatest single thing I have learned is that, if you have a rare cancer, sharing on ACOR can save your life.’ This was in the sense that, if you have a rare cancer, information on the various therapies is simply not going to be necessarily available at your local hospital or through your local oncologist. Therefore, being able to participate in a national and international network of patients, many of whom are real experts, including physicians, really can save your life. With more common therapies, you can get a lot of good information.

In summary, I would stress three points. The first is that, if you do a report that emphasises not just complementary and alternative cancer therapies but also integrative cancer therapies, which is the best of both sides, it will give you the opportunity to include a focus on helping patients make the best choices in mainstream therapies, which, from the patient point of view in terms of life-and-death outcomes is the single most important issue of all.

The second is that on the complementary side you can emphasise quality of life and the potential for life extension—particularly the kind of breakthrough work that Dr Ornish is doing, which may turn out to be not just because quality of life enhances the possibility of life extension but may be a medical, physiological treatment that extends life.

The third point is that I would encourage you to at least reference the linkage to prevention and the need to examine many factors in the environment. The American Cancer Society has joined with the American Heart Association and the American Diabetes Association in working against obesity, because obesity is such a tremendous risk factor for cancer. I would encourage you to include as a third dimension an interest in prevention that not only looks at obesity and other lifestyle issues like that but also asks whether the 800 or more chemicals that many of us are carrying in our bodies do not contribute to cancer and many other diseases, disorders and conditions as well. A well-crafted report from your committee could play an important part nationally and I would not exclude international benefits as well.

CHAIR—Dr Lerner, on behalf of the Australian Senate I want to thank you for making your time available to us today and for your very valuable contribution to our committee's investigations.

Dr Lerner—It is an honour to have participated and I wish you all the best of luck. I hope very much to see a copy of your report.

CHAIR—We will make sure you get one. Thank you.

Committee adjourned at 6.55 p.m.