

CHAPTER 5

GYNAECOLOGICAL CANCERS EDUCATION FOR THE MEDICAL COMMUNITY

Introduction

5.1 One of the key issues in improving gynaecological cancer care is the management of the disease by the medical community and their level of knowledge about gynaecological cancers.

5.2 Members of the medical community and individuals spoke about the ongoing need for better information about gynaecological cancers and improved educational opportunities for all professionals.

5.3 Education for the medical community was identified as a priority by many and an effective way to tackle the issues that caused delays between symptom presentation and definitive treatment.¹ The Committee heard that one of the biggest challenges was targeting information about gynaecological cancers more appropriately and making it more visible and accessible.

5.4 Education for the medical community on gynaecological oncology matters was argued to be particularly important because it is a relatively new sub-specialty. Although there was some indication that awareness of the sub-specialty was growing, evidence to the Committee suggested that whilst medical professionals knew about gynaecological cancers, many lacked understanding regarding appropriate referrals to gynaecological oncologists, optimal treatment and associated issues that women may experience.² This lack of knowledge could be attributed to the fact that women with gynaecological cancers often present with non-descript symptoms which in turn could delay diagnosis in a large proportion of cases.

5.5 Dr Lewis Perrin, Secretary and Treasurer of the Australian Society of Gynaecologic Oncologists (ASGO) argued that improving the knowledge of the medical profession, particularly general practitioners, was just as important as public education.

I do not think the practitioners are deliberately poorly treating their patients, but they are not aware of the now documented evidence showing significant improved survival going into one of these units. Of course education is needed for the public, but I would say it is mainly for the medical profession.³

1 *Submission 51*, p.26 (The Cancer Council Western Australia); *Submission 44*, p. 9 (NBCC).

2 *Committee Hansard 2.8.06*, p.63 (ASGO); *Committee Hansard 1.8.06*, p.65 (NBCC).

3 *Committee Hansard 2.8.06*, p.63 (ASGO).

The importance of education

5.6 Women turn to medical professionals for certainty about uncertain aspects of their health. Professionals, particularly general practitioners, play a pivotal role in providing care and advice to women. It is therefore critical that they have the knowledge and resources necessary to give the best possible care to women with, or at risk of, gynaecological cancers.

5.7 Although there is a lower incidence of gynaecological cancers in Australia relative to other tumour types, the Committee heard that education was vital in ensuring that the professionals themselves maintained and expanded their knowledge of, and core skills in, gynaecological oncology. With evidence informing best practice constantly evolving and changing, it was argued that the medical profession needed to keep pace with the standards and mechanisms to ensure that women could access quality treatment and care.⁴

5.8 The Committee was told that education about gynaecological cancers should not only focus on technical medical concepts and developments, but should improve awareness of the psychosocial and emotional needs of women and hone other professional skills, such as communication with patients.

5.9 Witnesses and submitters emphasised that a measured approach to education was needed to:

- ensure delivery of programs and information in a timely fashion;
- match the messages and activities with the needs of the target audience;
- improve retention of key messages;
- increase rates of participation in continuing professional education activities; and
- to improve service delivery for women.

The medical community

5.10 The extent to which members of the medical profession required education of risk factors, symptoms and treatment of gynaecological cancers varied across the professions and across the individuals within those professions.

5.11 Some educational issues were profession-specific, hence some professions have been examined separately. Some issues – such as the need for improved coordination of educational strategies – apply across the board and have been considered in the latter part of this chapter.

5.12 Particular attention was given to the education of general practitioners and nurses because of the roles they play in the detection of gynaecological cancers and

4 *Submission 56*, p.30 (The Cancer Council Australia, COSA and NACCHO).

referral to specialist care. Education for allied health professionals, gynaecologists and gynaecological oncologists is also considered briefly.

General practitioners

Role

5.13 In the context of gynaecological cancer, general practitioners practise in a very different setting and context to other medical professionals, and as such have different relationships with patients and different learning and educational requirements.

5.14 General practitioners were described as the 'gatekeepers' of the medical profession because of their role in detection, referral, follow up and care for women.⁵ In this role, it has been said that they need to be masters of uncertainty because symptoms were ill-defined and infrequently presented (perhaps one or two per year).⁶ Mr John Gower, Chief Executive of the Gynaecological Cancer Society argued:

The GPs have a hell of a job to do and they are not used to seeing gynaecological cancer, which can be 50 other things...They know their stuff; they know the symptoms; it is just not front of mind.⁷

5.15 In the case of ovarian cancer, the Committee heard stories of women for whom the diagnostic process was long, leading to delayed treatment and poorer survival rates.⁸ The Committee also heard similar experiences from women diagnosed with other gynaecological cancers.

5.16 The Committee heard that general practitioners experienced the following problems surrounding the management of women with gynaecological cancers:

- given the breadth of clinical encounters in general practice, general practitioners often did not have ready access to detailed information about gynaecological cancers and their treatment;
- general practitioners needed to be more aware of gynaecological oncology resources in their region and the evidence associated with treatment, to minimise referrals being made on less evidenced-based approaches;
- insufficient education about the benefits of treatment by a gynaecological oncologist, compounded by the lack of an academic base in the sub-specialty and resultant inadequate undergraduate training;

5 *Submission 44*, p.9 (NBCC).

6 *Committee Hansard 2.8.06*, p.38 (Gynaecological Cancer Society).

7 *Committee Hansard 2.8.06*, p.38 (Gynaecological Cancer Society).

8 *Committee Hansard 3.8.06*, p.4 (The Royal Women's Hospital).

- the structure of general practice itself often does not allow much time for, and unless the general practitioner is very motivated, investigation and management of vague and ill-defined symptoms; and
- insufficient support and incentives for the average general practitioner to up-skill in gynaecological cancer related issues as he or she only sees one or two new cases of a gynaecological cancer a year (particularly when so much of the person's care is undertaken by others medical professionals, such as gynaecological oncologists).

5.17 The referral process gave rise to particular concerns. It was argued that opportunities to improve referral pathways through education were important as the initial referrals of women to specialist services (widely agreed to be a critical role for general practitioners) were not always made. A number of reasons were put forward, with the main one being a lack of available information about referral pathways to specialist services. It was argued this meant general practitioners did not necessarily know who to refer patients to or they simply continued referring them to specialists to whom they had historical referral patterns.

Current education strategies

5.18 A large proportion of the educational material and programs produced for professionals by government, non-government and community-based organisations were aimed at general practitioners. The Commonwealth Department of Health and Ageing (the Department) and the National Breast Cancer Centre (NBCC) emphasised that their activities and efforts to raise awareness about gynaecological cancers had targeted general practitioners because they were the first point of contact for women with symptoms.⁹

5.19 The NBCC has produced various educational programs and products on ovarian cancer for general practitioners. In 2005, the NBCC developed a guide – *Assessing symptoms that may be ovarian cancer* – to assist general practitioners to assess women with a step-by-step process to follow in the investigation of symptoms. According to the NBCC:

This guide was disseminated to over 22,000 GPs across Australia. It continues to be the most widely disseminated guide from the whole NBCC resource list, with nearly 2,000 copies disseminated in 2005-06. It is regularly requested as the key resource for GP education sessions...¹⁰

5.20 The NBCC has also provided input into national seminars and a range of products, such as fact sheets, clinical practice guidelines and development packages, which target general practitioners and medical professionals more generally. Of note, is the *Directory of Gynaecological Cancer Services* which is an online resource that

9 *Committee Hansard* 1.8.06, p.59 (NBCC); *Committee Hansard* 23.6.06, p.42 (Commonwealth Department of Health and Ageing).

10 *Committee Hansard* 1.8.06, p.59 (NBCC).

provides general practitioners with contacts for referrals to gynaecological treatment centres and gynaecological oncologists.¹¹

5.21 The Cancer Council Australia and its State and Territory bodies also have educational strategies for general practitioners. In recognition of the fact that general practitioners are an important source of information for women, the Cancer Council Western Australia has held many GP cancer education programs events since 2001 with a gynaecological focus.¹²

5.22 Many community-based organisations and professionals acting in a volunteer capacity also conduct educational activities. For example, the NSW Psychosocial Support Project at the Westmead Hospital developed a new learning course for general practitioners with seven modules on psychosocial issues.¹³ Dr Yee Leung, a Western Australian gynaecological oncologist, said he and his colleagues made efforts to inform general practitioners on gynaecological cancers through lectures, workshops and seminars.¹⁴

5.23 ASGO also said that most gynaecological cancer centres in Australia run education programs on an 'ad-hoc basis' for general practitioners in their catchment area which were 'usually extremely well attended and very successful'.¹⁵

Is the current level of education appropriate?

5.24 The Committee heard that if the right decision regarding referral was to be made the right information needs to be available to general practitioners. General practitioners need to know what information is available, what information to seek and where to seek it.

5.25 It was difficult to judge the success of current education strategies without the presentation of empirical evidence, but anecdotally, the NBCC said that it had received positive feedback on its ovarian cancer guidelines from general practitioners.

5.26 Dr Helen Zorbas, Director of the NBCC said that one way to measure the success of the NBCC's approach was to examine changes in the referral patterns of general practitioners. Anecdotal evidence from one gynaecological oncologist suggested that the referrals he had been getting over recent times were growing in number and were 'much more appropriate'.¹⁶ Dr Zorbas argued:

11 *Submission 44*, pp.9-10 (NBCC).

12 *Submission 51*, p.25 (The Cancer Council Western Australia).

13 *Committee Hansard* 1.8.06, p.33 (NSW Psychosocial Support Project).

14 *Committee Hansard* 4.8.06, p.63 (Western Australian Gynaecologic Cancer Service).

15 *Submission 24*, p.11 (ASGO); *Submission 25*, p.9 (Hunter New England Centre for Gynaecological Cancer).

16 *Committee Hansard* 1.8.06, p.64 (NBCC).

It would seem to us from the feedback that we are getting that, drip by drip, we are getting through to the general practitioners, and they are vital in this process.¹⁷

5.27 A number of comments were made in relation to the barriers that general practitioners faced specifically in absorbing the information provided and/or pursuing educational opportunities.

- It is hard to educate general practitioners about something with vague symptoms, particularly when many diseases have similar symptoms.
- General practitioners are trained to look at the 'most likely cause of the disease before looking at the least common cause of the symptoms', which could be a gynaecological cancer.¹⁸
- ASGO argued that education programs were often conducted on an ad hoc basis by individuals and organisations in addition to their already heavy workload.¹⁹
- Gynaecological cancer education is usually a sub-set of cancer education and current gynaecological cancer educational strategies often focused on ovarian cancer and cervical cancer.
- Most general practitioners generally do not see a large number of individual patients with cancer, let alone gynaecological cancers, so it is hard to put a numerically uncommon tumour on the work plans of the Australian Divisions of General Practice.²⁰
- General practitioners are inundated with information on a daily basis and it is hard for them to make sense of it all.
- Educational opportunities are difficult to take due to lack of available time. When it is taken, technical training is generally more attractive to general practitioners than communication skills training.²¹
- There is a lack of communication between professionals from the gynaecological oncologists down about gynaecological cancers preventing education on-the-job.

5.28 On this last point about communication, Mrs Vickie Hardy from the National Ovarian Cancer Network (ACT and region) argued:

There is a lack of communication between all the agencies, from your gynaecologist down. Your GP is your first port of call and he has to be

17 *Committee Hansard* 1.8.06, p.64 (NBCC).

18 *Committee Hansard* 23.6.06, p.19 (National Ovarian Cancer Network – ACT and region).

19 *Submission* 24, p.11 (ASGO).

20 *Committee Hansard* 1.8.06, p.53 (GMCT).

21 *Committee Hansard* 4.8.06, p.7 (The Cancer Council Western Australia).

informed but quite often the GP was not informed on anything; he did not get information. So there are a lot of areas that need to improve, to help the patient.²²

5.29 The broad message to the Committee was that although current educational strategies were well-intentioned and executed, much more needed to be done to support general practitioners.

The way forward

5.30 Dr Zorbas from the NBCC argued that 'educating general practitioners is No. 1'.²³ Many also argued that educating general practitioners was equal in priority to educating women and the broader community.

5.31 Evidence to the Committee cautioned that a number of changes were needed to improve the effectiveness of future educational strategies and therefore maximise the health outcomes for women.

5.32 ASGO stressed that increased funding was needed to ensure that general practitioners had sufficient and current knowledge of gynaecological cancers, had access to a referral system and had access to educational material and the support they needed to care for patients.²⁴

5.33 The Cancer Council Australia stressed that research into getting the message across to general practitioners should be a high priority. It was argued that feedback and input from general practitioners should guide the content and direction of future activities, particularly because of the many different methods of delivery available.²⁵ Professor Ian Olver, Chief Executive Officer of The Cancer Council Australia said:

The difficulty these days is that there are so many methods to choose from in terms of web-based things and pod casts and whatever, but nobody knows what the most effective method is. People sort of guess and go along a line, but there needs to be research done. At least, if you get funding to disseminate information some of that funding should be used...to evaluate the impact that information.²⁶

5.34 Professor Olver and Dr Kendra Sundquist, also representing The Cancer Council Australia, emphasised the importance of coordination and planning in overcoming the current challenges posed by ad hoc approaches.²⁷ They argued that the development of nationally coordinated targeted messages for general practitioners on

22 *Committee Hansard* 23.6.06, p.21 (National Ovarian Cancer Network – ACT and region).

23 *Committee Hansard* 1.8.06, p.65 (NBCC).

24 *Submission 24*, p.11 (ASGO).

25 *Committee Hansard* 2.8.06, p.13 (The Cancer Council Australia).

26 *Committee Hansard* 2.8.06, p.13 (The Cancer Council Australia).

27 *Committee Hansard* 2.8.06, p.13 (The Cancer Council Australia).

gynaecological cancers would bring many advantages.²⁸ In relation to ovarian cancer, representatives from the National Ovarian Cancer Network argued strongly for an awareness campaign for general practitioners. Mrs Erica Harriss from the National Ovarian Cancer Network (ACT and region) argued:

...it needs to be a nationally coordinated ovarian cancer awareness campaign to make sure that GPs are very aware and consider the possibility of ovarian cancer. I was told my symptoms were vague, and that is what they say about ovarian cancer. But nobody considered it, and I knew nothing about ovarian cancer.²⁹

5.35 ASGO also argued that existing programs needed to be better coordinated, better advertised, and more frequent. Whilst there were some gaps in the current approach (for example, referral guidelines for general practitioners), it was argued that the present distribution and communication channels needed to be fine-tuned.

5.36 Witnesses also stressed the importance of leveraging existing processes to maximise access and penetration in the general practice community.³⁰ Recently, The Cancer Council Western Australia used the Royal Australian College of General Practitioners' (RACGP) web-based learning tool to give general practitioners messages about gynaecological cancers as part of their continuing medical education.

5.37 The Cancer Council Victoria suggested that the NBCC guide, *The investigation of a new breast symptom – a guide for General Practitioners*, was a 'highly commended' resource that could be used for general practitioners to assist them in identifying, investigating and appropriately referring women with a suspected gynaecological cancer.³¹

5.38 Where possible, advances in technology (particularly web-based) should be utilised to assist in message delivery to general practitioners, whilst remembering the value in face-to-face discussions.³²

5.39 To address concerns that referrals were largely ad hoc, the development of referral guidelines for general practitioners with information on who best to refer women to should be investigated. The NBCC's online directory of gynaecological oncology services was thought to be a valuable resource, but that more was needed to increase the profile and use of this product and the sub-specialty more generally amongst general practitioners.

28 *Committee Hansard* 2.8.06, p.13 (The Cancer Council Australia).

29 *Committee Hansard* 23.6.06, p.18 (National Ovarian Cancer Network – ACT and region).

30 *Committee Hansard* 4.8.06, p.7 (The Cancer Council Western Australia).

31 *Submission* 48, p.2 (The Cancer Council Victoria).

32 *Committee Hansard* 4.8.06, p.7 (The Cancer Council Western Australia).

5.40 The overall aim of general practitioner education is to bring gynaecological cancers to 'front of mind' and where a general practitioner suspects a gynaecological cancer is present, he or she has the knowledge to refer the woman to a gynaecological oncologist for further assessment (including diagnosis) and treatment.

Nurses

Role

5.41 Nurses from a very wide range of practice settings care for and support women with gynaecological cancers. Ms Tish Lancaster from Cancer Nurses Society of Australia (CNSA) argued:

...that the intimate nature of nursing care that is involved for women with gynaecological cancer well places nurses to identify the needs of women, to address some of those needs and to make appropriate referrals to other health practitioners that may also assist in addressing those needs.³³

5.42 Among their many roles, nurses provide education to women about gynaecological cancers and Ms Lancaster said that 'nurses are very well placed in a health promotion role for all gynaecological cancers'.³⁴

Current education about gynaecological cancers

5.43 The Committee heard about a number of educational programs for nurses on gynaecological cancers.

5.44 Since 2004, the Greater Metropolitan Clinical Taskforce (GMCT) in New South Wales has conducted 'highly successful' annual nurses' study days that were 'well attended by hundreds of nurses from both metropolitan areas and the country'.³⁵

5.45 Another successful initiative for nurses developed by the CNSA was the publication of a textbook on gynaecological cancers for nurses and allied health professionals.³⁶ In highlighting the positive feedback on this product, Ms Lancaster said:

...it has not just been a local thing. It has had this enormous spin-off that we did not ever anticipate. The nurses who come to the study days, the nurses who work in our units and even the junior medical staff really love it, because it is a practical, evidence based, woman centred approach to gynaecological cancer.³⁷

33 *Committee Hansard* 1.8.06, p.71 (CNSA).

34 *Committee Hansard* 1.8.06, p.73 (CNSA).

35 *Committee Hansard* 1.8.06, p.44 (GMCT).

36 *Committee Hansard* 1.8.06, pp.77-78 (CNSA).

37 *Committee Hansard* 1.8.06, p.78 (CNSA).

5.46 Representatives from the National Ovarian Cancer Network also told the Committee about a resource kit that was initially prepared for women recently diagnosed with ovarian cancer, but has also been of considerable use for oncology nurses. Ms Jane Harriss, Director of National Ovarian Cancer Network (ACT and region) said that nurses:

...were crying out for that information themselves. We talked with them about it, and they said that they were ready and waiting for us to provide them with that level of support.³⁸

5.47 The Committee heard from the CNSA and the GMCT that there was no specific formal education in gynaecological oncology offered for nurses and that the current post graduate studies, at least in New South Wales, tended to focus on cancer nursing more generally. Ms Jayne Maidens the GMCT's Gynaecological Oncology Group said:

Currently there is a graduate oncology nursing certificate that is run by the College of Nursing in Sydney. Some of the universities also have graduate certificates. They cover cancer nursing under a large umbrella, but there is nothing that is specific to gynaecological cancer...³⁹

Is the current level of education appropriate?

5.48 Evidence to the Committee showed that nurses wanted more education in gynaecological oncology and many nurses funded themselves to go on courses and attend conferences. Ms Lancaster from the CNSA argued:

I think nurses in general are very keen for educational opportunities and it is something that, in general, they do not get. They more junior you are the less likely you are to get out to those sorts of things.⁴⁰

5.49 The results of a 2004 study of 150 nurses (from a variety of settings in New South Wales) who attended the GMCT's nurses' study day showed that 66 per cent of nurses were either very or moderately confident about talking to women about gynaecological cancers in general and also about 'common practical issues', such as bladder and bowel problems.⁴¹ However, results showed that many nurses lacked confidence in their ability to manage more complex, yet still common issues experienced by women such as infertility, lymphoedema and psychosexual dysfunction.⁴²

38 *Committee Hansard* 23.6.06, p.22 (National Ovarian Cancer Network – ACT and region).

39 *Committee Hansard* 1.8.06, p.52 (GMCT).

40 *Committee Hansard* 1.8.06, p.79 (CNSA).

41 *Committee Hansard* 1.8.06, p.74 (CNSA).

42 *Committee Hansard* 1.8.06, p.74 (CNSA).

5.50 Despite the 'considerable experience and formal qualifications' of the nurses surveyed, many did not feel confident in addressing specialised gynaecological cancer issues. The CNSA said:

...only 12% felt very confident in discussing the management of gynaecological cancers, while 5% felt very confident in addressing genetic susceptibility, 8% for fertility issues, 12% for lymphoedema prevention and 15% for sexuality and body image (Maidens et al. 2004). Reports suggest that health care professionals require development of skills in psychosocial assessment and care. Nurses, like other health professionals require development of competency in this area...⁴³

5.51 The CNSA noted that the nurses who cared for women outside of specialist cancer centres indicated that they wished to provide better supportive care for women but that 'inadequate education hinders their efforts to do so'.⁴⁴

5.52 The CNSA argued that there was a clear demand for better educational opportunities for nurses. It stressed that when looking at offering skilling opportunities for nurses, a number of barriers existed, including:

- workforce shortages, high workloads and competing demands leading to problems associated with back-filling positions;⁴⁵
- poor links between education and career pathways;
- the cost of further education at university;
- the geographical location of nurses (greater barriers for nurses in rural areas); and
- insufficient training places, especially in the university system.⁴⁶

5.53 The Committee also heard that the formality of training to become a specialist gynaecological oncology nurse could be a barrier to many nurses who would be competent at the role. Ms Elizabeth Chatham, Director of Women's Services at The Royal Women's Hospital stated:

The hurdles to get over to be able to become a gynae-onc nurse are so high that they actually cut out a lot of the people that may be interested; but it still has to be credible and structured.⁴⁷

43 *Submission 20*, p.3 (CNSA).

44 *Submission 20*, p.3 (CNSA).

45 *Committee Hansard 1.8.06*, p.75 (CNSA).

46 *Submission 20*, p.3 (CNSA).

47 *Committee Hansard 3.8.06*, p.28 (The Royal Women's Hospital).

The way forward

5.54 To ensure that nurses have the skills required to give women optimal care and to work effectively within the gynaecological oncology system, including knowledge of appropriate referral and communication pathways, the current educational strategies for nurses need to be reviewed. Nurses caring for women with gynaecological cancers need to be adequately prepared to assess the physical as well as emotional needs of women and thus be able to collaborate with other medical professionals. Education is the key to achieving this outcome.

5.55 Formal education for nurses is currently tailored to general cancer issues, with very little focus on gynaecological oncology.⁴⁸ The CNSA argued that steps ought to be taken to examine the content of curricula at undergraduate and graduate levels of training to better prepare nurses.⁴⁹ The CNSA noted that Commonwealth government funding for nursing training through a program called 'EdCaN' is 'going a long way' towards addressing current training issues.

5.56 The Royal Women's Hospital argued that 'post-graduate specialist gynaecology nursing courses significantly improve workforce capacity'.⁵⁰

5.57 Ms Jayne Maidens said that work by the GMCT was already underway to raise the profile of gynaecological oncology in tertiary nursing curricula.

We hope to have some affiliation with either one of the universities or the College of Nursing to promote a package specific to gynae-oncology so that at the end of the day they will come out with a certificate or with some sort of recognition that they have this speciality in gynae-oncology. We are working through that at the moment.⁵¹

5.58 The CNSA argued that the specific needs of nurses need to be taken into account in the development of future educational strategies in gynaecological oncology. Ms Lancaster highlighted that the needs of specialist nurses would differ from the needs of nurses in non-specialist and rural settings.

As I said, the difficulty is probably in finding something that is tailored to the needs of a particular nurse. And to be fair, nurses in specialist gynaecological cancer centres will be looking at very specific educational opportunities but those in rural centres are probably seeing not just women but all sorts of patients with all sorts of cancers, so their needs are broader.⁵²

48 *Committee Hansard* 1.8.06, p.77 (CNSA).

49 *Committee Hansard* 1.8.06, p.81 (CNSA).

50 *Submission* 37, p.4 (The Royal Women's Hospital).

51 *Committee Hansard* 1.8.06, p.52 (GMCT).

52 *Committee Hansard* 1.8.06, pp.76-77 (CNSA).

5.59 Opportunities to pursue training to become specialist gynaecological oncology nurses was also supported by the CNSA, particularly because of the successful care coordinator role that specialist breast cancer nurses play for breast cancer patients.

While the evidence that specialist nurses contribute to improve patient outcomes comes from the field of breast cancer, it is likely that the same outcomes could be achieved if specialist nurses roles are supported for women with gynaecological cancers.⁵³

5.60 Nurses are an important source of information for women with gynaecological cancers and according to the CNSA there are 'no nursing education programs relating specifically to gynaecological cancer in Australia'.⁵⁴ For nurses to provide the required support, it is important that they are supported to pursue educational opportunities, and have better access to appropriate, authoritative information. The Committee heard that this would not only bring professional gains to the nurses, but also benefit women with, or at risk of, gynaecological cancers.

Allied health professionals

5.61 Allied health professionals have a significant role in treating and caring for women with gynaecological cancers. Professionals such as psychologists, social workers and physiotherapists, have contact with women at different points along their journey with gynaecological cancers, but not at the same level of frequency or closeness as others. Nevertheless, some level of interaction necessitates a degree of awareness and understanding of the symptoms, treatment and the latest developments in gynaecological oncology, and oncology more generally.

5.62 The Cancer Council Australia, the Clinical Oncological Society (COSA) and the National Aboriginal Community Controlled Health Organisation (NACCHO) argued that general education programs for allied health professionals should include a focus on cancer management:

...particularly as incidence rates rise and as the trend towards multidisciplinary care creates increased opportunities for a wider range of healthcare professionals to participate in patient care.⁵⁵

5.63 The Committee heard that many of the allied health professions were experiencing funding and resource shortages and this impacted their ability to pursue clinical and other education.

5.64 The evidence presented suggested that education about gynaecological cancers was not an area of significant focus for government and organisations that instead targeted their educational activities and programs at general practitioners and nurses. The GMCT emphasised it sponsored once or twice yearly educational sessions

53 *Submission 20*, p.2 (CNSA).

54 *Submission 20*, p.3 (CNSA).

55 *Submission 56*, p.32 (The Cancer Council Australia, COSA and NACCHO).

for 'health care practitioners' on gynaecological oncology, but little else was presented during the inquiry about education for allied health professionals.⁵⁶

5.65 The Royal Women's Hospital argued that 'allied health staff working in cancer services would benefit from structured training and professional development programs' in gynaecological oncology.⁵⁷

5.66 It was thought that education of members of more specialised health disciplines (that have small numbers in comparison to medicine and nursing) was still critical to the system's ability to provide a comprehensive level of care for women.

Gynaecologists

5.67 The Committee received little evidence on the educational needs of gynaecologists, however it heard it was important for them to develop sub-specialised skills in gynaecological cancers to ensure appropriate referral to a gynaecological oncologist and their multidisciplinary team.

5.68 Professor David Allen, representing The Cancer Council Victoria's Gynaecological Cancer Committee and Victorian Cooperative Oncology Group, said that it was 'not uncommon' for gynaecologists or general surgeons to refer women with a gynaecological cancer to a medical oncologist rather than a gynaecological oncologist.⁵⁸ He argued that national protocols be established to counter this.

I mentioned in the opening statement getting rid of a lot of the variation in the current practice. Only state-wide or national protocols and expectations and outcomes that can be written into practice are going to get rid of those variations and get people to the right centres.⁵⁹

5.69 The GMCT said some of its educational sessions on gynaecological oncology were targeted at gynaecologists.⁶⁰

Gynaecological oncologists

5.70 A gynaecological oncologist is a specialist in obstetrics and gynaecology, who has been assessed as being competent in the comprehensive management of women with a gynaecologic cancer, awarded the Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG), completed a

56 *Committee Hansard* 1.8.06, p.44 (GMCT).

57 *Submission* 37, p.4 (The Royal Women's Hospital).

58 *Committee Hansard* 3.8.06, p.88 (The Cancer Council Victoria and Victorian Cooperative Oncology Group).

59 *Committee Hansard* 3.8.06, p.88 (The Cancer Council Victoria and Victorian Cooperative Oncology Group).

60 *Committee Hansard* 1.8.06, p.44 (GMCT).

formal three year training program in gynaecological cancer care, and passed the examination for the Certificate of Gynaecological Oncology.⁶¹

5.71 Evidence to the Committee suggested that gynaecological oncologists did not have any specific or urgent educational needs pertaining to risk factors, symptoms and treatment of gynaecological cancers.

5.72 The Royal Women's Hospital did argue though that gynaecological oncology suffered from a lack of academic support.

There are only two full professorial positions in gynaecological oncology in New South Wales, one in Victoria, one in Western Australia and none in Queensland, South Australia or Tasmania.⁶²

General issues

5.73 A number of issues apply more generally across the medical and allied health communities and these warrant separate discussion.

5.74 The following were presented as barriers to the success of current education strategies:

- poor coordination and communication leading to duplication and gaps; and
- high workloads and workforce shortages that increased the burden of training.

5.75 The following were issues that needed to be considered in the development and direction of future education strategies:

- development and distribution of new clinical practice guidelines;
- dissemination of messages and awareness about medical advances;
- improvements to professional communication skills through more attractive training packages;
- short-term skills enhancement training; and
- the role of the Internet in the provision of education.

Coordination and communication

5.76 To achieve better education and training outcomes, improved coordination of organisations within the gynaecological oncology sector, and between this sector and health and educational institutions were thought to be needed.

5.77 There was also a clear need for individuals and groups with responsibility for education planning and delivery to improve communication with relevant players in

61 NBCC, *Directory of Gynaecological Oncology Services* (<http://www.ovariancancerprogram.org.au/dir/gynonc.html>).

62 *Submission 37*, p.4 (The Royal Women's Hospital).

order to ascertain: who was doing what; what was actually working and what needed to be done in future. A complete picture across the board was needed. There was widespread recognition of the need for improvements in the information base to better coordinate and manage activities.

5.78 The fragmented approach has meant that the medical community, particularly general practitioners, cannot easily receive and retain educational messages. Disconnected strategies in the delivery of education and training have had a negative effect on the capacity of the medical community to pursue skilling opportunities in the sub-specialty of gynaecological oncology.

5.79 The extent to which the medical community has input into the development of educational programs was also seen as important for ensuring the capacity of medical professionals to recognise and deal with gynaecological oncology issues.

5.80 Opportunities to improve coordination could also be made during the consultation and planning stages to enhance the effectiveness of material and the effort that groups put in (particularly community-based groups operating on minimal funds).

Workforce shortages

5.81 The Committee heard that the gynaecological cancer care workforce was not immune to the workforce shortages that exist in almost every medical and allied health professional field at the moment. The shortages in the gynaecological cancer sector often reflected the more general shortage, for example, in the nursing profession, but were also caused by the nature of gynaecological oncology training and time required to complete formal training.⁶³

5.82 Workforce shortages have meant that medical professionals typically have less time outside of their normal working hours to absorb information and also fewer opportunities to pursue further education. The shortages, particularly of gynaecological oncologists, have shown themselves more acutely in areas outside of capital cities, particularly Sydney and Melbourne.⁶⁴

Clinical practice guidelines

5.83 The *Guidelines for the management of women with epithelial ovarian cancer* were widely distributed to medical professionals. The Cancer Council of Australia, COSA and NACCHO argued that similar guidelines should be developed for other gynaecological cancers.

63 *Committee Hansard* 2.8.06, p. 87 (Royal Prince Alfred Hospital); *Submission* 39, p.2 (RANZCOG and Mercy Hospital for Women).

64 *Submission* 24, p.14 (ASGO).

5.84 It was also suggested that a quality assurance framework be put in place to ensure that the management of gynaecological cancers followed a national evidence-based and patient-centred approach.⁶⁵

Education on emerging issues

5.85 Educating the medical profession about 'breakthroughs' and other emerging issues in a timely fashion was argued to be important, particularly to:

- ensure changes to best practice are known as early as possible and to increase acceptance and compliance of the changes;
- enable delivery of accurate and consistent messages;
- educate women; and
- encourage broad uptake of new medicines, such as the HPV vaccine.⁶⁶

Communication skills

5.86 Encouragement and incentives for all care providers to undertake training and education to improve communication skills – from gynaecological oncologists to general practitioners – was argued to be a priority. The Committee heard it was essential that members of the medical community improve their ability pick up relevant cues from women, particularly in response to psychosocial and psychosexual effects of treatment.

5.87 Mr Terry Slevin, Director of Education and Research at The Cancer Council Western Australia commented:

We have programs in place where we try and bring people in and weave in communication skills, listening skills, as part of the more technical training that we offer. Certainly, it is the technical training that is generally more attractive to general practitioners. Those who are interested in communication skills training tend to be the ones who are at the higher end of that skill spectrum anyway.⁶⁷

5.88 The Committee heard that formal communication training would make a positive difference to the ability of professionals to recognise and respond to patient needs, particularly emotional issues.

5.89 Ms Connie Nikolovski, an ovarian cancer survivor, stressed the importance for medical professionals to have strong communication skills in order to draw information from their patients.

65 *Submission 56*, p.30 (The Cancer Council Australia, COSA and NACCHO).

66 *Submission 27*, p.18 (Ms Margaret Heffernan).

67 *Committee Hansard 4.8.06*, p.7 (The Cancer Council Western Australia).

Medical people do not extract enough information; maybe they are not educated to. So perhaps there is the need for more education about people skills; I understand that they are skilled at what they do, but that is just another area I noticed when my mother was being cared for that needed to improve.⁶⁸

5.90 Communication skilling should include a focus on catering for cultural sensitivities to raise awareness of the needs of people from culturally and linguistically diverse backgrounds.

Skills enhancement training

5.91 Given it takes many years to train in gynaecological oncology, the importance of providing opportunities for short-term fellowships for those wanting to improve their knowledge was recommended. Professor J Norelle Lickiss, a palliative medicine specialist, argued this short-term measure would have high yield.⁶⁹ Professor Lickiss also suggested:

...there should be clinical fellowships in improving understanding of symptoms alone...If we had those we would actually get some advance, because that is the bottom line. The rest can build on that.⁷⁰

The Internet

5.92 More recently, the Internet has created an additional source of medical and general information that medical professionals can look to and rely on. The Committee heard that there were credible information sites developed by government and non-government health organisations for medical professionals that contain freely available information on gynaecological cancers.

5.93 This rich resource of information is presently under-utilised by both women and professionals. In assisting women who choose to access online information distinguish between unbiased information and the information designed to push a product or service, professionals themselves need to feel comfortable enough with the Internet to guide their patients' online searches for medical information. As such, there is a clear need for professionals to be educated about, and be aware of, trusted and quality information websites.

5.94 Future education strategies need to empower professionals and women to use the Internet as part of a total health care strategy. For professionals, where possible, education should be as interactive and personalised as possible.

68 *Committee Hansard* 3.8.06, p.77 (Ms Connie Nikolovski).

69 *Committee Hansard* 2.8.06, p.72 (Professor J Norelle Lickiss).

70 *Committee Hansard* 2.8.06, p.81 (Professor J Norelle Lickiss).

Roles and responsibilities

5.95 Evidence to the Committee suggested that the 'plethora of funders and providers of health promotion...has resulted in some confusion about roles and responsibilities, and about leadership'.⁷¹ In evidence, the need for coordination of education was argued to be a priority because at the moment 'everybody is doing a little bit of everything'.⁷²

5.96 It was argued that educational initiatives and formal training opportunities would continue to occur in a piecemeal fashion without the establishment of a national framework or body to provide direction and oversight. A national approach would provide an avenue for existing players from across jurisdictions – governments, non-government organisations and community-based organisations – to come together to review the current approach and to develop new initiatives and practical implementations plans as required.

5.97 There was uncertainty expressed about the direction and leadership that Cancer Australia would provide in this area due to lack of understanding about its roles and responsibilities.

5.98 Evidence to the Committee suggested an expansion of the NBCC's role to cover education about other gynaecological cancers would be a viable approach.⁷³ However, the majority of witnesses and submitters thought that funding to set up a national centre would be an effective mechanism for better coordination of gynaecological oncology education across Australia. It was thought that a national centre could provide an overarching framework reflective of national priorities and the views of all stakeholders. Further discussion on a national approach is found in Chapter 2.

Conclusion

5.99 Associate Professor Anthony Proietto, Chairman of ASGO, argued that 'medical education is as important as public'.⁷⁴ Education is the key to telling the relevant people about the information they need to know.

5.100 The Committee heard that there was a varying degree of knowledge about gynaecological cancers within the medical community.⁷⁵ A low level of knowledge amongst professionals was linked to poor awareness of the symptoms and delayed or inappropriate referral of women to specialist care. Evidence to the Committee stressed

71 *Submission 27*, p.22 (Ms Margaret Heffernan).

72 *Committee Hansard 2.8.06*, p.89 (Royal Prince Alfred Hospital).

73 *Submission 56*, p.35 (The Cancer Council Australia, COSA and NACCHO).

74 *Committee Hansard 2.8.06*, p.63 (ASGO).

75 *Submission 28*, p.10 (Western Australian Gynaecologic Cancer Service).

that for women with gynaecological cancers, particularly ovarian cancer, these were barriers to effective diagnosis and care that could be minimised or overcome with better education.

5.101 As gynaecological oncology is a new sub-specialty, it was argued that its profile needed to be lifted amongst the medical community to ensure that professionals were aware of the benefits for women of referral to gynaecological oncologists. Out of all the professions, Dr Lewis Perrin from ASGO said that particular effort was needed to educate general practitioners who were not aware of the benefits.

5.102 The Gynaecological Awareness Information Network (GAIN) believed education and awareness was a two-way street – the public needed to be better informed, and the medical community needed greater education on how to diagnose, treat and manage women with gynaecological cancer.⁷⁶

Recommendation 21

5.103 The Committee recommends that an urgent review of the adequacy and provision of information to medical and allied health professionals about gynaecological cancers be undertaken by the Centre for Gynaecological Cancers.

5.104 The Committee further recommends that the gynaecological oncology medical and allied health communities, through the Centre for Gynaecological Cancers, have greater input into decisions about education strategies for professionals, women and adolescents.

Recommendation 22

5.105 The Committee recommends that the Centre for Gynaecological Cancers, with assistance from the gynaecological cancer community, develop culturally appropriate educational material focusing on the risk factors and symptoms of gynaecological cancers. Any such material should specifically meet the needs of general practitioners, nurses (including remote area nurses), Aboriginal health workers, gynaecologists and allied health professionals

5.106 The Committee further recommends that educational materials be provided to general practitioners to inform them about the sub-specialty of gynaecological oncology and the circumstances in which it is appropriate to refer women to gynaecological oncologists.

Recommendation 23

5.107 The Committee recommends that Cancer Australia formally investigate the referral patterns of general practitioners at a national level and devise appropriate strategies to address any concerning trends.

76 *Committee Hansard* 4.8.06, p.37 (GAIN).

5.108 The Committee further recommends that accurate and accessible service directories should be developed in all jurisdictions to support knowledge-based appropriate referrals.

Recommendation 24

5.109 The Committee recommends the development and distribution of clinical practice guidelines for all gynaecological cancers (or similar consistent and authoritative information) to ensure standard practice across the healthcare system.

5.110 The Committee further recommends that the Australian Divisions of General Practice include gynaecological cancer issues in at least one professional development seminar per year.

Recommendation 25

5.111 The Committee recommends that all gynaecologists involved in treating gynaecological cancers associate themselves with a recognised multidisciplinary specialist gynaecological cancer unit.

Recommendation 26

5.112 The Committee recommends that appropriate educational opportunities be offered to medical and allied health professionals from all settings to increase skills in gynaecological oncology. Appropriate financial incentives or assistance packages should be offered, and given where required.

Recommendation 27

5.113 The Committee recommends that doctors who are training to be general practitioners be exposed to the concept of multidisciplinary care and the sub-specialty of gynaecological oncology in their training.

5.114 The Committee further recommends that medical professionals receive instruction and experience, where relevant, in diagnosing malignant gynaecological cancers through educational programs.

