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OVERVIEW

REGIONAL CANCER SERVICES IN AUSTRALIA: SOME EVIDENCE OF IMPROVEMENT BUT A LONG WAY TO GO

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It is six years since the Clinical Oncological Society of Australia (COSA) held the first Cancer in the Bush summit in Canberra. This meeting brought together a multidisciplinary group of oncology health professionals and government representatives to discuss rural oncology services. It seemed timely to us to take stock of what has happened since then, by examining some of the key issues that were identified for cancer patients and their carers in regional and rural Australia.

In the Cancer in the Bush report eight issues were identified that needed to be addressed as priorities.1 These were:

- Transport and the need to remove inequities in the current Isolated Patient Travel and Accommodation Assistance Scheme arrangements.
- Improved patient support, including the provision of breast cancer nurses nationally and a cancer nurse demonstration project.
- Training to be nationally coordinated and funded.
- Workforce planning, including implementation of Australian Health Workforce Advisory Committee recommendations and development workforce planning for disciplines covering the special needs of rural areas.
- Networks and the development of national accreditation, commencing with chemotherapy services and trialling these standards in all disciplines; and the development of a regional cancer demonstration project.
- Epidemiology, in particular study comparative outcomes in survival, access, psychological support and quality of life in rural and urban Australia.
- Reimbursement for item numbers for rural services and tele-oncology.
- Issues of national priority, such as rapidly making specific cancer drugs available on the Pharmaceutical Benefits Scheme and action to be taken on the Radiation Oncology Strategic Plan and the National Cancer Control Initiative utilisation strategy.

We have invited a number of authors who have been involved in aspects of rural cancer service delivery to share their understanding. There are many issues common to both metropolitan and regional areas, centred on management of the various malignancies, the ageing population and special interest groups such as adolescent and young adults and rare cancers. These issues, while not unique to rural Australia, are often exacerbated by the tyranny of distance and small patient numbers, as well as limited resources.

Transport, to date, has not been reviewed or addressed in any systematic way. We are therefore very pleased to note that a Senate inquiry will investigate this issue in 2007 and we look forward to a strong government response to what many regard as a chronic, unresolved problem.

Enhancing educational opportunities is also an area not covered in this forum, however several initiatives have been undertaken or are in development. The National Breast Cancer Centre (NBCC) and the Medical Oncology Group of Australia (MOGA) ran a series of workshops in 15 regional centres around Australia, covering issues around adjuvant therapy of breast2 and bowel cancer.3 Materials from these workshops are available on CD-ROM for use by any centre wishing to hold such workshops from either the NBCC or MOGA. The Federal Government has funded several national projects, currently in late stages of development, that are aimed at up-skilling oncology professionals. The National Education Framework Cancer Nursing project will develop a national framework for cancer nursing, curricula for undergraduate and specialist cancer nursing practice and enhance access to education with online resource materials provided through a consortium of university and hospital partners.4 A web-
based project in development by MOGA on palliative care integrates additional ways that information technology can overcome issues of access to educational opportunities (Personal communication, K Francis, MOGA).

Cancer Australia is funding the development of continuing professional education modules for cancer professionals, counsellors and general practitioners, managed by the University of Sydney’s Centre for Innovation in Professional Health Education and Research, together with The Cancer Council Australia, COSA, National Breast Cancer Centre and The Royal Australian College of General Practitioners. This initiative will provide a national framework for the delivery of continuing professional development in cancer care, including: workplace-based, multi-professional packages, targeting skills in a variety of practice environments (including general practice) and targeted educational resources for practitioner groups in priority areas such as psychosocial assessment and appropriate referral for psychosocial care.6

Epidemiological issues have been examined in more detail since the Cancer in the Bush report. In this issue, Katharine Heathcote and Bruce Armstrong review the evidence for differences in outcomes between rural and metropolitan areas. They review data, some of which they have generated, which shows significant disparities between regional and rural Australia compared to metropolitan areas. They investigated what data there was that might explain this and came up with some important possible answers relating to both service delivery differences and the different levels of service received by minority groups, in particular Indigenous Australians.

Their findings, previously published but overviewed and updated here, make a strong case for more attention on improving services in order to improve outcomes. They also support a call for more health services research, specifically targeted at overcoming regional/ rural disparities. Internationally there is paucity of data in this field7 and Heathcote and Armstrong make the practical suggestion of gathering much more specific data, which would require an investment in hospital-based data registries and epidemiologists, as well as researchers, who examine health service delivery. Lack of investment in clinical data systems and health services research may be putting the national oncology service research may be putting the national oncology service into a position of being unable to provide the evidence needed to support the development of evidence-based practice. By planning services across all public/private and community/acute facilities, both state and federally funded, the project developed probably the first truly integrated cancer service in Australia. No single facility can solve service delivery problems on its own and adopting a collaborative approach led to efficiency gains for all facilities, improved care for patients and carers and better support for oncology professionals. If we are to continue to have health services delivered by both state and federal governments, improved planning at a local level may help overcome some of the jurisdictional tensions.

Another example of novel approaches to improved service delivery is demonstrated in the report on the Single Machine Radiotherapy Trial by Adam Chapman, Tom Shakespeare and Mary Turner. By ensuring adequate linkages with central service providers, the trial was able to demonstrate dramatic increases in local delivery of radiation services; a staggering 63% increase in numbers of patients receiving radiation in one area. This was not at the expense of adequate quality, as a clinical audit showed the single units exceeding hubs in meeting clinical criteria of quality.

These last two projects, the Border Care Coordination Project and the Single Machine Unit Trial, demonstrate the value in investment in regional cancer services. Not only have they addressed gaps in services and improving access, but in doing so have developed innovative systems that lead the nation in quality clinical service and support service delivery. There are lessons learnt for services everywhere, not just those in the bush.

While some progress has been made, not all of the recommendations of the Cancer in the Bush report have been adequately addressed and much remains to be done. The articles in this issue demonstrate some pathways to follow for solutions. There is a need for political will and leadership from both state and federal authorities to work in partnership to further improve regional and rural cancer services.

References

**Disparities in cancer outcomes in regional and rural Australia**

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**Abstract**

Cancer in Australia is largely a positive story. Despite increased incidence rates, which reflect an ageing population, the corresponding falling age-adjusted death rates and better survival suggest a health system well-equipped for early detection and treatment of cancer. However, there are inequalities in cancer survival among people in rural, regional and remote areas of Australia and disparities in cancer treatment, particularly in respect to colorectal, lung and breast cancer, are probably partly responsible. Other factors closely aligned with cancer risk and poorer survival in regional and remote Australia include: greater levels of socio-economic disadvantage, limited access to specialist cancer treatment services and a greater proportion of Indigenous people who have their cancers diagnosed at more advanced stages and may receive poorer treatment. In the absence of more complete data, the survival pattern we see in remote parts of Australia probably represents the cancer experience of Indigenous Australians. Questions about the ways in which all of these factors collectively explain the survival picture in Australia will remain unanswered, unless we enrich our understanding of what characterises cancer experience in rural and remote Australia.

Disparities in cancer survival

The current cancer landscape in Australia is one of increasing crude incidence, falling age-adjusted death rates and better survival,⁵ reflecting an ageing population and the likelihood that our health system is performing well for early detection and treatment of cancer.⁶ However, inequalities in cancer survival among Australians may still persist.

Earlier work assessing cancer survival by categories of remoteness⁷ in NSW, showed that people living in the most remote parts of NSW were 35% more likely to die as a result of their cancer within five years of diagnosis in 1992-96, than people living in areas with the greatest access to services.⁸ More up-to-date data from NSW for the period 1994–2000⁹ shows a relative excess risk of death higher than the NSW average, for over half of all rural Area Health Services (AHS),¹⁰ compared to about one-quarter of metropolitan and other urban AHS (Table 1). Regardless of the way in which ‘rurality’ is assessed, cancer survival seems to be worse in areas with moderately to very remote access to services. Stage at diagnosis, apparently more advanced in the less accessible areas,¹¹ does not appear to fully explain the poorer survival pattern for lung, colon, cervical and prostate cancer and cancer in general (Table 2).

Disparities in cancer treatment

Apart from stage, many other factors, such as socio-economic disadvantage and Indigenous identification, are thought to underpin these results. Poorer survival seems to persist after these are accounted for¹² suggesting that play. In NSW and elsewhere, there is now emerging evidence of treatment variations that could adversely affect people living in regional, rural and remote areas, which in turn might affect their survival prospects.

The best evidence comes from patterns of care studies, such as for colorectal cancer¹³ and data linkage studies, that can account for the clinical and non-clinical factors influencing care and survival. Patterns of care studies for colorectal cancer patients diagnosed in NSW 2000-01,¹⁴ show small surgical caseloads in rural areas and a greater likelihood that patients received early and highly accessible areas would have their surgery in rural hospitals. This was not as apparent for chemotherapy, though rural patients were more likely to be treated in public, rather than private facilities.

Patients in remote to very remote areas, who were referred to radiotherapy for high-risk rectal cancer, were less likely to have treatment compared to those from more accessible areas (Table 3). This was apparently not the case for chemotherapy for this cancer, but may have been so for node positive colon cancer (Table 4). Treating specialists were less likely themselves to follow up patients who lived in areas with limited access to services.¹⁵ Despite small numbers of patients available for these analyses, these findings are consistent with other data showing that rural and remote residents with colorectal cancer across the country were less likely to receive some treatments, according to the national guidelines, and were more likely to be treated by relatively inexperienced clinicians.¹⁶ Data linkage studies from Western Australia also corroborate these findings, showing an association between survival and completion of chemotherapy and that treatment in rural hospitals, compared with teaching or private hospitals, was a strong predictor of failure to complete therapy.¹⁷

Considerable area variation in treatment patterns for breast cancer has also been reported. Women in rural areas of NSW were more likely to have mastectomies

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Table 1. Five-year relative risk of excess all cancer death due to cancer with 95% confidence intervals Area Health Services in NSW 1994–2000

<table>
<thead>
<tr>
<th>Area Health Service</th>
<th>Relative Risk</th>
<th>95% CI Higher than</th>
<th>Proportion of patients referred</th>
<th>Proportion of those treated</th>
<th>Proportion of those referred</th>
<th>Proportion of those treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>0.96 (0.93-1.00)</td>
<td>0.88 (0.86-0.91)</td>
<td>1.06 (1.02-1.09) *</td>
<td>80% (n=357)</td>
<td>76% (n=273)</td>
<td>74% (n=243)</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>1.11 (1.06-1.16) *</td>
<td>1.01 (0.98-1.04)</td>
<td>1.09 (0.95-1.00)</td>
<td>60% (n=348)</td>
<td>67% (n=274)</td>
<td>66% (n=234)</td>
</tr>
<tr>
<td>Other urban</td>
<td>0.91 (0.89-0.94)</td>
<td>0.98 (0.95-1.01)</td>
<td>1.00 (0.97-1.04)</td>
<td>74% (n=274)</td>
<td>67% (n=234)</td>
<td>66% (n=234)</td>
</tr>
<tr>
<td>Rural</td>
<td>0.95 (0.91-0.99)</td>
<td>1.00 (0.97-1.04)</td>
<td>1.07 (1.02-1.13) *</td>
<td>76% (n=274)</td>
<td>74% (n=234)</td>
<td>74% (n=234)</td>
</tr>
<tr>
<td>Other urban</td>
<td>1.12 (1.06-1.18) *</td>
<td>1.04 (0.95-1.12)</td>
<td>1.01 (0.97-1.06)</td>
<td>76% (n=274)</td>
<td>74% (n=234)</td>
<td>74% (n=234)</td>
</tr>
</tbody>
</table>


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Table 2. Five-year relative risk excess death (95% CI) of death, for all cancers by ARIA category of remoteness in NSW people from 1992 to 1996

<table>
<thead>
<tr>
<th>ARIA category of remoteness</th>
<th>Without stage as a covariate</th>
<th>With stage as a covariate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible</td>
<td>0.99 (0.96-1.02)</td>
<td>1.02 (0.99-1.04)</td>
</tr>
<tr>
<td>Moderately accessible</td>
<td>1.04 (0.98-1.11)</td>
<td>1.02 (0.96-1.09)</td>
</tr>
<tr>
<td>Remote</td>
<td>1.35 (1.25-1.45)</td>
<td>1.25 (1.15-1.35)</td>
</tr>
<tr>
<td>Very remote</td>
<td>1.25 (1.15-1.35)</td>
<td>1.10 (1.01-1.19)</td>
</tr>
</tbody>
</table>


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Table 3. Chemotherapy and radiotherapy referral for patients with node positive colon cancer according to ARIA index of remoteness

<table>
<thead>
<tr>
<th>ARIA category of remoteness</th>
<th>Proportion of patients referred</th>
<th>Proportion of those referred who were treated</th>
<th>Proportion of patients referred</th>
<th>Proportion of those referred who were treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>80% (n=348)</td>
<td>76% (n=274)</td>
<td>76% (n=274)</td>
<td>67% (n=234)</td>
</tr>
<tr>
<td>Other urban</td>
<td>60% (n=234)</td>
<td>58% (n=234)</td>
<td>58% (n=234)</td>
<td>56% (n=234)</td>
</tr>
<tr>
<td>Rural</td>
<td>74% (n=274)</td>
<td>71% (n=234)</td>
<td>70% (n=234)</td>
<td>60% (n=234)</td>
</tr>
</tbody>
</table>


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Table 4. Chemotherapy referral for patients with node positive colon cancer according to ARIA index of remoteness

<table>
<thead>
<tr>
<th>ARIA category of remoteness</th>
<th>Proportion of patients referred</th>
<th>Proportion of those referred who were treated</th>
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<tbody>
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<tr>
<td>Other urban</td>
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<td>58% (n=234)</td>
</tr>
<tr>
<td>Rural</td>
<td>74% (n=274)</td>
<td>71% (n=234)</td>
</tr>
</tbody>
</table>


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* Includes 25 (5%) of patients in which chemotherapy referral was either missing or unknown.
and less likely to have private health insurance. Patients treated in a private hospital appear to have better survival from colorectal cancer19 and prostate cancer,20 compared to those treated in public hospitals. Surgical treatment for breast cancer in a regional public hospital is significantly and independently associated with poorer survival outcomes.21 However, similar results have not been found elsewhere for colorectal,22 lung and breast cancer survival,23 when private health insurance was assessed as a predictor of outcomes.

Indigenous origin

Given that Indigenous people are more economically disadvantaged than other Australians,24 it is possible that what we attribute to a socio-economic effect on cancer survival rates may be more an effect of race. Compared with other Australians, survival rates are worse for colorectal, breast, lung, cervix and non-Hodgkin's lymphoma in Indigenous Australians.25 Indigenous people with cancer diagnosed at a later stage and have a lower prospect of surviving their cancer for every stage of disease.26 Most of our information about cancer in Indigenous people has come from the Northern Territory and Western Australia, where high proportions live in remote areas. NSW has the highest proportion of Indigenous people and most of them inhabit rural and remote areas.27 Although NSW survival data has not been analysed according to Indigenous status, the combined findings of worse survival in the most remote areas of NSW and more advanced stage of diagnosed in less accessible areas of the state, suggest that Indigenous people could contribute substantially to the survival disadvantage of people in remote areas of the state.

Stage of disease

Stage of cancer at diagnosis, an important prognostic indicator, is probably influenced by socio-economic status; the more socially and economically disadvantaged a population is, the greater the likelihood of being diagnosed with localised disease.28 Studies of Indigenous Australians so far, have not found alternative explanations for diagnosis of their cancers at a relatively more advanced stage. The possible explanatory variables considered have included age, cancer type,29 remote residence, marital status, tobacco or alcohol use, chronic disease, access to private health care or time between onset of symptoms and diagnosis.30

The possibility of biological differences between the tumours of Indigenous and non-Indigenous people has also been considered. Some evidence has been found of such differences between white people and African and other Americans, at least in terms of oestrogen and progesterone receptor status.31 Differences in histology however, were not found between Indigenous and non-Indigenous Australians.32

Treatment disparities

On the basis of the available evidence, it appears that there are cancer treatment differences for lung, colorectal and breast cancer that would be likely to adversely affect survival in rural, regional and remote areas.

The cancer pattern in Indigenous people suggests that they may receive poorer treatment. For reasons that are most likely related to regular screening for chronic respiratory disease and tuberculosis, Indigenous people with lung cancer in the Northern Territory are more likely to be diagnosed with localised disease than non-Indigenous people, but they are more likely to die from it.33 Indigenous women are less likely to get breast cancer than non-Indigenous women, but are more likely to die from it.34 Treatment disparities however, do not appear to fully explain the poorer survival in Indigenous people, nor do factors such as stage of disease, co-morbidity, remoteness or socio-economic status.35 Significantly, they appear to be less likely to have treatment for cancer36,37 and when offered curative treatment, are less likely to accept and complete it.38 Language and culture might appear to be important to their cancer survival.39

If cancer survival is worse for Indigenous people and the socio-economically disadvantaged, to what extent, if any, does the health system pose a barrier to such people who need to access and use high-quality cancer services or high-volume surgeons? The possibility that there are systematic differences in the way healthcare institutions or professionals respond to minority groups, or indeed their doctors, has been speculated on both here40 and overseas.41,42 A recent review of racial and ethnic disparities provides compelling evidence of treatment disparities in cancer care for racial and ethnic groups,43 and for other non-clinical factors are also implicated.44 Assessing the health system's response to different population sub-groups is an area plagued with sensitivities and methodologically difficult to measure. A study of self-reported discrimination might be a start.45

More detailed information on the many factors that influence treatment for different cancers and population subgroups is needed to complete this picture. Currently, the Cancer Institute’s data system does not support detailed analyses of inequities in healthcare, and the infrastructure to support other data systems outside the health arena that could better inform us of the nature of clinical practice variations, is lacking.46 Collecting a wide range of data routinely, as part of the clinical pathway, would help us answer questions about the range of treatments offered to different population sub-groups, whether these treatments were accepted and completed and reasons for non-completion.

Conclusions

In all probability, cancer survival continues to be worse in rural, regional and remote areas for the Indigenous population, and poorer treatment appears to play a part. The exact nature of and reasons for these treatment disparities is not clear, nor is the relationship of other factors connected to patterns of cancer treatment and important to cancer survival, such as access to health services, race and culture, co-morbidity, stage of disease and socio-economic status.

Enhancing and better-coordinating cancer surveillance efforts would go some way in providing an answer, as well as assisting health services to further investigate areas where the greatest disparities lie. In addition, more focused research extending beyond the realms of clinical care is required to better understand the cancer survival story for socio-economically disadvantaged and Indigenous people. How, for example, does the health system respond to an Indigenous person’s needs and to what extent do language and cultural beliefs about cancer directly influence their ability to understand the full implications of a cancer diagnosis and the need to complete treatment?

Investigating the reasons for disparities in cancer treatment will require input from people in many disciplines such as epidemiology, physical, behavioural science, health administration and information technology. In the end, a structured and collaborative approach, addressing specific questions, will help attain the common goal of equity in cancer survival outcomes for all.

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4 Department of Health and Age Care. Accessibility/Remoteness Index of Australia (ARIA) Canberra: The Department, March 1999 (Occasional Papers Series No. 6).

planning of radiotherapy services has typically focused on the need for centralised services to optimise the management of cancer in Australia. This is supported by a review of the need for centralised services to optimise the management of colorectal cancer in Australia by J.R. Condon, B.K. Armstrong, A. Barnes, et al. (2003). The Cancer Council Australia and the Victorian Cancer Council also support the need for centralised services to optimise the management of colorectal cancer in Australia.

The National Radiotherapy Single Machine Unit (SMU) Trial was a joint Australian and Victorian Government initiative to establish single machine radiotherapy service in regional areas. The trial arose in response to the need for decentralised radiotherapy services to improve access to treatment for rural patients. The aims of the trial were to improve access to, and enhance the quality of, radiotherapy services in rural areas of Australia. The trial was conducted in collaboration with the Victorian Cancer Council and the National Radiotherapy and Oncology Collaboration (NROC). The trial was funded by the Commonwealth Government and the Victorian Government.

The trial involved the establishment of SMU radiotherapy services in three rural Victorian towns - Ballarat, Bendigo and Melbourne. As recommended in the AICL review, the SMUs were established in a hub-and-spoke model, with large metropolitan hub services responsible for managing and operating the trial. This was to ensure adherence to appropriate clinical standards and levels of quality and safety. In addition, the trial was designed to assess the impact of decentralising radiotherapy services on treatment quality and patient outcomes.

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between the proportions. Another factor is that the Bemis service reached its 2-year mark in 1999, with waiting lists increasing as a result. Quality While advances in technology may have rendered some of the poorer results from earlier studies of single machine radiotherapy services redundant, services still face a number of potential problems. These include the absence of back-up services between the SMUs and two spoke sites were audited using the validated evaluation. Randomly selected patients from two hub sites, however the only instances of sub-optimal quality of care. In terms of clinical management, there were some of the poorer results from earlier studies of single machine radiotherapy services redundant, services still face a number of potential problems and maintain an appropriate quality of service. In addition to providing a back-up machine, the hub facility supports the SMU through providing a forum for the discussion of cases, relief staff and clinical and quality protocols to help ensure an effective high quality service. A formal clinical audit of the quality of radio-therapeutic management was conducted as part of the SMU evaluation. Random selection of patients from two hub and two spoke sites were audited and the results showed the quality of care of patients treated with radiotherapy in the SMUs was equal to or greater than the care provided in the hub sites. In the hub sites, 79.6% of criteria audited were adequate, compared to 84.4% in the SMUs (p< 0.001). Much of the difference was related to documentation and quality processes which were better in the SMUs. It was apparent that the modern equipment and clearly defined processes in the new departments was beneficial in improving quality of care. In terms of clinical management, there were no significant differences between the SMUs and the hub sites, however the only instances of sub-optimal management occurred in the hub sites. Broad implications The evaluation of the National Radiotherapy SMU Trial has clearly shown that radiotherapy services can be successfully provided at single machine facilities under a hub-spoke model. Each of the broad objectives of the trial were met, with significant improvements in access and radiotherapy utilisation demonstrated for residents of regions adjacent to the SMUs, and quality outcomes being the equivalent of and in some instances bettering those of the hub services. However, there are a number of factors to consider before developing this model in other areas. Victoria’s regional population is highly dispersed, with large regional centres and smaller towns located throughout the state. This is unlike many other states, which have substantial unpopulated areas between regional centres. One reason for this is Victoria’s smaller size compared to other states, with few major regional towns more than a three hour drive from Melbourne. A benefit of this is that it removes the obstacle of excessive distance for services operating as hub-spoke models, improving the direct support capacity for regional radiotherapy services and providing a back-up (albeit a difficult one) for patients in the event of the main facility being unavailable. This has been particularly useful for contracted services, such as some equipment maintenance, with specialist support staff located in Melbourne, able to perform site visits to the SMUs within reasonable timeframes. The commencement of the SMUs led to substantial increases in demand for other cancer services within the local regions. This included increases in allied health referrals and significant increases in demand for chemotherapy. In addition, as patients from further afield were referred for radiotherapy, suitable patient and carer accommodation services were required. In most instances, pre-existing patient accommodation arrangements will not be sufficient to meet the additional demand from a radiotherapy service. These broader impacts require consideration in the development of regional radiotherapy services, not least in terms of the workforce implications. The quality of care provided by adequately funded SMUs is at least equivalent to that provided in larger metropolitan centres in Victoria. Indeed, the appropriateness of care also compares favourably to audits of Australian-staffed radiotherapy departments outside Victoria. This was not a surprising finding, given the levels of staffing, quality of staff training and quality of equipment and processes were the same as in larger centres (and in certain instances better). With modern radiotherapy equipment and appropriate funding, the applicability of the findings of the old American Patterns of Care studies has been superseded. Indeed, older established centres may learn some lessons from the newer SMUs, particularly in terms of applying modern processes and equipment in order to improve patient care. The outcomes of the National SMU Trial demonstrate the degree of unmet demand for radiotherapy services in regional areas. Prior to commencement of the SMUs, uptake of radiotherapy for regional cancer patients may have been low due to personal decisions based on time and costs associated with accessing treatment, or insufficient knowledge of this modality amongst referring clinicians in regional areas. A combination of both is likely, and the widespread regional media and community interest in the SMUs would have gone some way to meeting this patient’s statement that “oncologists in general, and radiation oncologists in particular, have a role in ensuring that information is widely available, to assist referring practitioners in determining whether radiotherapy is an optimal course of treatment”. Getting this message across from a distance of several hundred kilometers has been a challenge, although improving with video-conferencing and cancer reforms supporting practitioners in multidisciplinary care planning.

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8. Australian Health Technology Advisory Committee (AHTAC), Beam and Isotope Radiotherapy - A report of the AHTAC, 1996.

Abstract
Telehealth includes diagnoses, consultations and treatment. The ability to practise telehealth is constantly being simplified by new technology. The analogue telephone system had some useful applications, however the addition of vision with videophones increased the social dimension of the interaction. Linking centres with digital lines enhanced the transfer of data, but carried the expense of installation and limited accessibility, especially in remote areas. Now with fast broadband technology individuals can videoconference using the internet or mobile phones. This should hasten the application of videoconferencing to telehealth. One response to the increasing complexity of multimodality cancer care has been the formation of multidisciplinary teams. In rural areas teams can be formed by supplementing existing rural practitioners with experts from larger centres, using telehealth. Psychological support for patients and support for rural practitioners can also be delivered by videoconferencing. Other applications of teledermatology to oncology occur with transmission of pathology images and teleradiology. Remote radiotherapy planning can be achieved by transmitting a remote CT planning image to a planning computer in a tertiary centre. Robotic cancer treatment is widely available, to assist referring practitioners in determining whether radiotherapy is an optimal course of treatment. Transmitting images clearly stressed the analogue system, as occurred when the internet was accessed using phone lines. Linking centres with digital lines enhances the transfer of data, but carries the expense of installation and there are limits to the accessibility to digital lines, especially in remote areas. Now, fast broadband technology is being used for teledermatology, providing widespread access. There are fewer problems with compatibility of equipment; cheap webcams and free provision of videoconferencing software enable individuals to videoconference

Beyond the Bush Telegraph: Telehealth for Remote Cancer Control and Support
Ian Oliver, Louise Shepherd and Sid Selva-Nayagam
1 The Cancer Council Australia, Sydney NSW
2 Prince of Wales Hospital, NSW
3 Royal Adelaide Hospital, South Australia
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References
2. Australian Health Technology Advisory Committee (AHTAC), Beam and Isotope Radiotherapy - A report of the AHTAC, 1996.
Cancer management is becoming increasingly complex with multimodality treatment and supportive care. One response to this is the formation of multidisciplinary teams of health care practitioners from each treatment modality, palliative care and allied healthcare. Team meetings are also excellent continuing education opportunities. The challenge in rural and remote areas is to assemble such teams so that there is access to specialist information where there are no specialists in residence. There is also the need to try to achieve equity of outcomes by facilitating access for diagnosis and treatment to the rural and remote patient as well as the city one. Analogue videophones to palliative care nurses in Port Pirie (229km from Adelaide, population 15,200) to maintain telephone helplines for patients, their carers and the general public and reviews of these have found that they are widely used for emotional support, however the benefits of helplines have not been fully evaluated.

Studies overseas have shown that although patients have reported benefits from telephone counselling, it has not been easy to show statistically, significant benefits between telephone counselling and control groups. This is because centres offering such counselling, usually have well developed support programs which make it difficult to evaluate the impact of new technology for delivering them. Other trials have detected only small differences because all patients were counselled rather than those with ‘severe’ distress or depression. It is difficult to say whether the patients were benefitting from a useful service despite the leadership expertise not being available in their community.

Analogue telephone system

The analogue telephone system has some useful applications. It has long been used for counselling and is particularly useful for patients who are confined to hospital. The Cancer Councils in each state and territory provide telephone helplines for patients, their carers and the general public and reviews of these have found that they are widely used for emotional support, however the benefits of helplines have not been fully evaluated.

While videophones have been available for several years and has been applied to cancer treatment, little studies have yet evaluated its efficacy or cost-effectiveness.

Teleconferencing

Teleconferencing is well established in psychiatry. Small studies have examined psychological counselling for remote patients with cancer. Certainly the technique was found to be acceptable in one study of terminally ill patients with cancer who received alternating cognitive therapy face-to-face or by videconferencing. A clinical psychologist provided cognitive behavioural therapy to 25 cancer patients in rural Australia and reported that the service was acceptable. More than half of the patients involved had metastatic or advanced disease and there were improvements in terms of quality of life, mood and pain, but only during the intervention.

Videconferencing

The addition of a video image improves the social interaction, as we found in a study of the use of videophones to enhance palliative care outreach nursing in remote South Australia. In this trial we provided analogue videophones to palliative care nurses in Port Pirie (229km from Adelaide, population 15,200) to enable them to provide palliative care to patients when general nurses from the more remote Port Broughton (95km) and Booleroo Centre (65km) visited them in their homes and plugged a video phone into their analogue phone lines. The advantage was more contact between visits, without increased travel for the palliative care nurses and better communication for the patients, who reported better depression work with those they were talking to. Some disadvantages were long setup times if the remote nurse was technophobic and freezing or calls dropping out because of the addition of video over a standard busy phone line.

Installing digital lines enhances the transfer of data, but carries the expense of installation in fixed centres and limits the accessibility, especially in remote areas. Between fixed centres and rural areas, it is certainly feasible to conduct psychotherapy for patients who are confined to bed, for example, in hospice and palliative care. With the potential of videophones to enhance palliative care outreach nursing, investment in telephone networks for videophones to align with telemedicine to palliative care is potentially feasible.

Medical legal issues

The medical legal issues are not unique, but shared by other medical consultations and distant communications. Studies have reported, however, that the increase in technological developments has led to community concerns about the security of health information. This is a very real concern and is the responsibility of the patient and the consultation. Initially we had the slides mailed down, but with improved technology the image was considered sufficient to be able to provide an opinion and the slides were transmitted digitally. Telecytology and teledermatopathology trials have been reported as successful and telepathology has been used between a large academic center (Halifax, Nova Scotia) and a community-based centre (Saint John, New Brunswick) located 400km away. The initial experiment found it feasible, reliable and safe, with the potential to extend neurosurgical expertise to more rural and remote centres. Also in Canada in 2003, the world’s first telerobotic surgical service was established between the Mayo Healthcare Hamilton, a teaching hospital affiliated with McMaster University and North Bay community Hospital 40km away. Procedures included laparoscopic colon resections, again demonstrating the potential exists for exporting surgical expertise from major centres.

Team meetings are also excellent continuing education opportunities. The challenge in rural and remote areas is to assemble such teams so that there is access to specialist information where there are no specialists in residence. There is also the need to try to achieve equity of outcomes by facilitating access for diagnosis and treatment to the rural and remote patient as well as the city one. Analogue videophones to palliative care nurses in Port Pirie (229km from Adelaide, population 15,200) to maintain telephone helplines for patients, their carers and the general public and reviews of these have found that they are widely used for emotional support, however the benefits of helplines have not been fully evaluated.

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patients would like to have seen a recording of the videoconference. A further potential issue is that if there is a link available to remote experts to improve patient care, could the local practitioner be liable for not using it?

Evaluation
There is no standard evaluation of teleoncology or globally agreed parameters for evaluation. Often patient numbers are relatively small because of the small populations in remote centres which preclude randomised comparisons. Most studies have focused on patient and clinician satisfaction with the consultation. As recorded above, where interventions have measurable health outcomes, these have been measured. There has been little prospective evaluation of the economic impact of a telemedicine consultation. Most retrospective evaluations compare the costs of the telemedicine, with the costs of travel for a face-to-face consultation and offset the cost of the equipment and its operation against that. Health outcomes should be evaluated unless it is assumed they will be the same for telemedicine as for a face-to-face consultation. Certainly the equipment is becoming much cheaper as the technology evolves. Patient preferences will be important since remote patients may be prepared to pay more for the convenience of telemedicine, despite equal health outcomes.

Conclusions
Telehealth is one of the solutions to the problems of equity of access to specialist cancer consultations for rural and remote patients. With rapid advances in communication technology, which has seen us progress from analogue telephone lines to broadband internet, videoconferencing is now more accessible to the whole population.

Increasingly, cancer treatment is multimodal and requires management decisions to be made by multidisciplinary teams. These can be created for rural and remote patients by supplementing the clinicians who are geographically available, with experts from distant urban centres using videoconferencing. Moreover, counselling and psychological support can be provided using this technology. In turn, remote psycho-oncology staff can be supported by their urban peers.

Extrapolating from what is already possible, remote diagnosis, treatment planning for radiotherapy and even surgery will extend the reach of expert specialty care to include rural areas.

References
2 Department of Health and Aged Care. Accessibility / Remoteness Index of Australia (ARIA). Canberra: The Department, March 1999 (Occasional Papers Series No.6).
7 Sandgren AK, McCaul KD. Short-term effects of telephone therapy for cancer patients, their carers and families, despite our understanding that this was essential to best outcomes and an acknowledged dearth of psychosocial support for these people.
8 From 1999-2002 Albury and Wodonga health providers participated in the Victorian Breast Services Enhancement Program (BSEP), which demonstrated that coordination of care and multidisciplinary care could work across state, public and private, acute and community health boundaries. The Victorian positions are funded through the Department of Human Services (DHS) Victoria via the Hume Regional Improvement for Cancer Services (RICS). Locally, additional resources are contributed by Wodonga Regional Health Service and Upper Hume Community Health Services.
9 Michael Barton9 and was found to have successfully improved patient care and experience, established care coordination in a regional centre, successfully trialled the role of nursing, cancer care coordinators and modelled cancer care across borders.

The action research nature of the BCCCP had allowed the steering committee to deliver services, while at the same time evaluating their efficacy and refining their processes. At the end of the project phase, the level of cancer services in Albury and Wodonga had increased substantially and sustainably through the investment of additional resources (staff positions) in the region and improved patient care and experience, established care coordination in a regional centre, successfully trialled the role of nursing, cancer care coordinators and modelled cancer care across borders.

Cancer care in north-east Victoria and south-west NSW is complicated by the jurisdictional issues of borders in healthcare: two state health services requiring compliance with respective cancer frameworks, and cancer specialists who are for the most part private practitioners providing services in two public hospitals and two private hospitals. General Practice is Commonwealth-funded, supported through the Border Division of General Practitioners, which services both Albury (NSW) and Wodonga (Victoria) practices.

The difficulties of these jurisdictional issues has led to insufficient in the delivery of cancer and cancer support services to residents based on where they lived, rather than their needs.

Profile cancer services in the region
The twin cities of Albury and Wodonga support a municipal population of 83,000 people within a regional population of 150,000. Provision of chemotherapy and radiation oncology services is to an even larger catchment, estimated at 200,000. Up until 1998 the area had been serviced by cancer outreach services from Melbourne, but now has five resident oncologists, a clinical trials unit and a two machine radiotherapy service, treating some 750 local patients per year. While the clinical services are impressive and substantial, what had been lacking was the coordination of care for cancer patients, their carers and families, despite our understanding that this was essential to best outcomes and an acknowledged dearth of psychosocial support for these people.

Conclusions
The Border Cancer Collaboration is a coordination of care model developed from the documented success of the Border Cancer Care Coordination project. The collaboration is designed to overcome the difficulties of providing equitable services for cancer patients, their carers and families when federal, state, public and private, acute and community health borders exist. It provides a model of potential excellence in cancer care for regional Australia.
The BCCCP has:

- overwhelmingly improved the range and efficiency of multidisciplinary clinics;
- improved the operation of multidisciplinary clinics in all areas and assisted clinicians to make a more efficient use of their time;
- improved access to services, particularly to general support services available in the community. This was a particular asset of a cancer care coordinator with social work background;
- developed a viable model of care coordination outside a major city. BCCCP’s model should influence role design and function of cancer care coordinators rather than be subject to dictates from afar;
- identified and supported patients before and after they travel out of the region for treatment;
- made active attempts to involve general practitioners (GPs) in multidisciplinary clinics in a way that was innovative and leads the field;
- direct applicability to other regions in Australia that have similar geographic and jurisdictional circumstances.

BCCCP appears to have been an excellent implementation of cancer care coordination in a regional setting. The final draft report accurately portrays the project aims, methods and results. It may take several years to measure the full benefits and to assess sustainability.1

Characteristics of effective collaboration

The steering committee members are the decision makers of their respective organisations – CEOs, chairpersons or regional managers – each able to bring resources to the table and to make decisions. They bring individual excellence, defined by Kanter10 as having individual strength and something to contribute to the partnership.

The steering committee, through terms of reference and its formal status, has clear responsibilities and decision making processes. This extends beyond the particular people who formed it and cannot be broken on a whim.11

The committee has created a shared understanding of the aims of the alliance – to provide patient-centred, multidisciplinary coordinated cancer care to our local communities. The literature shows that tailoring the mission and goals to fit the goals of individual member organisations, has been found to increase the chance that members will support the partnership, contribute resources and remain active participants over time.12

In the Border collaboration, all members have to acknowledge the constraints and reporting demand made of the respective members by their funding or political masters. Internal memorandums of understandings and contracts have been developed that allow each partner to be able to fulfil their own individual organisational requirements, while still focusing on the larger picture.

The steering committee has an established history of trust and success (through the BSEP and BCCCP projects) and this has made it easier to coordinate work and divide responsibility.13 The partners have invested in each other with long-term commitments of financial and other resources to the relationship.14

Synergy and transformational leadership

From the inception of the BSEP project the steering committee has achieved synergy the power to combine the perspectives, resources and skills of a group of people and organisations resulting in creativity, comprehensive thinking, practical thinking and ‘transformatic’ thinking.15

All of the steering committee has had to embrace the mantle of transformational leadership.16 Transformational leadership produces change through its emphasis on new values and a vision of the future which transcends the status quo. Such leadership inspires all to put aside their own interests for a collective team; this is what the Border leaders do.

The collaboration now has the opportunity to contribute to market forces through public policy, playing a critical role in fostering competition.17 For example, it is possible that clinicians who do not participate in the multidisciplinary team decisions regarding patient care are missing market leverage and promotional opportunities and could be assessed over time as less attractive to patients. The Border group has attained a high level of domain consensus – the degree to which members agree and accept each others claims regarding products, services and clientele.18

Where to now?

Locally, the collaboration had been able to promote their ‘quick wins’19 and this, coupled with recurrent position funding by the NSW and Victorian governments, has resulted in a service platform which has been able to attract philanthropic and private investment. The collaboration now employs a considerable mixed workforce of professionals supporting cancer care coordination for the region (Table 1).

The collaboration now oversees monthly Albury Wodonga multidisciplinary team meetings for breast, colo-rectal, haematology and urology cancers, and a general tumour stream meeting in the city of Wangaratta. Through the Commonwealth research projects, the collaboration is also developing mentoring links toward multidisciplinary care in head and neck and paediatric cancers.

However, the differing politico-administrative culture of Victoria and NSW in the face of central policy dictates, creates barriers in mounting strategies relevant to local communities.20 The only components of the Border model that are not now recurrently funded are the management and infrastructure costs of keeping the collaborative model intact. This is the real risk of the collaboration. Without the management component to manage staff as an integrated team, to negotiate and manage the complex contracts and memorandums of understanding necessary in complying with various state and Commonwealth demands, the collaboration will have no future.

The Border Cancer Collaboration has overcome the classically renowned and long standing view that healthcare is ‘a strife of interests’.21 The steering committee and staff have achieved this by changing organisational culture in positive ways. The collaboration has built relationships, cooperated over the care of cancer patients and negotiated constructively when difficulties arise.22 The evidence seems to be saying that changing the structure of the financial and delivery aspects of a health system may be a precondition to horizontal and vertical integration, terms derived from economic theory, in patient care.23 Horizontal integration is defined as the integration of activities which occur at the same level in the production process.

Table 1. Professionals supporting cancer care coordination

<table>
<thead>
<tr>
<th>Position</th>
<th>Full-time equivalent</th>
<th>Funding source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer care coordinator - general</td>
<td>1</td>
<td>Cancer Institute NSW GSASHS</td>
</tr>
<tr>
<td>Continuity of care coordinator</td>
<td>0.8</td>
<td>DHNS Victoria – Hume RICS</td>
</tr>
<tr>
<td>Cancer care coordinator</td>
<td>0.8</td>
<td>Wodonga Regional Health Service</td>
</tr>
<tr>
<td>Oncology social worker</td>
<td>0.6</td>
<td>Cancer Institute NSW GSASHS</td>
</tr>
<tr>
<td>Oncology dietetic support</td>
<td>0.2</td>
<td>Cancer Institute NSW GSASHS</td>
</tr>
<tr>
<td>Loss and grief counsellor</td>
<td>0.4</td>
<td>Upper Hume Community Health</td>
</tr>
<tr>
<td>Multidisciplinary team meetings administrator</td>
<td>0.6</td>
<td>Cancer Institute NSW GSASHS</td>
</tr>
<tr>
<td>Multidisciplinary team meetings administrator</td>
<td>0.6</td>
<td>Hume RICS</td>
</tr>
<tr>
<td>Website development and management</td>
<td>0.4</td>
<td>Cancer Institute NSW GSASHS</td>
</tr>
<tr>
<td>McGrath breast care nurse</td>
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<td>McGrath Foundation</td>
</tr>
<tr>
<td>Leukaemia support services coordinator</td>
<td>1.0</td>
<td>Leukaemia Foundation</td>
</tr>
<tr>
<td>Manager mentoring research projects</td>
<td>1.8</td>
<td>Department of Health and Ageing</td>
</tr>
</tbody>
</table>

A key issue for all parties is the need to be able to provide local solutions, while still complying with funding body principles and policies. For example, the NSW Cancer Framework mandates that cancer care coordinators must be nursing positions with direct patient contact, while the Victorian direction does not mandate nursing care, viewing the cancer care coordinator as a position working to develop system capacity, rather than having direct patient contact. Locally, the BCCCP had demonstrated that care coordination could be effective as a non-nursing position, as long as nursing support was available and had also shown that direct patient contact was essential for the role, while still working on systemic development. The success of local work in the context of broader conflicting models, depends on the adoption of evidence-based principles and practice of successful partnerships.

Why is Albury Wodonga cross border cancer care working?

Once the project funding ceased, the steering committee reviewed terms of references and membership in order to facilitate sustainable collaboration.

Working in a regional cross-border setting, all health professionals had a shared understanding of the barriers that borders bring to effective healthcare, and had a true desire to see “good things” resulting from working together for the benefit of cancer patients. We had demonstrated that this could be achieved through our BSEP and BCCCP projects. What was now required was to ensure mainstream, long-term delivery under the models we knew worked for our region.

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In the border collaboration, the community health centre for example, employs the nurse cancer coordinator integrating a new product (cancer nurse coordination) into its more traditional social services product suite. The collaboration has also achieved integration vertically with the acute sector – inpatient surgical and oncology treatments – integrate with the community sector – psychosocial supports, general practice and primary care – to provide seamless continuity of care.

Towards a centre of excellence

Despite the governance arrangements of Australia, many people would agree it is high time we resolved the politico-structural impediments to providing healthcare in an integrated way.1 The multi-tiered nature of the Australian health system, particularly the discrepancies in state-to-state, state-to-federal and public-to-private systems, can create artificial and often frustrating and inefficient ways of working in cancer care. These can be overcome by health services seeking new, more cost effective configurations of services across specialty and organisational structures.2 As the report says: “We should move away from the mantra that country care should be the same as city care – we need innovative models of care that suit residents of rural Australia and deliver for them, equitable services”.3

The evidence, considering rural inequalities in cancer care and outcomes, strongly suggests that we need to develop well-defined patient pathways that each person with cancer can follow to receive timely expert care. Such pathways necessitate effective interaction between the many services involved in cancer care, innovative information systems and cooperation between government and the private sector.

The Border Cancer Collaboration is an innovative and flexible model that is integrating cancer services for our rural communities. It has demonstrated efficient navigable pathways for patients, their families and carers, and effective interaction between providers in multidisciplinary care. It is now time for policy makers at all levels to acknowledge the success of the model and allow the collaboration to develop its full potential as a regional centre of excellence in cancer care. This will involve allowing the assessment of the risk of doing things differently and the resources to allow those risks to be managed.

References
The direct method of standardisation was used for the international data and for all cancer types by Indigenous status. As such, the (then) Aboriginal Health Organisation, local hospital staff, regional medical record administrators and local Aboriginal health agencies to check the accuracy and completeness of recording of Indigenous status. As a result, a more accurate definition of incidence was achieved by Indigenous status than otherwise would have been possible.

Similar projects conducted in the NT and Queensland have greatly increased the quality of data available on cancer in Indigenous Australians. Reference is also made to the data from these jurisdictions. Members of the Department of Health Aboriginal Health Division and the Aboriginal Health Council of South Australia then considered these risk factors to determine the ones potentially most applicable to Indigenous Australians.

**Epidemiological methods**

Relativities of incidence (all cancer types combined) between Indigenous and non-Indigenous South Australians, as determined in the 1988-1994 project, were generalised to the broader 1977-2001 period, with apportioning by cancer type according to the distribution of cancer types by age and sex for that broader period.

The data were standardised by age and sex to the world population, as employed by the International Agency for Research on Cancer, to facilitate international comparison. The direct method of standardisation was used for the international data and for all cancer types combined in SA, whereas the indirect method was substituted for individual cancer types in SA, due to small numbers of these cancers in the Indigenous population, in order to gain greater statistical precision. It was assumed in this context that incidence differences by Indigenous status were consistent by age.

Use was made of 95% confidence limits when identifying likely non-random differences between incidence rates for Indigenous and non-Indigenous populations. Where differences were indicated, risk factors were investigated using the international literature. Members of the Department of Health Aboriginal Health Division and the Aboriginal Health Council of South Australia then considered these risk factors to determine the ones potentially most applicable to Indigenous Australians.

**Cancer incidence**

All cancer types

Indigenous Australians presented a 45% higher cancer death rate than other Australians of equivalent age, with elevated rates of melanoma, lip, prostate, female breast and bowel, where prospects for survival are relatively high. In addition, Indigenous Australians have an elevated risk of cervical cancer.

A corresponding elevation was seen in the Indigenous population of the NT. Again, this underscores the importance of tobacco control. Excess alcohol consumption is another risk factor for these cancers, plus diets low in fruit and vegetables.

**Lung cancer**

A 48% higher incidence was found for Indigenous than other South Australians (Figure 2). Higher elevations were observed in Indigenous populations of the NT and Queensland. As most lung cancers are attributed to tobacco smoking, the opportunity exists to decrease the incidence of this disease through reducing smoking.

**Intra-oral, pharyngeal and oesophageal cancers**

The incidence of these cancers was about three-and-a-half times as high in Indigenous as other South Australians (Figure 2). A corresponding elevation was also seen in the Indigenous population of the NT. Again, this underscores the importance of tobacco control.

**Pancreatic cancer**

The incidence was approximately twice as high in Indigenous as other South Australians (Figure 2), with corresponding elevations presenting in NT incidence and NSW mortality data. Again, tobacco smoking is associated with this cancer, and possibly poor diet.

**Stomach cancer**

This cancer had an incidence about twice as high...
in Indigenous as other South Australians (Figure 2). Diets high in salt and low in fat and vegetables may predispose to these cancers.1,3,11 Incidence figures for Indigenous people are variable around Australia,4 which may reflect variations in Helicobacter pylori infection.

Liver cancer

A marked elevation in incidence was evident in the Indigenous population of SA, at about seven times that of other South Australians (Figure 2). A greater excess was suggested in the NT.1 Apart from excess alcohol intake, risk factors include hepatitis B and C infection, and tobacco smoking.1,12-14 Hepatitis B vaccination has been used to combat this cancer in some populations.13,15

Liver cancer

Liver cancers include an incidence about three times as high in Indigenous as other South Australians (Figure 2). NT data also show an elevation for the Indigenous population.3 These cancers are often found when already well advanced and are often fatal. Lack of access to diagnostic facilities for regional and remote Indigenous communities would be a likely contributor.

Cervical cancer

A four-fold elevation in incidence applied to Indigenous compared with non-Indigenous South Australians (Figure 2). Corresponding elevations were evident from the NT and Queensland data.3,4 These elevations have implications for screening programs and for priority setting when delivering human papillomavirus vaccination.15

Unspecified cancers

Cancers of unknown organ origin had an incidence about 56% lower in Indigenous than non-Indigenous South Australians (Figure 3). This would reflect the protective effects of skin colouring for these sun-related cancers.21 Probably for similar reasons, no lip cancers were observed in the Indigenous population (Figure 3).

Prostate cancer

Indigenous South Australians had an incidence almost 80% lower than the non-Indigenous population (Figure 3). Insofar as these cancers have an upper socio-economic gradient, it would be expected that incidence rates would be lower in Indigenous people.12,13 Numbers of diagnosed prostate cancers are strongly influenced by prostate specific antigen (PSA) testing,12,13 which may be less common in Indigenous Australians.

Female breast cancer

The incidence in Indigenous women was about half that in non-Indigenous women (Figure 3). Corresponding findings also applied for the NT and Queensland.3 There are probably a number of explanations whereby Indigenous women tend to have their first full-term pregnancy at a younger age, and to have a higher parity, which is likely to be protective against breast cancer.13,14 In addition, their participation in breast screening programs is less common,13 such that breast cancer detection rates are likely to be lower.

Bowel cancer

An incidence in Indigenous people about 55% lower than for the non-Indigenous population was evident (Figure 3). Lower rates were also seen for Indigenous residents of the NT and Queensland.1 Again, insofar as these cancers have an upper socio-economic gradient, this finding would be expected.12,13 In addition, faecal occult blood testing (FOBT), which can increase the detection rate for these cancers, may be less common in the Indigenous population.13

Haematological cancers

The incidence of these cancers was about 42% lower in Indigenous than non-Indigenous South Australians (Figure 3). Confirmatory evidence has been found for the NT, in that lymphoma risk tended to be lower in the Indigenous population.4 These cancers have been linked to immune system disorders.11 Further research is warranted to explore differences and reasons for differences in incidence between Indigenous and non-Indigenous Australians.

Differences in survival

The results so far presented indicate that cancers in Indigenous Australians include a higher proportion of the more lethal types and a lower proportion of the less lethal types. However, this appears not to account fully for differences in survival. In SA, the five-year survival from cancer of Indigenous patients was 37% in 1988-1994, as compared with about 56% for other South Australians.6 Had non-Indigenous patients had the same distribution of cancer types as Indigenous patients, and the same age profile, their five-year survival still would have been 49%, which greatly exceeds the 37% for Indigenous patients.4

Cancers are found at a more advanced stage of progression in Indigenous than non-Indigenous patients, as indicated by SA, Queensland and NT data.4,10,13,21 However, further adjustment of survival for Indigenous and non-Indigenous patients in SA, by stage of progression of cancer at diagnosis, still left a survival deficit for Indigenous patients (p<0.051).21

More recent survival data from the NT and Queensland are confirmatory, in that survival differences were not fully explained by type of cancer or stage of progression of cancer at diagnosis.2,21 In the NT, the deficit in survival in Indigenous patients after stage adjustment was observed to be comparable with that observed in an Indigenous language.21 There is also evidence from the NT and Queensland that Indigenous patients obtain less comprehensive treatment,2,21 which would be less conducive to cure. In addition, higher levels of co-morbidity are likely to complicate the treatment of many Indigenous patients.21

Future direction

Steps that could be taken to reduce cancer incidence in Indigenous Australians have been specified already. They include addressing specific risk factors, such as smoking, poor diet, excess alcohol consumption and obesity, and undertaking vaccination programs. In addition, earlier detection should be pursued through screening and related early detection initiatives.21 These control measures are the same as those required by the non-Indigenous population. However, additional challenges present in many Indigenous communities due to socio-economic deprivation, cultural marginalisation and geographic isolation.

Cancer control initiatives for Indigenous people are likely to be most effective when there is a devolution of decision-making to local communities to define their health needs and priorities.21 Mainstream health services should include Indigenous people in their governance structures and partner with the Indigenous health sector to promote culturally acceptable services, as advocated by the Australian Health Ministers’ Advisory Council.21 Service providers should be educated about Indigenous culture and about culturally safe and respectful care, as built into the action plans of a number of Australian Health agencies.21 Outreach health services should be introduced, wherever practicable, for remote Indigenous populations, and appropriate transport and accommodation should be available when remote residents need to travel to metropolitan centres for care.

Reference

CANCER SERVICES TO BE PROUD OF IN RURAL AUSTRALIA: LESSONS LEARNED FROM THE CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA CANCER SERVICE AUDIT

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2 Border Medical Oncology, Albury-Wodonga
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Abstract
Recent evidence suggests that there are differences in cancer outcomes between metropolitan and rural/ regional areas in Australia and internationally1-3. Late stage of presentation as a consequence of delayed diagnosis has been identified as a key driver in these differences.4-8 Improved access to cancer services, particularly regional centres, can improve patient outcomes.9,10 The first step in solving any problem is to clearly define and understand the extent of the problem. In this regard, COSA’s effort to analyse existing services in rural Australia and to compare them with identified metropolitan and regional standards can be seen as the first step towards understanding the disparities and developing effective solutions.11-13

When Martin Luther King quoted the words “we hold these truths to be self-evident, that all men are created equal,” he had in mind a very different disparity that exists in rural Australia and internationally. Reasons for this disparity are numerous, such as a lack of standardized care, a relative scarcity of resources and an efficient referral system. Moreover, the rural health care issue is both a health services and a population-based issue. The rural health care issue is one that has been extensively studied and its impact is felt in many parts of the country by the deepening of disparities. For those passionate about healthcare reform in rural Australia, it has been pleasing to see that government bodies like the Australian Health Ministers’ Advisory Council and Cancer Council Australia have found that disparity in cancer outcomes is a reality, which is to be addressed as a matter of urgency.14-16

The Australian Cancer Forum’s “Cancer services to be proud of in rural Australia: lessons learnt from the Clinical Oncological Society of Australia Cancer Service Audit” provides a valuable analysis of the current state of cancer services in rural Australia and how it compares with metropolitan standards. The report identifies areas for improvement and provides recommendations for future action. In particular, it highlights the importance of ensuring that cancer services in rural areas are properly funded and supported to improve patient outcomes.

The COSA report is an important contribution to the ongoing effort to improve cancer services in rural Australia. It serves as a reminder that, while there have been significant improvements in recent years, there is still much work to be done to ensure that all Australians have equal access to high-quality cancer care. The report also underscores the need for continued investment in research and education to address the challenges faced by rural cancer services.

The COSA report is a call to action for all stakeholders involved in cancer care. It is a reminder that, while progress has been made, much remains to be done to ensure that all Australians have equal access to high-quality cancer care. The report serves as a catalyst for further action and highlights the importance of collaboration and commitment to achieving the best possible outcomes for all Australians.
of their resources and to build regional oncology centres that they and their communities can be proud of.

Change is often challenging for bureaucrats, however, established patterns of management need to be analysed and altered where they are producing inferior clinical outcomes. One example of this is the widespread reliance on medical outreach clinics from metropolitan centres. These services provide crucial medical input in centres too small for a regional oncology centre, but in themselves can delay the move to a regional oncology centre model due to perceived cost savings.

Good quality cancer care does cost money, however a full-time medical presence in a regional centre provides significant cost savings as well as quality improvements, which need to be articulated to area health services.

Can the quality of regional oncology centres be maintained?

It is sometimes argued that the isolation of regional practice will necessarily lead to gradual erosion in quality. This may be true in an under-resourced and understaffed regional oncology centre, where the pressures of patient care and administration squeeze out peer review and continuing education.

It is contingent upon quality planners and professional bodies to provide mechanisms to support regional oncology centres, which may be staffed by one to two cancer specialists in each sub specialty, as well as smaller numbers of cancer nurses and allied health professionals. These facilities will need funding and programs which enable attendance at national and international conferences through provision of locums, travel grants and other forms of professional support.

While there are significant advantages to being in a large metropolitan department, there are many joys to be had as a clinician in a regional community, where one’s involvement and contribution to a community can be powerful and extremely satisfying. Cancer clinicians also need adequate support from diagnostic services, such as radiology and pathology services. Any review of oncology centres needs to guarantee the quality and consistency of these vital inputs to cancer decision making.

In this information technology age, it seems crucial for issues of quality and safety that we make use of technological advances to improve our provision of cancer care. The Cancer Institute NSW has recognised the importance of this with the development of the C-SYCT protocol website, and with moves to consider how information technology tools can be used more effectively, in both metropolitan and regional Australia.

Research and education

Two of the great pillars of cancer practice in the 21st century are clinical research and medical/nursing education. As part of the endeavor to select, build and staff regional oncology centres, there must be a will to promote and resource high quality clinical cancer research and the education of students and undergraduates.

The benefits of clinical research are well understood for both patients and clinicians. Funding to seed research programs, as well as sustain them, is of crucial importance. Clinical research is one of the first things to go when patient load increases and efforts to provide protected time for regional clinicians to conduct research should be encouraged. Investment in rural medical and nursing schools in Australia should be commended as an initiative that is likely to bear fruit in terms of rural cancer clinicians in the long term.

To persuade a clinician who has grown up in metropolitan Australia and done all of their training there, to move to regional Australia at the completion of their training, is a near impossible task. However, to encourage individuals who have had a breadth of exposure to all types of career options is likely to encourage them to choose a regional/rural pathway.

Conclusions

The COSA report has provided a sobering snapshot into the state of rural and regional cancer services. Its recommendations divide rural cancer services into regional oncology centres and those without the current size and infrastructure to justify such a development. It is vital that we not only work at identifying and developing the regional oncology centres, but adequately resource those centres in smaller, more remote communities, with the basic facilities that they require to provide adequate cancer care for their populations. In centres where this cannot be justified, we need to look more carefully at the travel and accommodation needs of patients, so that they can equitably access regional oncology centres.

As a society we need to decide whether cancer care for Australians is a right or a privilege. If we believe that it is a right, then we need to work out how best to provide adequate levels of service for even the most remote and disadvantaged. It is pleasing to see the focus on rural and regional Australia, however it is crucial that we rapidly turn our good intentions into practical suggestions, concrete plans and rural oncology centres that we can all be justifiably proud of. We need all levels of government to recognise the problem and work together to put solutions in place.

References


Health workers’ perceptions of psychosocial support services for cancer patients in rural Victoria

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Abstract

Literature attests to the fact that psychosocial needs for cancer patients are not being adequately addressed. The tools, frameworks and guidelines developed, reflect differing professional perspectives and models of disease. Most studies have usually looked at what is happening from the patient and family’s viewpoint in terms of medical and other needs. New national initiatives in psychosocial care include the organisation of nationwide practitioner workshops to encourage the implementation of the Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer. These guidelines focus mainly on the emotional and existential areas of need.

The aim of this study was to understand how a diversity of approaches and professional perspectives play out in everyday practice within a rural context; see how issues of distance and access affect this process; and highlight the deficiencies in the delivery of psychosocial services for cancer patients in rural Victoria. The study involved 59 questionnaire respondents (a 71% response rate), from which two interviews and six focus group discussions were drawn.

Key findings were: regional and metropolitan hospitals and specialists not referring for support services; private cancer patients’ journey. McGrath4 suggests that this should occur at the time of diagnosis. Hill et al, Pascoe et al, and Marlow et al acknowledge that the initial steps in the professional intervention, the process of need identification and the elicitation of patient concerns are specialised skills. By discussing the need for assessment training, Hill5 reinforces this viewpoint. Furthermore, over the course of cancer, the diagnostic, pre-treatment, treatment and post-treatment phases, patients and their families needs do not remain static. That is, their experience of illness changes.

Researchers from a range of health disciplines have studied cancer patient and family needs and concerns. The tools, frameworks and guidelines that they have developed reflect the authors’ differing professional perspectives and models of disease, including reductionist biomedical and bio-psychosocial frameworks. Some have developed tools to measure patient need such as the Supportive Care Needs Survey1 and the Breast Cancer Patients’ Needs Questionnaire.1 Many of the tools incorporate patient or family, medical and non-medical needs.

Differing psychosocial frameworks and conceptions have been developed. Coates et al,1 Sanson-Fisher et al,1 Sanson-Fisher et al,1 Bloom et al1, and Bonevski et al1 categorise needs using concepts relating to the individual such as, emotional, physical, psychological, instrumental or tangible, and spiritual. The Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer4 focuses mainly on the emotional and existential areas of need, however also acknowledges the importance of the practical needs. The overarching schema of practical, emotional and existential needs is another useful typology.1 Wright et al1 break down the areas of need spatially into the domains of home, workplace and recreation and Marlow et al also come from the patients’ subjective experience using constructs such as “sense of control”. Patient needs are multidimensional.1,24 Furthermore, there is a presumption in some studies that psychosocial problems require an action, resolution or answer.1 However, sometimes validation is all that is warranted. Overall, patient psychosocial needs can be perceived and constructed from worker/outside perspectives or patient/family perspectives.1

Most studies have usually looked at what is happening from the patient and family’s viewpoint in terms of medical and other needs and have focused on the support received. Often the studies have presented findings that represent population types (for example rural, a particular cancer stream), rather than identifiable communities and specific healthcare organisations.

The current focus on improving cancer patient care has seen the production of guidelines at a national level for psychosocial care of adults with cancer.15 New initiatives include the organisation of nationwide practitioner workshops to encourage the implementation of these guidelines16 and the development of a tiered model of psychosocial care in oncology by The Cancer Council Queensland.17 In the UK, guidelines have been developed to critique existing services and implement improved service delivery.18

Problems of delivery of health services in rural areas in Australia centre around shortages of specialised skilled workers, difficulties of services accessing resources19 and the incorporation of new approaches in healthcare.20 We know of the difficulties of costs, accommodation and separation of seriously ill patients travelling to access services.21

Often the tools, measures and frameworks discussed above reflect the diversity of approaches and professional perspectives involved in contemporary healthcare. The aim of this paper is to: understand how this diversity of approaches and professional perspectives play out in everyday practice within a rural context; see how issues of distance and access affect this process; and highlight the deficiencies in the delivery of psychosocial services for cancer patients in rural Victoria.

Procedure

This study was carried out in the Grampians region, Victoria, in 2005. The region has 11 health services, including 23 public hospitals with acute beds, one private hospital and one private cancer treatment centre. From 2000-2002 there were 2992 new cancer cases diagnosed in the region.22

The overarching framework of practical, emotional and existential domains23 was adopted because it covered the diversity of patient needs at a range of levels and was accessible from health professionals’ perspectives, whether or not they were working within a biomedical model.

Participants targeted were nurses, occupational therapists, psychologists, social welfare workers and a lymphoedema physiotherapist. These workers saw most cancer patients, usually had most interactions with these patients and addressed most psychosocial needs either themselves or took the responsibility to refer on. Key organisations involved were hospitals, community health centres, treatment centres (chemotherapy and radiotherapy), carer services, district nursing and palliative care services. Eighty-two letters of introduction and accompanying questionnaires were mailed to all relevant known practitioners, in organisations delivering services to cancer patients in the Grampians region. The study involved 59 questionnaire respondents (a 71% response rate), from which two interviews and six focus group discussions were drawn.

The breakdown of the 59 respondents to the questionnaire was:

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>37</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>5</td>
</tr>
<tr>
<td>Social workers</td>
<td>8</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1</td>
</tr>
<tr>
<td>Managers</td>
<td>8</td>
</tr>
<tr>
<td>By organisation:</td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>34</td>
</tr>
<tr>
<td>District nursing</td>
<td>4</td>
</tr>
<tr>
<td>Palliative care</td>
<td>4</td>
</tr>
<tr>
<td>Community health</td>
<td>10</td>
</tr>
<tr>
<td>Carers</td>
<td>3</td>
</tr>
<tr>
<td>Radiotherapy/chemotherapy treatment</td>
<td>3</td>
</tr>
</tbody>
</table>

Findings

The following six themes were deemed of highest significance by all focus groups:

1. Regional and metropolitan hospitals and specialists not of questionnaire findings; and prioritisation of themes. The same focus group structure and content was used for the two interviews when only one focus group member was able to attend.

The qualitative data from questionnaires was analysed according to themes and geographic locations and then questionnaire respondent comments were checked with focus groups during discussions. Recordings of focus group discussions were analysed according to themes, then categorised according to whether they were common across the region or specific to a particular town. Themes for analysis were extracted in an evolving process, building first from questionnaire responses and then developed in interview and focus groups, where two more themes were added. An item had to be reiterated at least three times to be considered a theme. Findings were prioritised according to the rank ordering of themes by focus groups.
we can assist with symptom control, rather than patients.

Late referrals to palliative care and district nursing

There's no clear pathway from the medical centre to local support services was seen as a major concern. GPs not referring to support services; and

Discussion

This study suggests that the delivery of psychosocial care for cancer patients in rural Victoria is haphazard. There is an overlap of some services and gaps in other services and apparently a diminution of services the more rural the region.

There is a lack of clarity about the kinds of tasks undertaken by the different professionals and health workers themselves have diverse perceptions about their roles. For example, one occupational therapist saw her/his role as providing grief counselling and another did not see he/she offered any psychosocial support at all. In another town, nurses and social workers were both providing assistance with financial needs of patients. In many cases these professionals were working from quite different models of disease, as formerly discussed by Sprenger,1 sometimes because they represented different professions and sometimes just because of the kind of person they were and the world they lived in. Because they were all nurses for example, it didn't necessarily follow that they shared the same disease model. These factors, of themselves, merely outline a problem. However, for patients and doctors wanting to access services, the pathways can be extremely unclear.

When there is a lack of services and shortage of specialised workers, healthcare workers have the need of necessity being creative and flexible in order to meet the needs of patients, as described by Wilkes et al19 and Murray et al.20 They are practicing psychosocial care at varying levels. Some of the workers demonstrated a lack of understanding about the range and complexity of psychosocial needs. They were unfamiliar with existing frameworks and guidelines and unaware that validation was just as legitimate as an action or resolution, as Markov et al have argued. Furthermore, depending on a town’s health worker networking and communication patterns, patients can be serviced appropriately, inadequately, ineffectively or not at all.

Phrases like “that’s the way it’s always been here” and “that’s the way it’s always been that way” were encountered by the medical centre to services. They’ve [GPs] known the person for a long while and followed up by a specialist privately, they were unlikely to be referred back to support services in their local community. “You’ve got to be careful,” said a health worker in a rural town. If a patient from a Melbourne hospital is a public patient they get great service. If they’re a private patient, going to the private hospital; seen by a private practitioner in his /her rooms, they’re the ones that slip through the net. The only way we pick those up is if the family knows our service and ring us, or if the GP sees them quickly after their return and refers, or if a friend will ring up.21

GPs not referring to support services

Except for workers in Ballarat, GPs not referring patients to local support services was seen as a major concern. “There’s no contact anywhere” were the replies to the question “Who do you turn to?” Many workers stated that if the patient was being treated in a private Melbourne hospital and followed up by a specialist privately, they were unlikely to be referred back to support services in their local community. “You’ve got to be careful,” said a health worker in a rural town. If a patient from a Melbourne hospital is a public patient they get great service. If they’re a private patient, going to the private hospital; seen by a private practitioner in his /her rooms, they’re the ones that slip through the net. The only way we pick those up is if the family knows our service and ring us, or if the GP sees them quickly after their return and refers, or if a friend will ring up.21

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Referring for support services

We can assist with symptom control, rather than patients.
Providing accommodation services for rural cancer patients: the experience in south Australia

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Abstract

People from rural and remote areas face additional psychological and financial burdens associated with the need to travel for cancer treatment and follow-up. To reduce these burdens, The Cancer Council South Australia has established an affordable accommodation service that provides a friendly, homely, supportive environment, where people from non-metropolitan areas can stay while accessing treatment services in the city. The model adopted is very similar to the concept of ‘hope lodges’ advocated by the International Union Against Cancer, in that it focuses on the needs of guests.

A key aspect of the service is the provision of practical and psychosocial support. Support is provided through a variety of avenues; a qualified social worker on site, trained volunteer visitors, social and recreation programs to encourage informal peer support and transport to major treatment centres. These services are available to people with cancer, their carers and any family or friends staying with them.

In many countries around the world, people with cancer often face difficulties accessing effective care because of the need to travel long distances to treatment centres.1 This is true for Australia where it is estimated that approximately 30% of all people with cancer live outside a major population centre.2 Rural and remote residents experience more problems and concerns associated with travel for treatment and follow-up care, than their peers who reside in urban or regional cities.

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Following the purchase of Seaview Lodge, priority was placed on improving and extending services to other communities. The most significant development was the appointment of a social worker to work across both sites. The support coordination role now established in response to both the research literature and community feedback. Evidence from the literature indicates that psychosocial interventions are associated with improved physical and psychological outcomes for people affected by cancer.3 Consultations conducted by The Cancer Council South Australia with rural cancer patients and carers have identified a need for better liaison between metropolitan services and rural communities (internal report).

In 2003, the Board again reviewed future accommodation needs. Findings indicated that The Cancer Council was likely to meet the demands from rural and remote South Australians attending for radiotherapy for the next five years, but would need to increase capacity to cater for other cancer care needs (eg. investigation, assessment, chemotherapy, follow-up care), as well as clients coming from Mildura (Victoria), Northern Territory and Broken Hill (NSW). In light of this, the Board began investigating opportunities to expand the current style of accommodation and support. In July 2006, The Cancer Council South Australia purchased another 75-room motel complex adjacent to the city, which is currently being developed along the lines of Greenhill Lodge. Once capacity is fully operational the total capacity will be 130 rooms.

The facilities and services

Support services

Cancer patients who feel well supported, tend to have better health outcomes and cope better with having cancer.4 Particular importance is placed on ensuring a supportive environment for people who are a long way from their usual social network, as well as clients coming from far away areas.

Support is provided through a variety of avenues; a qualified social worker on site, trained volunteer visitors, social and recreation programs to encourage informal peer support and transport to major treatment centres. These services are available to people with cancer, their carers and any family or friends staying with them.
The support worker coordinates and supervises a group by The Cancer Council, which is located next door or information and support resources and programs offered. In addition, guests also have access to the full range of emotional and financial issues.

Volunteer programs
The support worker coordinates and supervises a group of volunteers, including friendly visiting volunteers who meet with guests on a weekly basis and provide social contact and practical assistance such as transport to other appointments or shopping. They also facilitate links with other services as needed.

Volunteers are involved in providing recreational activities such as cooking classes, art classes or event-based functions such as the Melbourne Cup lunch. Activities are held in the recreation room at Greenhill Lodge and are open to patients and family members. Activities such as craft and cooking are hosted by volunteers with skills in a specific area, who are often personally affected by cancer themselves, and occur on a weekly basis. Weekend bus trips are also provided to extend support to those people who cannot travel home for the weekends or are isolated from family and friends.

Managing the service
Running a facility such as Greenhill Lodge is based on the same principles as a commercial accommodation facility, with standard operating procedures relating to reservations and services offered. The ambiance of the property is purposely designed to create a homely atmosphere. The major difference between commercial facilities and the lodges is the level of understanding needed by employees in relation to guest needs. This applies to housekeepers, volunteers, catering and reception staff. To equip staff with skills to relate effectively with guests, a specialised training program was developed for accommodation services. Delivered over two sessions to staff from all sections (catering, housekeeping and reception), the program focused on developing empathetic communication styles. It also emphasised the need to recognise when guests need additional support and refer them to professional support services (ie. the social worker).

No medical services are offered or available. Guests are required to be able to care for themselves, or have a carer present at all times. Whilst staff are present at Greenhill Lodge 24 hours a day, emergency situations are handled by phoning an ambulance. The response time is approximately seven minutes.

Occupancy at Greenhill Lodge now averages in excess of 90% per annum. A commercial hotel of this size would be closer to 65%. This places considerable stress on the resources, both human and physical.

Financial aspects
The operation of a facility such as Greenhill Lodge has required a careful balance between what is needed by clients and the financial viability of this model of operation (Figure 2). A cash surplus allows for the provision of extra services not normally associated with a commercial operation and the ongoing upgrading of facilities.

The accommodation facilities also provide a focal point for various fundraising events undertaken by The Cancer Council South Australia branches. Sixteen of the 17 branches are located in rural areas of South Australia, hence potential donors can see direct links and benefits for their communities. Accommodation services have been a central theme in rural doorknock appeals in the past and continue to be promoted in relation to other major Cancer Council events in regional areas. Daffodil Day. Individual branches also run their own local events with specific fundraising objectives. For example, one rural branch held a concert to raise money to purchase an additional bus for Greenhill Lodge. A large number of donations are also received from former guests and family members, either directly or through in memoriam donations and bequests.
address guests’ practical and emotional needs is a priority. Feedback indicates that the provision of services to guests has been consistent and supportive. All guests indicated they would recommend Greenhill Lodge to others. 566 (99.7%) indicated they would stay at Greenhill Lodge again in the future. All guests indicated they would recommend Greenhill Lodge to others. 566 (99.7%) indicated they would stay at Greenhill Lodge again in the future.

Evaluation and continuous improvement

Surveys of guest satisfaction at Greenhill Lodge have been undertaken annually since 2000, as part of The Cancer Council’s commitment to continuous improvement. Each year, all non-commercial guests staying at Greenhill Lodge during a specific month are sent a postal survey, four to six weeks after their stay, which they could complete and return anonymously. Response rates have ranged from 65% to 79%. Due to the smaller number, only one survey of Seaview Lodge guests has been undertaken.

Trends indicate a change in the profile of Greenhill Lodge guests over the past six years, with significant decreases in both the mean length of stay (35 days in 2000, compared with 18 days in 2005) and the proportion receiving radiotherapy while at the Lodge (67% in 2000, compared with 40% in 2005). In 2005, only 30% of those surveyed were first time guests (Figure 3).

Satisfaction with the facilities and services has been consistently high. Of the 568 guests surveyed in total, 566 (99.7%) indicated they would stay at Greenhill Lodge again in the future. All guests indicated they would recommend Greenhill Lodge to others. Guest feedback has led to continuous improvements in the facilities and services provided at the Lodge. For example, the kitchen facilities have been upgraded and larger fridges placed in rooms, in response to guests’ desire for more self-catering options. Room upgrades have incorporated guests’ suggestions where possible. Additional information has been added to the information directory, reflecting guests’ needs. Greater restrictions have been placed on smoking at Greenhill Lodge in light of a notable shift in attitudes and numerous negative comments about exposure to others’ “second-hand” smoke (Table 3).

Seaview Lodge guests rate the facilities as highly as those at Greenhill Lodge. While the self-catering style was preferred by many, a few guests felt isolated and unsupported at Seaview Lodge. This feedback has led to a stronger commitment to ensuring Seaview Lodge guests are aware of and have access to support services at Greenhill Lodge.

Conclusion

The Cancer Council South Australia has been committed to supporting rural communities through the provision of affordable, supportive accommodation for rural patients and their families. The model adopted by The Cancer Council South Australia has proved to be highly successful, both in terms of its popularity with guests and as a viable financial venture. In our experience it is possible to provide a quality accommodation service and return a profit, which can be utilised to continually improve facilities for guests. Success has been due to sound financial management, continued growth in demand, ongoing evidence-based improvements, well-integrated support services and strong community support for such a service. In light of our positive experience, The Cancer Council South Australia endorses the concept of hope lodges. We encourage other organisations interested in supporting people with cancer (or other medical conditions) to consider establishing similar facilities where there is an obvious need.

References


Table 1. Guests’ use of services at Greenhill Lodge

<table>
<thead>
<tr>
<th>Use of support services at Greenhill Lodge</th>
<th>Per cent of Greenhill Lodge survey respondents (2001-2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Short stay &lt;7days+ (n=218)</td>
</tr>
<tr>
<td>Used bus/transport service</td>
<td>45</td>
</tr>
<tr>
<td>Used dining room service</td>
<td>60</td>
</tr>
<tr>
<td>Used guest kitchen</td>
<td>44</td>
</tr>
<tr>
<td>Used recreation room</td>
<td>25</td>
</tr>
<tr>
<td>Used information directory</td>
<td>82</td>
</tr>
<tr>
<td>Had contact with friendly visitor</td>
<td>19</td>
</tr>
<tr>
<td>Had contact with support worker</td>
<td>15</td>
</tr>
<tr>
<td>Attended recreation program</td>
<td>8</td>
</tr>
<tr>
<td>Used Cancer Council services/resources</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 2. Helpfulness of services at Greenhill Lodge

<table>
<thead>
<tr>
<th>Helpfulness/convenience of Greenhill Lodge services</th>
<th>Per cent of guests surveyed who used service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very good or good</td>
</tr>
<tr>
<td>Helpfulness of the visitor program (n=84)</td>
<td>92</td>
</tr>
<tr>
<td>Helpfulness of the support worker (n=63)</td>
<td>95</td>
</tr>
<tr>
<td>Rating information and recreation programs (n=84)</td>
<td>98</td>
</tr>
<tr>
<td>Convenience of accommodation services (n=444)</td>
<td>99</td>
</tr>
<tr>
<td>Convenience of guest kitchen (n=282)</td>
<td>99</td>
</tr>
<tr>
<td>Reliability of transport service (n=296)</td>
<td>100</td>
</tr>
<tr>
<td>Usefulness of the information directory (n=355)</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 3. Guests’ views on smoking restrictions at Greenhill Lodge

<table>
<thead>
<tr>
<th>Policy re smoking at Greenhill Lodge</th>
<th>Per cent of guests surveyed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2003</td>
</tr>
<tr>
<td></td>
<td>(n=85)</td>
</tr>
<tr>
<td>Smoking allowed anywhere outdoors</td>
<td>24.7</td>
</tr>
<tr>
<td>Smoking banned</td>
<td>18.8</td>
</tr>
<tr>
<td>Smoking in designated areas</td>
<td>56.5</td>
</tr>
<tr>
<td>Smoking allowed anywhere outdoors</td>
<td>24.7</td>
</tr>
</tbody>
</table>

Figure 3. Length of stay and per cent having radiotherapy (2000-2005)
\section*{Australian Behavioural Research in Cancer}

\subsection*{Viertel Centre for Research in Cancer Control (VCRCC), Queensland}

Pilot project to investigate the supportive care needs and adjustment concerns of adults with brain tumours and their carers.

A collaboration between The Cancer Council Queensland, Griffith University and BrizBrain and Spine, this pilot project was developed in response to a need for better understanding of the impact of primary brain tumours on individuals and their families and their associated supportive care needs.

The results will inform the development of a larger study to assist in providing strategic direction for the development of future resources and services, including The Cancer Council Queensland's Brain Tumour Support Service, Cancer Helpline and Cancer Counselling Service, as well as external cancer care services.

The pilot project aims to:

1. Describe the medical and allied health support provided to individuals with a brain tumour and their families;
2. Complete a supportive care needs assessment of individuals with brain tumours and their families;
3. Understand the quality of life of people with brain tumours and their families;
4. Investigate patterns and relationships between individuals' cognitive abilities, neuropsychological assessment and support needs;
5. Understand the economic impact to individuals and families associated with brain tumour diagnosis and treatment and how this relates to their quality of life.

Approximately 80 adults with brain tumours will be recruited to the study via The Cancer Council Queensland Brain Tumour Support Service and BrizBrain and Spine neurosurgical practice. BrizBrain and Spine patients will provide the point of view of recently diagnosed patients, while approximately half of the members of the Brain Tumour Support Service are five to 10 years post-diagnosis. The study will be conducted in two stages. In stage one, individuals will take part in a semi-structured interview investigating emotional well-being, psychological functioning and quality of life. In stage two, individuals will have the option of undergoing cognitive and neuropsychological testing.

The project will commence with the recruitment of participants in early 2007 and will run until the end of 2007. The results of the pilot study will inform the development of a larger study for which external funding will be sought in 2008.

\subsection*{Centre for Cancer Control Research (CCCR) & Tobacco Control Research and Evaluation Program (TCRE), South Australia}

Solaria compliance in metropolitan Adelaide (CCCR)

A study of 30 randomly selected solaria was conducted in December 2006 to assess the level of compliance that solaria in Adelaide have with the Australia/New Zealand Standard for solaria use for cosmetic purposes. Results revealed a very low level of compliance to the standard, with most centres allowing access to under-aged people and people with fair skin. This shows the need for the regulation of solarium centres in order to reduce skin cancer risk.

Evaluation of smoking cessation education among dental hygiene students (TCRE)

TCRE is working with QuitSA to determine whether knowledge, attitudes and delivery of a clinical intervention about tobacco education for dental patients improve over time among students participating in a tobacco cessation intervention course. Results will be available in 2008.

Evaluation of three QuitSA interventions to increase interaction with Quitline advisors (TCRE)

TCRE is evaluating the effects of three separate interventions to increase the proportion of callers who discuss smoking cessation with a Quitline advisor, rather than terminate the call after requesting written materials on quitting. The interventions involve increasing access to Quitline advisors and follow-up contact with callers requesting only written information. Results will be available in late 2007.

Evaluation of smoke-free hospitality legislation in South Australia (TCRE)
TCRE is undertaking a comprehensive evaluation of the smoke-free hospitality legislation, which is due to take effect from 31 October this year. As part of this evaluation a survey will assess venue compliance with current phase-in provisions and to assess bar managers opinions of the impending laws. Results will be available in early 2008.

Centre for Behavioural Research in Cancer Control (CBRCC), Western Australia

Longitudinal investigation of pharmacological smoking cessation aids in real-life settings

CBRCC has commenced its longitudinal study from 2007 to 2009 to track the incidental use of pharmacological smoking cessation aids by smokers, as funded by the National Health and Medical Research Council. To date 1300 smokers have been successfully recruited and initial interviews have been conducted. Recurrent interviews will now take place every three months for the next two years to measure attitudes towards and reasons for use of pharmacological smoking cessation aids, tracked by advertising, previous personal experience, health professional recommendations and recommendations from family and friends. That’s disgusting! Evaluation of a youth tobacco control advertisement distributed by chain-email deemed too vulgar for television (but the kids loved it!)

Most adolescents appear unmoved by warnings about the long-term health consequences of smoking: they believe they have time to quit ‘before it gets to them’. However they are particularly sensitive to the short-term cosmetic effects of smoking such as bad breath, smelly hair and bad skin. Indeed a common word-association adolescents provide for smoking is “disgusting”.

A series of near-finished television advertisements was developed with funding from Healthway to strengthen this association by overtly associating smoking with other things disgusting, including excrement, cockroaches and maggots. In partnership with The Cancer Council WA these advertisements will be distributed using chain-emails and assessed via an online survey in 2007. The number of hits to the advertisement webpage and origin of viewers will be automatically tallied using Webalizer software.

Reducing overweight and obesity in mothers with young children (MYC)

Funded by Healthway for two years, this project will develop, implement and evaluate a community-based intervention to influence the physical activity and nutrition behaviours of mothers with young children attending playgroups in Western Australia. It is expected to reduce prevalence of overweight and obesity in this group over the long-term. As women still do the majority of childcare in Australia, an intervention that successully improves physical activity and nutrition behaviours will also impact on behaviours of the family, making it a ‘whole family’ approach.

Centre for Behavioural Research in Cancer Control (CBRCC), Victoria

The prostate cancer screening debate: public reaction to medical controversy in the media

This study explored older men’s and their partners’ reactions to a television news program on the medical debate surrounding the use of the prostate-specific antigen (PSA) test for prostate cancer screening. Both qualitative (six focus groups) and quantitative (self-completion questionnaire) methods were employed. In general, viewers seemed to appreciate from the debate that there was controversy surrounding prostate cancer screening and they recognised that PSA testing is more applicable to certain sub-groups of men.

Additionally, it appeared that exposing health consumers to medical uncertainty and expert conflict can help raise awareness of the issues and complexities involved. However, there was evidence to suggest that lay people may be better equipped to negotiate conflicting medical information if the different sides of the argument are plainly noted and a clear distinction is made between opinion and evidence.

[Dixon H, Scully M, Wakefield M, Murphy M. Public Understanding of Science (in press)]

LORNE CANCER CONFERENCE

Record numbers of cancer researchers flocked to Erskine House in February for the 19th Annual Lorne Cancer Conference. The conference was spearheaded by two of the most influential researchers into the aetiology and biology of cancer, Doug Hanahan (University of California, San Francisco) and Bob Weinberg (The Whitehead Institute). Their landmark co-publication in Cell, The Hallmarks of Cancer, describes what a cell needs to become malignant and the ancillary features that aid tumour progression. As such, this year’s Lorne Cancer Conference focused on the biology of cancer cells and the important supporting role of the microenvironment.

In the Ashley Dunn oration, Professor Weinberg suggested that the multi-step nature of tumour progression follows a Darwinian-like law of succession; he presented several examples of “gene acquisitions” that can transform normal cells and promote metastasis. As such, Weinberg provided evidence that loss of growth control and potential re-activation of dormant embryonic-like mechanisms that endow metastatic propensity in tumour cells can be achieved through deregulation of the Ras, NF-kB and Smad signalling pathways, leading to activation of transcription factors Twist, Slug and FoxC2. Excellent presentations by John Blenis (Harvard Medical School) and Rick Pearson (Peter MacCallum Cancer Centre) further detailed the molecular events that underpin tumour initiation and progression following aberrant activation of the PI3 kinase pathway. A selection of these presentations on signal transduction was developed with funding from Healthway to strengthen this association by overtly associating smoking with other things disgusting, including excrement, cockroaches and maggots. In partnership with The Cancer Council WA these advertisements will be distributed using chain-emails and assessed via an online survey in 2007. The number of hits to the advertisement webpage and origin of viewers will be automatically tallied using Webalizer software.

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Women are the primary target group, and their children and partners, secondary target groups. The project will be conducted in two stages over 24 months, consisting of formative research via a series of in-depth interviews and focus groups, and the development, implementation and evaluation of an intervention.

Encouraging the right women to attend for cervical cancer screening: results from a targeted television campaign in Victoria

This study assessed whether a mass media campaign could encourage women who were overdue for a Pap test to have one, without prompting unnecessary early re-screening. A telephone survey of a representative sample of 1000 Victorian women aged 25-65 years assessed recall of the advertisement and intention to act after seeing it.

The television advertisement was recalled by 61.5% of women. Significantly more who said they usually had a Pap test longer than two years apart indicated they would have a Pap test more often as a result of seeing the advertisement (63%), than women who had Pap tests every one (6%) or two (12%) years.

Data from the Victorian Cervical Cytology Registry from mid-2002 to the end of 2004 showed that during the four-week campaign period the number of Pap tests conducted increased by 18% (coefficient 0.169, df 0.029).

The rate increased most among those due or overdue for a Pap test. In a population with a high level of awareness of cervical screening, it is possible to run a mass media campaign encouraging screening specific...
Andreas Strasser from the Walter and Eliza Hall Institute provided evidence suggesting that cancer stem cells (as currently defined) may not be as rare as first thought. Significantly more work is required to differentiate between the rare cell that sustains the first series of oncogenic lesions leading to neoplastic transformation and the more prevalent amplifying cells that can sustain and propagate the growth of established tumours.

The conference clearly reflected that the progression of a tumour is dependent not only on the cell of origin, but also on its relationship with local and distant microenvironments. In his plenary speech, Doug Hanahan addressed the multi-faceted nature of the tumour microenvironment and described how despite representing 0.3% of the total cell component of a tumour, neutrophils can control tumour angiogenesis by regulating the bioavailability of VEGFs. The concept of “vascular normalization” was introduced by Ruth Ganss (Western Australian Institute for Medical Research), who showed that RGS5 deletion increased the maturity of pericytes supporting tumour blood vessels, which intriguingly potentiated T-lymphocyte infiltration and an anti-tumour immune response. The importance of VEGFR-3 and the Notch signaling pathway in the sprouting growth of tumour lymphatic and blood vessels was outlined by Tuomas Tammela (Bio-Medicum, Helsinki), while Natasha Harvey (Hanson Institute) presented a colourful investigation indicating that myeloid cells may act as a circulating pool of lymphatic endothelial progenitors. Michael Defter (Institute of Pharmaceutical Sciences, Zurich) later described how tumours can activate lymphangiogenesis in sentinel lymph nodes prior to the arrival of metastatic cells. Importantly, the establishment of this “pre-metastatic niche” can promote spread to more distant sites.

Marc Achen (Ludwig Institute for Cancer Research) provided evidence suggesting that cancer stem cells (as currently defined) may not be as rare as first thought. Significantly more work is required to differentiate between the rare cell that sustains the first series of oncogenic lesions leading to neoplastic transformation and the more prevalent amplifying cells that can sustain and propagate the growth of established tumours.

The high quality of research presented was echoed in the poster sessions, which for the first time had to be split over two nights. A large number of students this year took the opportunity to present their own data and interact with some of the greatest researchers in the field. With Lorne turning on stellar beach weather, networking and discussions continued outside of the seminar rooms on to the sand and well into the evening. That cutting-edge research was still being discussed late into the night was a keen reflection of how inspirational the meeting had been. The organisers would like to thank the many sponsors of the conference and look forward to another beneficial partnership for next year’s 20th anniversary.

The Lorne Cancer Conference is supported by The Cancer Council Australia

Experts release new guidelines on sun exposure

New guidelines have been released to tell Australians how much sun they need to avoid vitamin D deficiency, and stay healthy without increasing their risk of skin cancer.

The guidelines follow research from The Cancer Council’s National Sun Survey, which found that 17% of teenagers and 13% of adults thought they needed to go out in the sun more without sun protection as a result of hearing media reports about vitamin D.

“We’re alarmed that a small but significant number of Australians are deliberately seeking sun exposure without sun protection because they are concerned about vitamin D, and are therefore more likely to be putting themselves at risk of skin cancer,” The Cancer Council Australia’s CEO, Professor Olver said.

The Cancer Council has joined with other health experts from Osteoporosis Australia, the Australasian College of Dermatologists and the Australian and New Zealand Bone and Mineral Society to address the public’s confusion about Vitamin D deficiency.

The new guidelines recommend:

- Fair skinned people can maintain adequate vitamin D levels in summer from a few minutes of exposure to sunlight on their face, arms and hands or the equivalent area of skin on either side of the peak UV Index periods on most days of the week.
- In winter in the southern parts of Australia, where UV radiation levels are less intense, people need about 2-3 hours of sunlight to the face, arms and hands or equivalent area of skin over a week.
- Medical Director of Osteoporosis Australia, and Head of Endocrinology, University of Melbourne at Western Hospital, Professor Peter Ebeling, said it was important to stress that the majority of Australians had sufficient levels of vitamin D. “However, those likely to be at risk of vitamin D deficiency include people with very dark skin, people who are housebound or in institutionalised care, women who wear concealing clothing for cultural purposes, and breastfed babies of vitamin D deficient women,” Professor Ebeling said. “Anyone who thinks they may be vitamin D deficient should seek medical advice, not seek more sun.”

Secretary of the Australasian College of Dermatologists, Dr Stephen Shumack, stressed that the new advice developed by the four organisations took into account the intensity of the sun in different parts of Australia. “While those in southern states in many cases don’t need sun protection in winter, sun protection is necessary in places like the Northern Territory, Queensland and parts of Western Australia, all year round, because UV Index levels are high enough to cause significant skin damage,” he said.

The new guidelines – The risks and benefits of sun exposure - can be found at www.cancer.org.au/positionVITD.

One million Australians targeted in first bowel cancer screening program – Cancer Council urges eligible Australians to take the test

Ever been told you are one in a million? If you are, you soon will be.

Phase one of the Federal Government’s National Bowel Cancer Screening Program is now underway with around one million men and women being urged to screen for a disease that kills 90 Australians every week.

As part of Bowel Cancer Awareness Week in June, The Cancer Council Australia encouraged all eligible Australians to take part in the free testing program. Those eligible in the first phase will receive a simple, at-home kit in the post to test their bowel motion for early signs of bowel cancer.

The Cancer Council Australia’s CEO, Professor Ian Olver, said that if detected early enough, “90 per cent of bowel cancers are curable.”

Professor Olver said that while Pap testing and mammograms had been available to women for many years, this was the first time both men and women had been included in a national, population-based cancer screening program. “The National Bowel Cancer Screening Program has the potential to save more lives each year than breast and cervical screening combined,” he said.

“Around one million people are being targeted in the first phase of the program. However, when the program is running at full capacity, we estimate more than five million people will be eligible for regular bowel cancer screening,” he said.

The Cancer Council is urging all Australians targeted in this first phase to take part to ensure the...
ongoing success of the program."

Working with cancer

Many cancer patients continue to work during their treatment and recovery, just as many people caring for someone with cancer are also holding down jobs. Often colleagues don’t know what to say or how to help.

Our Work: With Cancer, it helps to make attending work or returning to work easier for patients, carers and survivors and their colleagues.

Working with cancer was developed in association with employers and with people diagnosed with cancer. It is suitable for companies large and small, and includes case studies, handouts and workshop materials on:

- Supporting patients and carers in the workplace
- Talking to workmates about cancer
- Developing supportive policies
- Employer responsibilities
- Helping everyone cope with cancer at work
- Balancing company and individual needs
- Coping with death and bereavement


The Cancer Council Australia welcomes skin cancer awareness and obesity survey measures in Budget

The Cancer Council Australia has welcomed the Federal Government’s Budget commitment to continue its skin cancer awareness campaign over the next two years and to put additional funding into an ongoing national nutrition and physical activity survey program.

The Cancer Council Australia’s Chief Executive Officer, Professor Ian Olver, said the $11.5 million the Government had allocated to the national skin cancer campaign over the next two years would provide a significant additional return on the $7 million invested in running it last summer.

“Skin cancer is Australia’s most expensive cancer in terms of overall burden on the health system and it claims more than 1600 lives each year, many of them young people with melanoma,” Professor Olver said.

“The Federal Government’s ongoing campaign should help to remind Australians of the dangers of excessive exposure to ultraviolet radiation and reduce the unacceptable burden skin cancers imposes on our community.”

Professor Olver also commended the Government’s $10.6 million commitment over four years to roll out a national nutrition and physical activity survey program, as well as a number of other initiatives aimed at reducing the impact of obesity.

“Obesity and overweight are a major cause of cancer in Australia and will cause a significant increase in future cancer incidence and mortality, on top of the increases we can expect through population ageing, if steps aren’t taken soon to reverse the obesity epidemic,” he said.

“The Government’s national survey program will be pivotal to understanding the changing dietary and physical activity habits of Australians and thereby inform better targeted programs for addressing obesity.”

Professor Olver also welcomed the ongoing support for the Council of Australian Governments’ Australian Better Health Initiative and the increase in medical research infrastructure funding announced in the budget.

“With a federal election likely to be called this year, we hope to see a continuation of the support for reducing the impact of cancer we have seen from across the parliament over recent years, such as measures to reduce disparities in treatment access between urban and rural patients.”

Growth in solariums alarms skin cancer experts

Skin cancer experts have expressed alarm at new Cancer Council research showing an explosion in solarium numbers across Australia, with one capital city recording a 1000 per cent increase over the past decade.

The new figures, published in the Australian New Zealand Journal of Public Health, show the number of solariums advertised in the Yellow Pages16 in Australian capital cities increased four-fold between 1996 and 2006.

The startling rise has prompted a call for tighter regulation of the industry, which currently operates under a voluntary code.

The Cancer Council Australia’s Chief Executive Officer, Professor Ian Olver, said the figures were staggering, yet understated as the research did not cover solariums in beauty salons or fitness centres.

“This study backs existing research showing that hundreds of thousands of Australians are being needlessly exposed to excessive UV radiation and an increased risk of skin cancer,” Professor Olver said. “Solariums emit ultraviolet radiation up to five times as strong as the sun and there is clear evidence of the link between solariums and skin cancer.”

Professor Olver said the findings were especially worrying in light of a recently published international study, which found a 75 per cent increased risk of melanoma for people using solariums before the age of 35.

According to the Chair of The Cancer Council’s National Skin Cancer Committee, Craig Sinclair, more than 1600 Australians lose their lives each year to skin cancer and the revelation that solariums were increasing at such a rapid rate would be of enormous concern to skin cancer and public health experts.

“We are particularly worried about the risk to young Australians,” Mr Sinclair said. “We already know the voluntary code is not working and our own studies show poor compliance in restricting solarium access to those under 18.

“While funds are still being counted, we are well on the way to our $8 million target thanks to the many morning teas held throughout May in schools, at home, in the workplace and in the community.

Australians’ Biggest Morning Tea is one of The Cancer Council’s foremost fundraising events and the largest, most successful event of its kind in Australia.

The funds raised by generous Australians will help The Cancer Council continue its fight to defeat cancer.

Cancer Council releases bowel cancer screening forum report

A whole-of-government approach to bowel cancer screening built around quality assurance is the key to ensuring the Australian Government’s National Bowel Cancer Screening Program reaches its potential to reduce bowel cancer mortality in Australia.

Moving forward on bowel cancer screening in Australia is a summary report of the expert presentations and panel discussion on bowel cancer screening documented at a national forum hosted by The Cancer Council Australia in Melbourne late last year, under the auspices of the Commonwealth Department of Health and Ageing.

Population-based bowel cancer screening using faecal occult blood testing has been shown to reduce bowel cancer mortality by up to 40 per cent among the screened population. But, according to the report, converting this evidence-based potential into optimal success in terms of bowel cancer mortality reduction requires a commitment by governments at all levels. It requires the application of minimum standards, quality controls, adequate follow-up, ongoing monitoring of the program, measures to maximise screening participation and improved support for the medical workforce, as explored in the report.

The report is available at www.cancer.org.au.

Palliative care community education initiative

Palliative Care Australia has launched a new National Aussies make every cup count for Australia’s Biggest Morning Tea

The help of more than one million Australians from all corners of our country has ensured another successful Australia’s Biggest Morning Tea in 2007.

While funds are still being counted, we are well on the way to our $8 million target thanks to the many morning teas held throughout May in schools, at home, in the workplace and in the community.

Hellooo yellow!

Daffodil Day 2007

Say goodbye to the dark hues of winter and hello to all things yellow for The Cancer Council’s Daffodil Day on Friday 24 August. With more than two million daffodils on sale, along with the ever popular Dougal Bear, funny yellow ‘hope’ wristbands, pins and pendants and a myriad of other items, it’s easy to brighten your day and the lives of thousands of Australians affected by cancer.

By purchasing a daffodil or other item in memory of a loved one, to celebrate a survivor, or to simply give hope for a brighter future, you can help us reach our fundraising target.

All funds raised during Daffodil Day activities contribute directly to The Cancer Council’s initiatives in cancer research, education, information, advocacy and patient support services.
Breast Cancer (2nd edition)

DJ Winchester, OP Winchester, CA Hudis, L Norton
BC Decker (2006)
ISBN: 978155092721
607 pages
RRP: $245.00

The mission of publishing company BC Decker, according to their website, is to produce premium quality information for medical and allied health professionals in the form of text books, journals and electronic media. Their areas of medical speciality are varied and this text on breast cancer is one of many in their oncology collection.

This latest edition of Breast Cancer has a comprehensive list of distinguished contributors from various well-known cancer institutions across America. No surprise then that this has a distinctly American flavour, however this does not in any way detract from the high quality information discussed.

The textbook includes a CD-Rom with the book in PDF and with full text and images. This is a positive aspect of the package as it enables the user to access information in a convenient format. It is also ideal for printing information for patient education at the discretion of the health professional.

The stated goals of this book are clearly articulated in the preface. These goals are to identify and disseminate significant developments in the areas of breast cancer prevention, diagnosis and treatment.

My first perusal of the table of contents revealed 37 chapters beginning with the history of breast cancer and finishing with a chapter on a ‘patient’s perspective’, with a woman detailing her breast cancer experience. All disciplines involved in the management of breast cancer are represented.

Areas covered include epidemiology, hereditary breast cancer and the role of risk assessment and management. Diagnostic imaging is covered over three chapters with a focus on magnetic resonance imaging. Pathology and staging of breast cancer is discussed. The book also discusses various breast pathologies with chapters devoted to ductal carcinoma in situ and unusual breast histology.

Early stage disease is discussed in detail, with a chapter devoted to each treatment modality. Of note is a chapter devoted to multi-focal, multi-centric and bilateral breast cancer. Of interest was the management of breast cancer in the previously augmented breast, an issue that will only increase with the ageing population of women who have breast implants and the challenges this will pose for treatment and aesthetics.

Breast reconstruction is highlighted with a chapter detailing the evolution of these procedures; perhaps more diagrams and photos could be of use here. Special chapters are devoted to breast cancer and the pregnant woman and importantly the male with breast cancer.

The organisation and flow of the book is easy to follow and is highly systematic and comprehensive in its approach. Importantly it details areas of controversy as appropriate to the subject discussed and has summaries of all relevant clinical trials as they stand at the time of printing.

It is disappointing not to find reference to the role of breast care nurses as part of the multidisciplinary approach to breast cancer. This is discussed in passing early on in the book with a chapter devoted to a discussion on what constitutes a specialist breast centre, with a focus on the different operational models evolving in the concept of the specialised breast cancer centre.

Attention is paid to the value added dimension of health professional. The emphasis really is on early stage breast cancer, with a chapter devoted to locally advanced breast cancer.

Despite some shortcomings from a breast care nurse perspective, this textbook fulfils its stated objectives, which are medical in context. I would recommend this as an introduction to any student of breast cancer either from a medical, nursing or allied health stream for a useful medical overview. It would be a useful addition to any oncology collection in a medical/hospital library in a teaching institution.

Julie McGarr
Department of Surgical Oncology, Peter MacCallum Cancer Centre, Melbourne, Victoria

Breast Cancer Research Protocols
SA Brooks, A Harris (eds)
Humana Press (2006)
517 pages
RRP: $135.00

This is one of the latest books of the Methods in Molecular Medicine series. It is primarily targeted at clinicians and research scientists interested in initiating translational breast cancer research. One of the main problems in translational research is the wide variation and lack of standardisation in the methods and protocols used. This book introduces and summarises the current methods and protocols in obtaining and analysing breast cancer tissue specimens from the patient to the molecular level.

The content is divided into five parts covering important and current topics in preparation of cell and tissue samples, markers of clinical outcome and prognosis, analysis of tumour-derived proteins and antigens, analysis of gene and gene expression in tumour specimens and studying cancer cell behaviour both in vitro and in vivo.

Each part is subdivided into smaller chapters and written by experts in the related field. Each chapter has a summary, introduction, methods, notes and references. The summary and introduction at the beginning highlight major discussion points. Methods and protocols are described in a concise and easy to follow numerical sequence. The notes provide practical advice in dealing with problems encountered during the research. A list of references for the methods and protocols is conveniently available at the end of each chapter for more in-depth discussion. The black and white illustrations of molecular techniques and histopathology make interpretation difficult at times.

In an era where translational research in breast cancer is rapidly progressing and becoming an exciting reality in its clinical application, this book is a useful reference point for current methods and protocols in this area and highly recommended for those interested or initiating translational breast cancer research.

Weng Ng
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Cancer Control Knowledge into Action: WHO Guide for Effective Programmes

ISBN: 92-4-154699-9
40 pages
RRP: $US13.50

Cancer Control Knowledge into Action: WHO Guide for Effective Programmes is one of a series of six modules (booklets) that provides practical advice for program managers and policy-makers on how to advocate, plan and implement effective cancer control programs. The module is essentially an instruction manual for developing a cancer control plan targeted to low and middle income countries.

The booklet is based on several key principals: that a comprehensive cancer control strategy allows more efficient and equitable use of resources; the context and past experiences need to be considered; the plan must be goal-orientated and people-centred; and consideration of the social and economic environment is essential. Input for the resource was provided from a range of low and middle income countries including Cameroon, Vietnam, Hungary, China, India and Pakistan, with core content contributed by a range of experts in developed countries.

While targeted to low and middle income countries, the booklet may also be useful for students in policy development. Other booklets in the series are: Prevention; Early Detection; Diagnosis and Treatment; Palliative Care; and Policy and Advocacy.

Anne-Marie Dewar
The Cancer Council Queensland

Clinical Fundamentals for Radiation Oncology Residents

Hasan Murshed
ISBN: 978-1-930524-28-6
343 pages
RRP: $US60.00

This small textbook is written primarily for radiation oncology residents and registrars. The information covered was written by the author as part of his preparation for his final specialist exam in radiation oncology. It aims to provide a management approach and summary of all the key literature on neoplasms treated with radiotherapy.

To this end, the book achieves its aim and provides a concise, well-written summary of each topic. Information includes the relevant epidemiology, symptoms/signs, investigations, management, expected outcomes and complications of treatment. Radiation techniques are also provided in reasonable detail. Images of simulator films and digitally reconstructed radiographs are used to supplement the written information on radiation techniques.

Extremely useful is the annotated bibliography of key articles at the end of each chapter. These are summarised by the author including key discussion points, which most radiation oncology trainees would find particularly helpful.

The book is written mainly in note format, which is reasonable given its aim. Overall it is well written, but does use some US terminology. The main disadvantages are that recommendations for treatment follow US approaches which are used less often in Australia. Some approaches used in Australia are not part of the recommended treatment approaches for certain tumour sites. For example, short course pre-operative radiotherapy without chemotherapy is not included as an option for treatment of rectal adenocarcinoma.

Having said that, this book does not aim to provide a comprehensive review of the literature and so it does not significantly detract from the book’s usefulness. Regrettably, topics such as melanoma and melanoma carcinoma are not included. These have been used in the part two Royal Australian and New Zealand College of Radiologists exams indicating the importance of these areas of cancer management in Australia.

I highly recommend this book to radiation oncology trainees who wish to have a small summary book on radiation oncology management of neoplasms. It would be of most use as a quick review reference book, especially in the lead-up to the final exit exams in radiation oncology. Trainees in other specialties may also find it useful for a small reference on the various neoplasms covered.

Mark Lee
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Communicating with dying people and their relatives

J Lugton
Ausmed (2003)
ISBN: 0-9579876-7-6
184 pages
RRP: $49.95

Over the last decade, books on communication and how to do it better are appearing with increasing regularity on our bookshelves. Yet few exist specifically on the topic of communicating with dying people and their relatives. Jean Lugton has attempted to fill this gap.

Communicating with dying people and their relatives at 184 pages, with nine chapters, appendices, references and suggestions for further reading, offers strategies for improving our communication with this vulnerable group of patients (the dying) and their relatives. To this end, I believe the book has been successful.

It begins by establishing the importance of good communication in palliative care. From the outset, it differentiates between terminal care and palliative care, always a necessary distinction to make. Subsequent chapters provide lists of what nurses need to possess to work in palliative care, such as educational preparation and self awareness concerning attitudes to death and dying. There is a chapter on how to break bad news which perhaps repeats what others have written about
in this area, namely Robert Buckman. Yet the chapter also extends Buckman’s work in that it outlines differing coping styles to the ‘bad news’ scenario. While I don’t necessarily agree with the use of Kubler Ross’ stages to explore coping in terminal illness, it does provide a vehicle from which to talk about impending loss and the implications that this loss may have on those closest to us.

The only other chapter I will specifically mention is ‘Making communication more effective’, which explores the controversial issue of nurse-patient friendships, the development of which has been frowned upon in recent years. Rather than actual friendships, Lugton supports the development of covenant relationships, relationships aimed at listening and befriending, without the imposition of duties on the patient or their family. She suggests that traditional barriers between nurse and patient can be broken down by the use of first names, by the use of the same nurse in daily patient care and by identifying and supporting families’ areas of strength. These suggestions are not new in the palliative care arena, however have not often been seen as therapeutic.

The use of conversational extracts throughout the book to illustrate salient points are effective in grounding the discussion in the experiences of actual people living with a life-limiting illness and make the book highly readable. I found the list of questions at the end of each chapter useful as prompts for reflection.

In summary, Lugton’s book provides a useful resource for all healthcare professionals. It would appeal to medical students, as well as nurses and other allied healthcare providers in relation to the chapter topic; for all healthcare professionals. It would appeal to a number of other international agencies. The introduction states that it is ‘intended primarily for use by healthcare providers working in cervical cancer control programs in health centres and district hospital settings with limited resources. However, it may be of interest to community and tertiary-level providers, as well as workers in other settings where women in need of screening might be reached’.

The main focus of the guide is on the knowledge and skills needed by healthcare providers, particularly those at level one and two. It has been field-tested by reviewers in China, Egypt, India, Lithuania, Trinidad and Zimbabwe. The information presented is evidence-based and broadly applicable, however of course may need to be adapted to local health systems, needs, language and culture.

There are seven chapters:

- Background
- Anatomy of the female pelvis and natural history of cervical cancer
- Health promotion, prevention, health education and counselling
- Screening for cervical cancer
- Diagnosis and management of pre-cancer
- Management of invasive cancer
- Palliative care

Each chapter includes:

- a description of the role and responsibilities of various healthcare providers in relation to the chapter topic;
- a story illustrating or personalising the topic;
- essential background information on the subject, followed by discussion of established and evolving practices in clinical care, and recommendations for practice;
- information on service provision at each of the four levels of the healthcare system (ie. community, primary, secondary and tertiary level);
- counselling messages to help providers communicate with women about the services they have received and the follow-up they will need; and
- a list of additional resources.

Most chapters have associated practice sheets that provide step-by-step information on specific components of care (eg. obtaining informed consent, taking a history and performing a pelvic examination, taking a Pap smear, colposcopy, cone biopsy, hysterectomy, radiation therapy, pain management and management of vaginal discharge and fistulae). These sheets are intended to be used as “job aids, to remind providers of the essential steps and to help them to educate, counsel and correctly explain services to women and their families”.

Nine annexes provide guidelines on specific areas of clinical practice (eg. management flowcharts and treatment protocols for screen-detected abnormalities, cervical pre-cancer and invasive cancer), as well as strategies for improving service delivery. A glossary and a list of abbreviations and acronyms are also included.

The guide is compact in size and the use of spiral binding and good quality paper make it likely to be a durable resource. There is extensive use of key points, lots of simple figures and tables throughout and good cross-referencing to practice sheets and annexes. This makes it an easy-to-use reference document.

Regardless of the resource setting, I would highly recommend this publication to general practitioners and medical students, as well as nurses and other allied health professionals working in the area of women’s health and/or oncology.

Annie Stenlake
Department of Gynaecological Oncology, Westmead Hospital, NSW

Comprehensive Textbook of Genitourinary Oncology

Genitourinary Oncology (3rd edition)

NI Vogelzang, PT Scardino, WU Shipely, FMJ Debruyne, WM Linehan (eds)

Lippincott Williams & Wilkins (2006)

ISBN: 07817498-40

897 pages

RRP: $328.90

Comprehensive Textbook of Genitourinary Oncology is a large and well-researched reference book for clinicians working in this field. The third edition is designed to incorporate the latest medical and scientific advances in each clinical domain – surgery, medical and radiation oncology – from laboratory to bedside. The editors are well recognised and highly respected in their fields, and with over 200 international contributing authors, the reader is provided with a strong philosophical foundation for multidisciplinary care. Evidence in the medical literature indicates that an integrated team-based approach, including surgeons, pathologists and medical and radiation oncologists, can lead to improved survival and better quality of life for patients affected by these malignancies.

The textbook is divided into five parts – prostate, bladder, testicular, kidney and other rare genitourinary malignancies. The contents are clearly listed, ensuring the reader has quick and easy access to all relevant information. Each part of the textbook follows a logical structure covering epidemiology, genes, risk factors, screening, symptoms, diagnosis and management for the differing stages for these malignancies. There are a number of interesting and varied diagrams and illustrations, including histopathology, imaging technologies, anatomy and surgical techniques. There are also flow charts and tabulated data that are clearly labelled and easy-to-understand. For example, if you needed to find information on survival advantages for high risk prostate cancer using adjuvant hormonal treatment and radiotherapy, you can readily find the relevant table and summary of the major prospective trials using this form.
of treatment.

In essence, the textbook encompasses a thorough review for each genitourinary cancer from a clinical and scientific context and aims to guide the clinician by providing answers to clinical questions that are evidence-based. The importance of research is a common theme that links each chapter and the authors identify gaps in knowledge for future study. The search to identify new molecular markers for prostate cancer that indicate faster disease progression are in progress; this will in turn enable us to more effectively target aggressive therapeutic management towards patients who will gain the most benefit.

There have been many significant advances across each genitourinary cancer and the following are a few examples that illustrate some of the changes. There are faster recovery times, less morbidity and lower rates of positive surgical margins for patients having radical prostatectomy; we have seen the development and wider availability for laparoscopic and robotic surgical techniques. The delivery and accuracy of radiotherapy for prostate cancer has also improved; knowledge from prostate motion studies has seen the introduction of prostate cancer fiducial markers that allow more effective tracking of its movement during treatment. Other significant advances include IMRT in radiation oncology and the use of taxanes for hormone resistance in medical oncology. The future for renal and bladder cancers also looks promising with the introduction of anti-angiogenic drugs allowing non-researchers to keep up-to-date with some of the latest research, as the contributors themselves are researchers. An entire chapter is devoted to new agents such as Bortezomib, immunomodulatory agents such as thalidomide and mTOR inhibitors. In the treatment chapters there are discussions on conventional treatments such as CHOP and ABVD and the role the monoclonal antibodies have played in current treatment of non-Hodgkin’s lymphoma.

This is a text meant for medical clinicians. However, for nurses with considerable experience in managing lymphoma patients, there are selected chapters that are easily read and understood. The chapters are very specific in their coverage of individual lymphomas and if you were looking for a complete book on the pathology and treatment of lymphomas, then this would be a good buy.

**BOOK REVIEWS**

**Doctors and Paintings**

J Middleton and E Middleton
ISBN: 9781846190520
102 pages
RPP: $78.00

As a physician and a painter myself, I welcomed the opportunity to review this book, subtitled to afford “insights and replenishment for health professionals”. Although it is an easy read, I found the conversational style of the book irritating, the content too simple for a physician audience, and the tone prescriptive and somehow patronising of patients, as though doctors and patients have little common ground and the humour just didn’t work.

Early on, the authors seem to have a clear focus, ie. to highlight the importance of doctors’ self-knowledge/self-awareness to better understand our patients, and to do this through the medium of painting. There is a lot to explore about the impact of art for physicians, the creative process as enlightenment to this end and the parallels between this, medicine and humanity. If one goes beneath the surface, this topic has enormous relevance to how doctors perceive themselves and others, how we integrate information, how we respond to difficult situations and how we evolve as compassionate, caring clinicians who don’t burn out through the very practice of doctoring.

After the first third of the book, the authors quickly lose their own way, a problem for the self-confessed, self-aware. While some worthy points are made early on, even these seem self-evident; for example that the arts help to stimulate insights into common patterns of response, highlight individual differences and can enrich the language and thought of the practitioner, and the exploration of a doctor’s own feelings and defences – but there is nothing new about this.

The authors raise other pertinent issues, such as the value and risks of vulnerability as it relates to professional virtue, the concept of healing for the healer as well as the patient, the use of narrative and story-telling, and how, as in life, doctors may arrive in the middle of a patient’s story. In addition they discuss notions of ambiguity in painting and in life, the value of interpreting the patient’s own language and how we bring our own perceptions to the interpretation of either a painting or a patient, so that the processes can be seen to run in parallel.

The authors refer to some well-known artists: Frida Kahlko, her physical disability; Mark Rothko, his depression; Francis Bacon, his childhood sexual abuse and adult homosexuality; Vincent Van Gogh, his presumed mental illness (I always thought he had acute intermittent porphyria myelf); Tracey Emin, her own life narrative, bringing the distasteful or unspoken into full view (eg. abortions); Rembrandt van Rijn, his life tragedy; and Lucien Freud, his struggle for power and concerns about ageing. It all feels a bit flat and superficial, though.

The fact that one author chooses to use her own paintings (which aren’t particularly engaging) to highlight some concepts is a tad self-referential and narcissistic. Sadly, the book ends up feeling like an opportunity for self-promotion, billed under the guise of something nobler. In the end, the authors are saying, “first, know thyself”. We all have different routes for getting there; for some of us, the act of painting or art appreciation may help us getting along the way. It is patronising, though, to suggest that it will help all of us, and these authors, for one, fail to really tell us why.

Lesley Ades
Department of Clinical Genetics,
The Children’s Hospital Westmead, NSW

**Hodgkin’s and Non-Hodgkin’s Lymphoma**

JP Leonard, C Morton (eds)
Springer (2006)
488 pages
RPP: €119.95

This book is a comprehensive overview of the diagnosis, treatment and future directions in the treatment of lymphomas. It is part of a Springer series on Cancer Treatment and Research and its contributors are mainly lymphoma researchers. As such, the text offers a current review of the standard diagnostic and therapeutic approaches to lymphoma, as well as covering the most promising new directions in treatments.

There are 14 chapters, each individually written and covering the entire range of lymphomas. At 450+ pages, it gives a broad overview of the disease but is easily read. There are plenty of headings in each chapter to enable a logical progression. There is an introduction at the start of each chapter which gives a notion for what the chapter will cover.

The chapters cover such topics as pathology of lymphomas and multiple myeloma, the use of monoclonal antibodies, transplantation and treatments for both Hodgkin’s and non-Hodgkin’s lymphomas and nuclear medicine techniques in diagnosis. There is also an excellent chapter on the role viral infections play in the development of lymphomas. This covers well known viruses such as Epstein-Barr, Kaposi’s sarcomas and HTLV-1.

In each chapter, there is also an in-depth mention of relevant and recent clinical trials relating to the subject matter. This is one of the best aspects of this text as it allows non-researchers to keep up-to-date with some of the latest research, as the contributors themselves are researchers. An entire chapter is devoted to new agents currently being developed and trialled in the treatment of lymphomas, including proteasome inhibitors such as Bortezomib, immunomodulatory agents such as thalidomide and mTOR inhibitors. In the treatment chapters there are discussions on conventional treatments such as CHOP and ABVD and the role the monoclonal antibodies have played in current treatment of non-Hodgkin’s lymphoma.

This is a text meant for medical clinicians. However, for nurses with considerable experience in managing lymphoma patients, there are selected chapters that are easily read and understood. The chapters are very specific in their coverage of individual lymphomas and if you were looking for a complete book on the pathology and treatment of lymphomas, then this would be a good buy.
BOOK REVIEWS

Jaye Manning
Haematology and Oncology Clinics of Australasia, Brisbane, Queensland

Living Dying Caring: Life and Death in a Nursing Home
R Hudson, J Richmond
Ausmed (2000)
299 pages
ISBN: 0-9577988-6-5
RRP: $49.95

Hudson and Richmond’s earlier publication – Unique and Ordinary: reflections on living and dying in a nursing home was a remarkable book published in 1994, well in advance to the surge in interest that now surrounds the issue of death and dying in residential aged care facilities. I was delighted to see a second publication by these authors and the incorporation of implications for practice pertinent to the stories told.

These practice implications are geared toward three different audiences – the gerontic nurse, management and indirect carers (by indirect, the authors identify those workers who are non-nursing staff such as domestic services, clerical, allied health professionals and volunteers). I was surprised that there were no practice implications specifically for the nursing/ personal care workers who make up such a large proportion of the workforce. A further issue with these practice implications is that they are not referenced and with the increasing trend to evidence- based practice, this may be a limitation for use. There is however, a comprehensive further reading list at the back of the book.

Notwithstanding this issue, the reader is privileged to read the intimate relationships that are often missing from the literature, which is dominated by quality issues and the functional aspects of providing care for the dying. The book is separated into nine chapters, each one with sub-headings for the main point of interest of the stories to be told. A boxed text area introduces who the story is about, a short discussion of the pertinent issue and reflections that further explore some of the issues raised in the story. Important stories that reflect the complexity of care in these settings include the death of significant residents, the issue of shared rooms, cultural sensitivity, sudden death and organisational factors that shape the dying experience.

I was particularly taken by the beautiful and touching notes written in the residents’ case files following their death, much more dignified than leaving the final record as respirations ceased. This book is not all about ‘good death’ stories, the authors are willing to explore when deaths were not well managed and provide suggestions of what could be done better.

I would recommend this book to those who are not familiar with this setting or for those that are, but want a different perspective than that offered by journals and textbooks.
Deborah Parker
Dementia Collaborative Research Centre, Queensland University of Technology, Queensland

Lymphoedema
R Twycross, K Jones, J Todd (eds)
Ausmed (2003)
377 pages
ISBN: 0-9579876-6-8
RRP: $64.95

This text is a compilation of information on all aspects of lymphoedema and its management. It is an excellent resource for health professionals involved in the care of patients with lymphoedema or those interested in learning more on the subject. Primarily a UK text, it also contains contributions from Israel, Belgium and India.

The 23 chapters come from a range of multidisciplinary authors, including medicine, nursing and physiotherapy. The opening chapter of a patient’s perspective is an excellent inclusion.

Each chapter concentrates on a particular aspect of lymphoedema. It can be read chapter by chapter, or used as a reference to investigate certain aspects of care. The format of the text and inclusion of many photos, drawings and tables, makes it easy to understand. However, some lymphoedema sufferers and carers may find the language too technical, especially in relation to the chapters on pain and drug treatments.

The text begins by outlining the pathophysiology, classification and clinical features of lymphoedema. The psychological aspects of lymphoedema are dealt with in a brief chapter, while psychological issues relating to aspects of lymphoedema treatment are also dealt with throughout the text.

The management strategies of lymphoedema are the main focus, including chapters on skin care, manual lymphatic drainage and drug treatments. Step by step exercises, massage techniques and instructions for bandaging are included, though cannot replace practical instruction. Novel treatments and surgery for lymphoedema are also discussed.

The remaining chapters of the text investigate specific instances of lymphoedema, such as in childhood, head and neck, breast, male genital and advanced cancer. The final chapter discusses an Indian perspective, highlighting the challenges in managing lymphoedema with limited resources. A thorough index allows the reader to find information easily and extensive reference lists allow for further investigation if required.

Anne Mellon
Hunter Centre for Gynaecological Cancer, John Hunter Hospital, Newcastle, NSW

Nursing Patients with Cancer: Principles and Practice
N Kearney, A Richardson
Churchill Livingstone (2006)
864 Pages
ISBN: 978-0-443-07288-8
RRP: $159.90

This book has been expressly written for European healthcare workers. The text refers to adult cancer nursing and is aimed at providing key skills and knowledge for specialist cancer nurses.

Contributors to the book comprise nurses, doctors, allied health professionals, and therapists - overall 60 authors. The text is well formatted into a logical series of six inter-related sections. The information is easy to access and provides the practitioner with a comprehensive guide to cancer nursing practice.

Section one considers the principles of self care and deals with the social and cultural aspects of cancer nursing. This is a refreshing view of issues relating to the media, the internet, partnerships (both personal and professional) and cultural concepts. Section two explores the scientific basis of cancer, while section three deals with health promotion including cancer prevention and early detection. Section four examines treatment strategies in detail based on current practice and future trends. This is a particularly informative section relating to specific nursing interventions. Section five discusses optimal supportive care strategies with a thorough consideration of morbidities experienced by patients with cancer and section six discusses care delivery systems, including intensive care nursing of the cancer patient, rehabilitation and survivorship and palliative care.

The hard copy edition has 864 pages and is supported by well-defined and comprehensive tables throughout the text. The text is well-referenced and would be a very useful addition to any oncology ward library.
## Australia and New Zealand

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## International

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<td>Joint European Conferences: International Symposium on State-of-the-Art Imaging</td>
<td>Dubrovnik Croatia</td>
<td>Continuing Medical Education Courses Stanford University Radiology Palo Alto, CA, United States Tel: +1 888 556 2230 Fax: +1 650 473 5962 Email: <a href="mailto:radiologycme@med.stanford.edu">radiologycme@med.stanford.edu</a> Web: <a href="http://www.radiologycme.stanford.edu">www.radiologycme.stanford.edu</a></td>
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<td>16 – 20 9th World Congress of Psycho-Oncology</td>
<td>London, UK</td>
<td>International Psycho-Oncology Society (IPOS) Charlotte, VA, United States</td>
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<td>Tel: +1 634 293 5500</td>
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<td>Fax: +1 434 977 1856</td>
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<td>Email: <a href="mailto:info@popsociety.org">info@popsociety.org</a></td>
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<td>Web: <a href="http://www.popsociety.org">www.popsociety.org</a></td>
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<tr>
<td></td>
<td>18 – 20 IACR 07: 29th Annual Meeting of the International Association of Cancer Registries</td>
<td>Ljubljana, Slovenia</td>
<td>Institute of Oncology Ljubljana Ljubljana, Slovenia</td>
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<td>Tel: +386 1 5879 563</td>
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<td>Email: <a href="mailto:iacr2007@onko-i.si">iacr2007@onko-i.si</a></td>
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<td>Web: <a href="http://www.iacr2007.si">www.iacr2007.si</a></td>
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<tr>
<td></td>
<td>21 – 23 3rd ESH-EHA Conference on Focus on Paediatric Haematology and Oncology</td>
<td>Sestri Levante, Italy</td>
<td>European School of Haematology (ESH) Centre Hayem, Hôpital Saint-Louis 1, av. Claude Vellefaux Cedex 10</td>
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<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
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<tbody>
<tr>
<td>23 – 27</td>
<td>ECCO 14 – the European Cancer Conference</td>
<td>Barcelona, Spain</td>
<td>Federation of European Cancer Societies (FECS) Brussels, Belgium</td>
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<td>Tel: +32 2 775 0201</td>
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<tr>
<td>25 – 28</td>
<td>4th World Congress of the World Institute of Pain</td>
<td>Budapest, Hungary</td>
<td>World Institute of Pain (WIP) c/o Kennes International Geneva, Switzerland</td>
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<td>Tel: +42 2006 0488</td>
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<td>Fax: +42 20 732 2850</td>
</tr>
<tr>
<td>27 – 29</td>
<td>7th Asia-Pacific Hospice Conference</td>
<td>Manila, Philippines</td>
<td>Philippine Cancer Society Manila, Philippines</td>
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<td>Tel: +63 2 733 3485</td>
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<td>Fax: +63 2 735 2707</td>
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<tr>
<td>28 – 29</td>
<td>4th Congress of South Caucasian Oncologists and Radiologists</td>
<td>Tbilisi, Georgia</td>
<td>National Cancer Centre of Georgia Tbilisi, Georgia</td>
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<td>Fax: +99 32 397 716</td>
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<tr>
<td>30 – 3 October</td>
<td>National Cancer Research Institute Conference</td>
<td>Birmingham, UK</td>
<td>National Cancer Research Institute (NCRI) London, United Kingdom</td>
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<td>Tel: +44 20 7069 420</td>
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<td>Fax: +44 20 7069 1004</td>
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<td>Email: <a href="mailto:ncrcconference@ncri.org.uk">ncrcconference@ncri.org.uk</a></td>
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<tr>
<td>October</td>
<td>1 – 4  Global Summit on International Breast Health Care 2007</td>
<td>Budapest, Hungary</td>
<td>The Breast Health Global Initiative (BHGI) c/o Fred Hutchinson Cancer Research Centre Seattle, WA, United States</td>
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<td>3 – 6</td>
<td>9th Annual Conference of the Society for Research on Nicotine and Tobacco</td>
<td>Madrid, Spain</td>
<td>Society for Research on Nicotine and Tobacco</td>
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<td>Web: <a href="http://www.srnt2007madrid.com">www.srnt2007madrid.com</a></td>
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<td>4 – 6</td>
<td>EUROPIN 2007 International Multidisciplinary Conference New Strategies of Cervical Cancer Prevention</td>
<td>Monte Carlo, Monaco</td>
<td>European Research Organisation on Genital Infection and Neoplasia (EUROPIN) Paris, France</td>
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<tr>
<td>5 – 7</td>
<td>1st International Liver Cancer Association Annual Conference</td>
<td>Barcelona, Spain</td>
<td>International Liver Cancer Association (ILCA) Brussels, Belgium</td>
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<td>Tel: +32 2 789 2345</td>
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### CALENDAR OF MEETINGS

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<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
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</table>
| 9 – 10 | Joint Conference of the Canadian Association of Radiation Oncology and the Canadian Organisation of Medical Physicists 2007 | Toronto, Canada | Email: info@caro-online.org  
Web: www.caro-acro.ca |
| 11 – 13 | 4th European Conference Tobacco or Health 2007       | Basel, Switzerland | Swiss Cancer League, German Cancer Society Bern, Switzerland  
Tel: +41 31 389 9163  
Fax: +41 31 389 9160  
Email: office@ectoh07.org  
Web: www.ectoh07.org |
| 17 – 20 | ESH-EHA Conference: Focus Paediatric Haematology and Oncology | Sitges, Spain | European School of Haematology (ESH) Paris, France  
Tel: +33 1 4206 6540  
Fax: +33 1 42 06 05 87  
Email: mary.hooney@uhn.on.ca  
Web: www.esh.org/agenda07/paed/paedinfo.htm |
| 18 – 21 | 4th Congress of the World Society for Breast Health | Tianjin, China | Tianjin Medical University Cancer Institute and Hospital Tianjin, China  
Tel: +86 22 2335 9337  
Fax: +86 22 2335 9337  
Email: info@2007tmb.org  
Website: www.2007tmb.org |
Tel: +27 21 689 5359  
Fax: +27 21 689 5350  
Email: info@aortic2007.org  
Web: www.aortic2007.org |
| 26 – 28 | 4th International Conference on Thrombosis and Haemostasis Issues in Cancer | Bergamo, Italy | Associazione Italiana di Oncologia Medica Bergamo, Italy  
Tel: +39 035 249 899  
Fax: +39 035 257 852  
Email: info@beproconferenza.com  
Web: www.beproconferenza.com |
| 28 – 31 | TIMM 2007: 3rd Trends in Medical Mycology | Turin, Italy | European Organisation for Research and Treatment of Cancer (EORTC) A’s Hertogenbosch, Netherlands  
Tel: +31 73 690 1415  
Fax: +31 73 690 1417  
Email: info@congresscare.com  
Web: www.TIMM2007.org |

### CALENDAR OF MEETINGS

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<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
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| 28 – 1 | 49th ASTRO Annual Meeting                            | Los Angeles, US | American Society for Therapeutic Radiology and Oncology (ASTRO)  
Fairfax, United States  
Tel: +1 703 502 1550  
Fax: +1 703 502 7852  
Email: meeting@astro.org  
Web: www.astro.org |
| 30 – 3 | 2007 International Society of Paediatric Oncology (SIOP) Annual Congress | Mumbai, India | SIOP 2007 - International Society of Paediatric Oncology  
Local Organising Committee  
37/900, Adarsh Nagar Century Bazaar, Worli  
Mumbai  
Tel: +91 22 24 38 10 68  
Email: siop2007@varriance.com  
Web: www.siop2007.in |

**November**

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<tr>
<th>Date</th>
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<th>Place</th>
<th>Secretariat</th>
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</table>
World Cancer Research Fund International Washington DC, United States  
Tel: +1 202 328 7744  
Fax: +1 202 328 7226  
Email: aicrweb@acr.org  
Web: www.aicr.org |
| 3 – 10 | 24th International Papillomavirus Conference and Clinical Workshop | Beijing, China | Chinese Medical Association  
c/o International Convention Services  
Beijing, China  
Tel: +86 10 8515 8149  
Fax: +86 10 6512 3754  
Email: ipc2007@cmca.org.cn  
Web: www.ipc2007.org |
| 7 – 9  | Cancer in the Developing World                      | Cairo, Egypt | National Cancer Institute, Cairo University Cairo, Egypt  
Tel: +20 2 535 1424  
Fax: +20 2 532 8286  
Email: a.badran@link.net  
Web: www.nci.edu.eg |
| 8 – 10 | Geriatric Oncology: Cancer in the Elderly            | Madrid, Spain | Society for Geriatric Oncology (SGOG) Gencier, Switzerland  
Tel: +41 22 366 9106  
Fax: +41 22 366 9131  
Email: siog@genero.ch  
Web: www.cancerworld.org/siog |
| 9 – 11 | 2007 Oncology Nursing Society (ONS) Institutes of Learning | Chicago, US | Oncology Nursing Society (ONS) Pittsburgh, PA, United States  
Tel: +1 866 257 4667, +1 412 859 6100  
Fax: +1 877 369 5497, +1 412 859 6162  
Email: customer.service@ons.org  
Web: www.ons.org |
| 10 – 14| International Conference on Clinical PET and Molecular Medicine | Bangkok, Thailand | International Atomic Energy Agency (IAEA) Vienna, Austria  
Tel: +43 1 2600 7  
Email: ipet2007@iaea.org  
Web: www.iaea.org |
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<tr>
<th>Date</th>
<th>Name of Meeting</th>
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<tr>
<td>12 – 14</td>
<td>Cancer 2007: From Molecular Biology to Treatment</td>
<td>Sao Paulo, Brazil</td>
<td>8th Sao Paulo Research Conference University of Sao Paulo Sao Paulo, Brazil Tel: +55 11 3361 3056 Fax: +55 11 3361 3089 Email: <a href="mailto:eventsus@eventus.com.br">eventsus@eventus.com.br</a> Web: <a href="http://www.eventus.com.br/bioconferences">www.eventus.com.br/bioconferences</a></td>
</tr>
<tr>
<td>15 – 17</td>
<td>Making Connections: A Canadian Cancer Research Conference celebrating NCCIC's 60th Anniversary</td>
<td>Toronto, Canada</td>
<td>National Cancer Institute of Canada (NCIC) c/o DR Dunlop &amp; Associates Ottawa, Canada Tel: +1 613 235 8879 Fax: +1 613 235 0094 Email: <a href="mailto:dunlopdr@rogers.com">dunlopdr@rogers.com</a> Web: <a href="http://www.ncic-cancer.ca">www.ncic-cancer.ca</a></td>
</tr>
<tr>
<td>22 – 23</td>
<td>8th International Netherlands Cancer Institute Head and Neck Symposium</td>
<td>Amsterdam, Netherlands</td>
<td>The Netherlands Cancer Institute Amsterdam, Netherlands Tel: +31 20 512 2550 Fax: +31 20 512 2554 Email: <a href="mailto:kno@nk.nl">kno@nk.nl</a> Web: <a href="http://www.hoofdhals.nl">www.hoofdhals.nl</a></td>
</tr>
<tr>
<td>25 – 28</td>
<td>2nd International Cancer Control Congress</td>
<td>Rio de Janeiro, Brazil</td>
<td>National Cancer Institute (INCA) c/o International Conference Services Vancouver, Canada Tel: +1 604 681 2153 Fax: +1 604 681 1049 Email: <a href="mailto:cancerccontrol2007@meet-ics.com">cancerccontrol2007@meet-ics.com</a> Web: <a href="http://www.cancercontrol2007.com">www.cancercontrol2007.com</a></td>
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<tr>
<td>25 – 30</td>
<td>RSNA 2007: Radiological Society of North America Annual Meeting</td>
<td>Chicago, US</td>
<td>Radiological Society of North America (RSNA) Oak Brook, United States Tel: +1 630 571 2670 Fax: +1 630 571 7837 Email: <a href="mailto:kchristianson@rsna.org">kchristianson@rsna.org</a> Web: <a href="http://www.rsna2007.rsna.org">www.rsna2007.rsna.org</a></td>
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<tr>
<td>26 – 27</td>
<td>BASO-ACS and ABS at BASO Joint Scientific Conference</td>
<td>London, UK</td>
<td>BASO – the Association of Cancer Surgery London, United Kingdom Tel: +44 20 7404 5612 Fax: +44 20 7404 6574 Email: <a href="mailto:admin@baso.org.uk">admin@baso.org.uk</a> Web: <a href="http://www.baso.org.uk/content/acs-Meetings.asp">www.baso.org.uk/content/acs-Meetings.asp</a></td>
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<tr>
<td>29 – 30</td>
<td>Cell Signalling and Novel Cancer Therapeutics</td>
<td>London, UK</td>
<td>British Association for Cancer Research (BACR) Sutton, United Kingdom Tel: +44 20 8722 4208 Fax: +44 20 8770 1395 Email: <a href="mailto:bacr@nrc.ac.uk">bacr@nrc.ac.uk</a> Web: <a href="http://www.bacr.org.uk/scientificmeetings/meetingdetail.asp?id=58">www.bacr.org.uk/scientificmeetings/meetingdetail.asp?id=58</a></td>
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<tr>
<td>12 – 15</td>
<td>47th American Society for Cell Biology Annual Meeting</td>
<td>Washington DC, United States</td>
<td>American Society for Cell Biology (ASCB) Bethesda, United States Tel: +1 301 347 9100 Fax: +1 301 347 9310 Email: <a href="mailto:ascbinfo@ascb.org">ascbinfo@ascb.org</a> Web: <a href="http://www.ascb.org/meetings/index.cfm">www.ascb.org/meetings/index.cfm</a></td>
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<tr>
<td>25 – 27</td>
<td>International Conference on Burkitt Lymphoma and Related Lymphoproliferative Disorders</td>
<td>Kampala, Uganda</td>
<td>Department of Pathology and Human Oncology University of Siena Siena, Italy Tel: +39 0577 232 000 Fax: +39 0577 232 134 Email: <a href="mailto:servcong@unisi.it">servcong@unisi.it</a> Web: <a href="http://www.unisi.it/eventi/burkitt">www.unisi.it/eventi/burkitt</a></td>
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<tr>
<td>26 – 28</td>
<td>Childhood Cancer: In Quest of a Complete Cure 5th SIOP Asia Conference</td>
<td>Muscat, Oman</td>
<td>International Society of Paediatric Oncology (SIOP) c/o Infomed Events Dubai, United Arab Emirates Tel: +971 4 269 9030 Email: <a href="mailto:ifodub@emirates.net.ae">ifodub@emirates.net.ae</a> Web: <a href="http://www.infomedweb.com/ourevents/SIOP2008/">www.infomedweb.com/ourevents/SIOP2008/</a> index.htm</td>
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<tr>
<td>27 – 14</td>
<td>5th American Psychosocial Oncology Society (APOS) Annual Conference</td>
<td>Portland, Oregon</td>
<td>American Psychosocial Oncology Society (APOS) 2007 Portland, Oregon Tel: +1 503 774 2060 Fax: +1 503 774 2061 Email: <a href="mailto:info@apos-society.org">info@apos-society.org</a> Web: <a href="http://www.apos-society.org">www.apos-society.org</a></td>
</tr>
<tr>
<td>29 – 30</td>
<td>19th Asia Pacific Cancer Conference (APCC) 2007</td>
<td>Tehran, Iran</td>
<td>Tehran University of Medical Sciences Department of International Relations PO Box 14155-6559 Tehran Tel: +98 21 649 1070 Fax: +98 21 641 9537 Email: <a href="mailto:office@tsa.tums.ac.ir">office@tsa.tums.ac.ir</a> Web: <a href="http://www.tums.ac.ir/about/index.html">http://www.tums.ac.ir/about/index.html</a></td>
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<tr>
<td>29 – 30</td>
<td>Cell Signalling and Novel Cancer Therapeutics</td>
<td>London, UK</td>
<td>British Association for Cancer Research (BACR) Sutton, United Kingdom Tel: +44 20 8722 4208 Fax: +44 20 8770 1395 Email: <a href="mailto:bacr@nrc.ac.uk">bacr@nrc.ac.uk</a> Web: <a href="http://www.bacr.org.uk/scientificmeetings/meetingdetail.asp?id=58">www.bacr.org.uk/scientificmeetings/meetingdetail.asp?id=58</a></td>
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<td>29 – 30</td>
<td>Cell Signalling and Novel Cancer Therapeutics</td>
<td>London, UK</td>
<td>British Association for Cancer Research (BACR) Sutton, United Kingdom Tel: +44 20 8722 4208 Fax: +44 20 8770 1395 Email: <a href="mailto:bacr@nrc.ac.uk">bacr@nrc.ac.uk</a> Web: <a href="http://www.bacr.org.uk/scientificmeetings/meetingdetail.asp?id=58">www.bacr.org.uk/scientificmeetings/meetingdetail.asp?id=58</a></td>
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<tr>
<td>27 – 29</td>
<td>6th European Oncology Nursing Society (EONS) Spring Convention</td>
<td>Geneva, Switzerland</td>
<td>Federation of European Cancer Societies (FECS) Brussels, Belgium Tel: +32 2 775 0201 Fax: +32 2 775 0200 Email: <a href="mailto:EONS@febs.be">EONS@febs.be</a> Web: <a href="http://www.febs.be">www.febs.be</a></td>
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<tr>
<td>15 – 19</td>
<td>EBCC 6: 6th European Breast Cancer Conference</td>
<td>Berlin, Germany</td>
<td>European Breast Cancer Conference (EBC) – EUROMA Europa Donna Brussels, Belgium Tel: +32 2 775 0201 Fax: +32 2 775 0202 Email: <a href="mailto:EBC@febs.be">EBC@febs.be</a> Web: <a href="http://www.febs.be/eurm2as/passid=1309">www.febs.be/eurm2as/passid=1309</a></td>
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<tr>
<td>May</td>
<td>30 – 3 June 44th ASCO Annual Meeting</td>
<td>Chicago, US</td>
<td>American Society of Clinical Oncology (ASCO)</td>
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<td>Tel: +1 703 299 0158, Fax: +1 703 299 0255, Email: <a href="mailto:meetings@asco.org">meetings@asco.org</a></td>
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<tr>
<td>June</td>
<td>4 – 7 10th International Conference on Malignant Lymphoma</td>
<td>Lugano, Swiss</td>
<td>Instituto Oncologico della Svizzera Italiana (IOSI)</td>
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<td>Tel: +41 91 922 0575, Fax: +41 91 922 2084, Email: <a href="mailto:Cristiana.brentan@lymphcon.ch">Cristiana.brentan@lymphcon.ch</a></td>
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<td>4 – 8 5th World Conference on Breast Cancer</td>
<td>Winnipeg, US</td>
<td>Canadian Breast Cancer Foundation</td>
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<td>Port Robinson, ON, Canada</td>
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<td>9 – 13 10th World Congress of Psycho-Oncology</td>
<td>Madrid, Span</td>
<td>International Psycho-Oncology Society (IPOS)</td>
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<td>Tel: +1 434 293 5350, Fax: +1 434 293 5350, Email: <a href="mailto:info@ipos-society.org">info@ipos-society.org</a></td>
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<td>Web: <a href="http://www.ipos-society.org">www.ipos-society.org</a></td>
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<tr>
<td>July</td>
<td>5 – 8 EACR 20: European Association for Cancer Research Conference</td>
<td>Lyon, France</td>
<td>Federation of European Cancer Societies (FECS)</td>
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<td>Brussels, Belgium</td>
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<td>Tel: +32 2 775 0246, Fax: +32 2 775 0209, Email: <a href="mailto:EACR20@feacs.be">EACR20@feacs.be</a></td>
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<td>Web: <a href="http://www.eacr.org">www.eacr.org</a>, <a href="http://www.feacs.be">www.feacs.be</a></td>
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<tr>
<td>August</td>
<td>17 – 22 12th World Congress on Pain</td>
<td>Glasgow, Scot</td>
<td>International Association for the Study of Pain (IASP)</td>
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<td>Seattle, WA, United States</td>
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<td>Web: <a href="http://www.iasp-pain.org.2008Congress.htm">www.iasp-pain.org.2008Congress.htm</a></td>
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<td>27 – 31 UICC World Cancer Congress 2008</td>
<td>Geneva, Swiss</td>
<td>UICC Congress Secretariat</td>
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<td>62, route de Frontenex 1207 Geneva, Switzerland</td>
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<td>Tel: +41 22 809 1811, Fax: +41 22 809 1810, Email: <a href="mailto:congress@uicc.org">congress@uicc.org</a></td>
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<td>September</td>
<td>10 – 13 ESSO 2008: 14th Congress of the European Society of Surgical Oncology</td>
<td>The Hague, Netherlands</td>
<td>Federation of European Cancer Societies (FECS)</td>
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<td>October</td>
<td>1 – 6 SIOP 2008: 40th Congress of the International Society of Paediatric Oncology (SIOP)</td>
<td>Berlin, German</td>
<td>SIOP Secretariat, c/o MCI Berlin Office</td>
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<td>Web: <a href="http://www.sion.org">www.sion.org</a></td>
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<td>19 – 23 32nd World Congress of the International Society of Haematology</td>
<td>Bangkok, Thai</td>
<td>International Society of Haematology (ISH)</td>
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<td>Tel: +66 2 201 1765, Email: <a href="mailto:webmaster@ish2008.org">webmaster@ish2008.org</a></td>
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<td>21 – 24 20th EORTC-NCI-AACR Symposium on Molecular Targets and Cancer Therapeutics</td>
<td>Geneva, Swiss</td>
<td>Federation of European Cancer Societies (FECS)</td>
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<td>25 – 28 12th Biennial International Gynaecologic Cancer Society Meeting</td>
<td>Bangkok, Thai</td>
<td>International Gynaecologic Cancer Society</td>
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THE CANCER COUNCIL AUSTRALIA

The Cancer Council Australia is the peak national cancer control organisation. Its members are the leading state and territory cancer councils, working together to undertake and fund cancer research, prevent and control cancer and provide information and support for people affected by cancer.

MEMBERS
The Cancer Council ACT
The Cancer Council New South Wales
The Cancer Council Northern Territory
The Cancer Council Queensland
The Cancer Council South Australia
The Cancer Council Tasmania
The Cancer Council Victoria
The Cancer Council Western Australia

AFFILIATED ORGANISATIONS
Australasian Association of Cancer Registries
Clinical Oncological Society of Australia Inc
Palliative Care Australia

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Dr K White PhD

THE CANCER COUNCIL AUSTRALIA

CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA INC

The Clinical Oncological Society of Australia (COSA) is a multidisciplinary society for health professionals working in cancer research or the treatment, rehabilitation or palliation of cancer patients.

It conducts an annual scientific meeting, seminars and educational activities related to current cancer issues. COSA is affiliated with The Cancer Council Australia.

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Ms A Woollett

MEMBERSHIP
Further information about COSA and membership applications are available from: www.cosa.org.au or cosa@cancer.org.au

Membership fees for 2007
Ordinary Members: $160
Associate Members: $100
(includes GST)

INTEREST GROUPS
ANZ Children’s Haematology and Oncology
Breast Oncology
Cancer Nurses Society of Australia
Cancer Research
Clinical Research Professionals
Epidemiological
Familial Cancer
Gastrointestinal Oncology
Gynaecological Oncology
Lung Oncology
Medical Oncology
Melanoma and Skin
Neuro-oncology
Palliative Care
Pharmacy
Psycho-Oncology
Radiation Oncology
Regional and Rural Oncology
Social Workers
Surgical Oncology
Urological Oncology