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Glossary

ABS  Australian Bureau of Statistics
AGPN  Australian General Practice Network
AHPA  Allied Health Professions Australia
AIHW  Australian Institute of Health and Welfare
ANF  Australian Nursing Federation
ANZSIC  Australian and New Zealand Standard Industrial Classification
APS  Australian Psychological Society
ASGO  Australian Society of Gynaecological Oncologists
ASCO  Australian Standard Classifications of Occupations
ASCED  Australian Standard Classification of Education
CanNET  Cancer Service Networks National Demonstration Program
CI-SCaT  Cancer Institute: Standard Cancer Treatment
CoN  College of Nursing
CPCN  Cancer and Palliative Care Network (WA)
DAA  Dietician’s Association of Australia
DEEWR  Department of Education, Employment and Workplace Relations
DoHA  Department of Health and Ageing
GMCT  Greater Metropolitan Clinical Taskforce (NSW)
MDC  Multidisciplinary care
MDT  Multidisciplinary team
NBOCC  National Breast and Ovarian Cancer Centre
Ob-gyn  Obstetrics and Gynaecology
RANZCOG  Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP  Royal Australian and New Zealand College of Psychiatrists
RANZCR  Royal Australian and New Zealand College of Radiologists
RCNA  Royal College of Nursing, Australia
Executive Summary

Approximately 3,800 women are diagnosed with gynaecological cancers each year (AIHW & AACR 2007). Although this is about one-third of the incidence for breast cancer, gynaecological cancers have a higher mortality rate resulting in half as many deaths as breast cancer. The survival rate for ovarian cancer is particularly low. Accounting for around a quarter of the incidence of gynaecological cancers, it causes just over half of all deaths. This combination of relatively low incidence rates with high mortality rates shapes the workforce.

This report reviews the workforce of professionals who provide diagnosis, treatment and care to women with gynaecological cancers. Its focus is on understanding features of the workforce relevant for ensuring that an adequately skilled workforce will be available into the future, even as the organisation of treatment and care for gynaecological cancer patients changes. The report is based on data from five sources: 1) existing data, 2) patients and their carers, 3) health professionals, 4) consultations with key stakeholders regarding action on the state Cancer Control Plans, and 5) the academic and grey literature on multidisciplinary care. Approximately 100 people and over 50 professional, advocacy, research and health service organisations contributed to the research.

The designated gynaecological cancers workforce is very small, comprised of gynaecological oncologists, gynaecological oncology nurses and a few medical specialists with a subspecialty in gynaecological oncology. A much larger group of health professionals have a designated role in the treatment and care of women with gynaecological cancers. Of those who have a designated role, few will see this as career-defining. Instead, their work with women with gynaecological cancers occurs as part of their broader occupational field and interests. They are best seen as a part of the wider health workforce whose contribution to treating and caring for women with gynaecological cancers is essential. This presents challenges for workforce planning: How does it affect the coordination of health services? How does it impact on changing models of care? What does it mean for training and skills development? What are the implications for patient outcomes?

Existing Data on Gynaecological Cancers Workforce

Existing data provides a limited picture of the gynaecological cancers workforce. Some data is available for gynaecological oncologists, of whom there are currently 36 practising in Australia. For other occupations involved in gynaecological cancer care, from specialist medical practitioners to general medical practitioners to nurses and allied health professionals, existing data do not allow separate identification of those with a specific gynaecological oncology role, or whether it relates to all of their jobs or only a part of them.

Efforts to make existing data more informative about the gynaecological cancer workforce are unlikely to be very feasible or useful. Aside from a very small number of professionals with highly specific skills in gynaecological cancer care, most workers with designated roles in relation to gynaecological cancer are drawn from larger workforces. It is data on these larger workforces, along with understanding
how they move into designated gynaecological cancer roles, that is relevant for workforce planning.

**Patient Experiences**

The consultations with patients and their carers indicated that:

- Overall the acute phase of treatment and care was good.
- In some hospitals, patients were caused considerable distress by being located in maternity wards, mixed gender wards, or other inappropriate wards. This location of patients sometimes meant that they did not have specialised nursing care, and it possibly also made the provision of any psychosocial or psychosexual support more difficult. Patient experiences could be improved by placing them in cancer-oriented wards without men.
- Difficulties for women tended to occur when they went home from hospital. Lack of coordination with GPs meant that when things went wrong, women felt isolated and unsure of what to do. Such problems were exacerbated for women living in rural areas. There was also very little psychosocial or psychosexual support provided either in hospital or on return home. Thus, there is scope for improving the coordination of patient’s post-discharge care with their GPs or other primary health care facility, and including a wider range of disciplines in multi-disciplinary care.

**The Gynaecological Cancer Workforce**

Our review of the workforce and work organisation in five case study sites showed that:

- Gynaecological oncologists have the central role in shaping the treatment and care of women with gynaecological cancers. Medical oncologists and radiation oncologists also play central roles in developing and implementing treatment plans. These highly trained specialists believe they have the skills they need to undertake their work to the highest standards.
- Nurses in jobs ranging from gynaecological cancer coordinators to surgical and ward nurses perform essential roles in caring for gynaecological cancer patients. They vary in the extent to which they feel they have the specific skills they would like for their jobs. Short courses could probably provide the additional training some would like. A similar situation exists for psychosocial support staff (social workers, counsellors and psychologists).
- Some nursing and allied health staff probably develop highly specific skills in gynaecological cancer care through long experience. These skills are not formally certified or recognised.
- Hospital organisation and the organisation of the wider health care system affect the roles of all categories of healthcare workers in the gynaecological cancer workforce. They also influence how models of care are operationalised.
The Implementation of Cancer Control Plans

To some extent state cancer control plans address the structural coordination of roles by providing a systemic, strategic approach to implementing models of care. These are inclusive of a greater range disciplines, including allied and primary health, palliative care and nurse coordinators. The plans have implications for the cancer workforce:

- They create efficiencies by streamlining processes and enhancing opportunities for skills escalation (where people provide the aspects of care that only they have the qualifications or experience to do).

- They expand the cancer workforce by creating new roles (lead clinicians, nurse coordinators), expanding the roles of other occupations (allied health, primary health) to be systematically involved in cancer care, and extending services to rural and remote areas (i.e. provide better geographic coverage of services). These roles need to be (re)defined and their incorporation into models of care clearly delineated.

Implementation of the plans is not uniform across Australia. Most attention has been placed on getting the service frameworks, clinical networks and referral pathways in place. There has been less attention on patient-centred care (including rural service provision), and using multidisciplinary teams to manage care across the illness trajectory. Consequently the systematic involvement of allied health and primary health care professionals has still not happened.

The analysis of the plans highlighted the multiple meanings associated with the concept of ‘multidisciplinary team’ and some of the issues associated with its use as a model of care across the illness trajectory. Multidisciplinary teams in gynaecological oncology are traditionally pathology driven and operate at the tumour board level. Questions remain as to how to involve specialists efficiently in multidisciplinary teams across the illness trajectory (e.g. avoiding membership of multiple teams, ensuring input is required/relevant); and how to systematically incorporate a broader range of health professionals (e.g. primary health and allied health workers, nurse coordinators).

Review of Literature on Multidisciplinary Team Initiatives in Gynaecological Cancer Care

The literature review reinforced the findings from our research that multidisciplinary teams are widely advocated and used in the treatment of a variety of illnesses including cancer. Australian cancer services appeared well advanced in their approach and research.

Multidisciplinary teams are used to systematically involve a range of disciplines in the care and treatment of women with gynaecological cancer. However, there is a tension between having a systematic approach to multidisciplinary teams and having teams that are flexible enough to properly address patient needs (which vary depending on type of tumour, stage of illness, location, resources etc.). As a result of this tension, multidisciplinary teams tend to be somewhat idiosyncratic.
While some guidelines exist about the preferred composition of multidisciplinary teams, there is little evidence about the required competencies.

Overall, more information is required about the relationship between multidisciplinary teams, the outcomes for women and the efficiencies for health professionals.

**Implications for Models of Care and Workforce Development**

The review’s findings support the view that desirable models of care in gynaecological cancer will have the following features:

- Allow co-location of patients with gynaecological cancers when they are hospitalised, in female-only, cancer-focused wards. This will improve patient’s experiences and assist workforce development.
- Provide psychosocial/sexual and allied health care as an integral part of treatment and care programs.
- Ensure adequate coordination between acute, specialist, hospital-based services and ongoing care and monitoring when women return to their homes and communities. This is likely to require involving GPs in care plans.
- Acknowledge and integrate the roles of patients’ carers (spouse, child, family member, friend, etc.) in their care plans, involving carers in developing plans where possible.
- Provide adequate systems to ensure that the needs of rural and remote women are met, given that acute services remain likely to be focused in metropolitan areas.
- Ensure that, where services are being provided to Aboriginal women, well known general principles for effective and culturally safe healthcare provision are followed.

The provision of an adequate future workforce will be enhanced by paying attention to the following implications of the research:

- Gynaecological oncologists - a small, highly specialised group of practitioners - are likely to continue to be the core of the gynaecological cancers workforce. Acute treatment is therefore likely to remain concentrated in metropolitan areas.
- Future models for the organisation of gynaecological cancer treatment and care may usefully be viewed as vehicles for workforce skill development, as well as models for patient treatment. Particularly for nursing and allied health care staff, how patient care is organised has great effect on the opportunities and incentives for on-the-job learning. This form of learning is likely to remain the dominant form through which these occupational groups gain specialist gynaecological cancer skills.
• There is some scope for developing short-courses for nursing and some allied health care staff to address their skill needs, and for fostering special interest groups in gynaecological cancer care within these occupations.

• Hospital organisation and the wider arrangements of healthcare will affect the viability of models for organising gynaecological cancer treatment and care.

• Collegial relationships between specialist medical practitioners may be an important mechanism for coordinating care, especially where more formal organisational processes or linkages are absent or ineffective.

• How public gynaecological cancer services are organised can be affected by the needs of specialists’ private practices.

• Having access to only private gynaecological cancer services for patients from rural and remote areas may affect the ease, convenience and cost of services for women reliant on the public system.

• Development of psychosocial/sexual care for gynaecological cancer patients will be best served if those providing these services develop some specialist skills in the area. This will be enhanced if the organisation of care promotes on-the-job learning for this group of workers.
1. Introduction

Gynaecological cancers are the fourth most common form of cancer; and the fifth most common form of cancer mortality for women in Australia. Affecting more than 3,800 women each year, in 2003 it accounted for 8.5 per cent of all female cancer deaths (AIHW & AACR 2007). Outcomes for women with gynaecological cancers are influenced by many factors including advances in technology, surgical techniques and drug regimes, and the patient’s medical history and access to services. Outcomes are also affected by the skills, composition, distribution and capacity of the workforce.

This review was conducted with the aim of improving outcomes for women by informing the development of a workforce strategy for the sustainability of services for women with gynaecological cancers. The scope of the review is broad and involved conducting five concurrent research projects based on accessing information from five sources: 1) the existing data, 2) patients and their carers, 3) health professionals, 4) consultations with key stakeholders regarding action on the state Cancer Control Plans, and 5) the academic and grey literature on multidisciplinary care. Approximately 100 people and over 50 professional, advocacy, research and health service organisations contributed to the research. The focus of this review is specifically on the workforce rather than the clinical aspects of care. Throughout the review we draw on our experience in conducting research on other health and medical workforces to inform our methodology and analyses. This report presents our findings. In constructing the review so that it met time requirements the projects have been conducted and reported upon as independent pieces of research. Key points and common themes across the projects are discussed in the conclusion.

Each of the following five sections of the report presents a particular research component of the review. The review begins in Section 2 by examining the existing data on the designated gynaecological cancers workforce. This component of the review was undertaken to assess the extent to which baseline data on the current workforce was available. As such we sought data that would provide information about the demographic characteristics, skills, type of employment, and career paths of health professionals with a designated role in the care and treatment of women with gynaecological cancers. The gynaecological cancers workforce is, however, a relatively small subset of a larger group of health/oncology professionals. Beyond gynaecological oncologists, the difficulties of identifying this workforce from the data, or the proportion of time that is allocated to gynaecological cancers by different professions meant that what we could ‘know’ from the existing data was limited. To better understand the workforce we needed to rely on other sources of information.

Section 3 provides information about the roles and activities of the workforce from consultations with 25 patients (and 6 carers) about their treatment and care. This includes a small sub-group of Aboriginal women. The focus in this section is on patient’s satisfaction with their experiences and interactions with a range of health professionals within the gynaecological cancers workforce; the issues arising from different elements of the models of care they experienced during their illness trajectory; and the contribution of carers (mostly family) to their care. The chapter
concludes with suggestions made by patients and carers that would have improved their care and treatment.

The majority of the patients recruited for these consultations were from five health services that were selected as case studies for the review. These health services – the Royal Adelaide Hospital, Monash Medical Centre, Flinders Private Hospital, the Royal Darwin Hospital and Border Medical Oncology Unit – were selected because they had particular characteristics in relation to their geographic location (metropolitan-regional-rural), the stage of implementation of state or territory cancer control plans, and whether they were public or private.

Section 4 draws on interviews conducted with medical specialists and other health professionals who worked at these five health services. A total of 37 people, over half of those with a designated role in the gynaecological cancers workforce in these services, were interviewed. The health professionals in these occupations discussed their roles in care provision, their career and skill acquisition pathways, the models of care used in the treatment of women with gynaecological cancers, and the organisation of the health service. Nationally, the designated gynaecological cancers workforce is relatively small. There are 36 gynaecological oncologists and a small, but unknown, number of gynaecological nurse coordinators who work almost exclusively with women with gynaecological cancers. Other members of the workforce with a designated role in gynaecological cancer care allocate a significant proportion, but not all, of their clinical time to the treatment of gynaecological cancers. The interviews provide insights into the various roles of the workforce and how these roles are coordinated to provide the required treatment and care to patients.

The provision of cancer care operates within particular organisational and policy contexts. The states in which the selected health sites were located operated under specific health policy regimes, with related cancer control plans: Victoria had just completed the three year cycle of its first cancer control plan and was about to implement its second; NSW was into its second cycle; SA was in the early stages of implementing its first plan; while the NT did not have a health plan specifically focused on cancer control. Cancer control plans aim to provide a framework for developing a comprehensive, effective and efficient approach to the treatment and care of people with cancer, irrespective of whether they are located in metropolitan or rural areas. This involves the implementation of a service framework, models of care and (elements of) workforce planning that takes account of the shift in cancer care from being an acute to a chronic disease. The analysis of these plans and the action taken on them is discussed in Section 5 of the review. Each of the mainland states has a cancer control plan. Consultations with key stakeholders in each state, plus those in professional and advocacy organisations were conducted to ascertain the impact of the plans on the workforce. Specifically, their views on three issues were sought: workforce capacity; changes in the models of care toward multidisciplinary teams; and the implications of the plans on services for women with gynaecological cancer. The analysis in this section of the report reinforces and builds upon the findings from the patient and workforce interviews.

The information gathered in the previous sections of the review indicates that women require treatment from health professionals across many disciplines at
various stages throughout their illness trajectory. These roles are coordinated through the development and implementation of models of care. One such model of care being advocated is the multidisciplinary team. Section 6 discusses the evidence relating to multidisciplinary teams for the treatment of women with gynaecological cancers in Australia and comparable Anglophone countries. The discussion draws on the academic and grey literature on multidisciplinary team care to identify how multidisciplinary teams work, the implications of innovations in models of care for the workforce and workforce planning, and whether there are evidence-based outcomes of these innovations for women with gynaecological cancer. As one of the key cross-cutting themes of the review, this section on multidisciplinary teams adds depth and context to the issues raised throughout the report.

In bringing together these perspectives on the gynaecological cancers workforce we identified several themes which cut across different sections of the review:

- **Multidisciplinary care:** The review took place within a policy context that is implementing new models of care across the cancer workforce. As such the report provides a focus on the implementation and experience of multidisciplinary care for women with gynaecological cancers. Issues regarding which professions are included in multidisciplinary care, the use of multidisciplinary teams, and access to multidisciplinary care are addressed in sections 3, 4, 5 and 6.

- **The management of cancer as a chronic disease:** The management of cancer has moved beyond its traditional focus on the acute, surgical intervention phase. This has resulted in an increased emphasis on the capacity of the patient to manage their own health. Issues regarding the shift to patient-centred care, including the geographical location of patients, their resources and their access to a range of health professionals are addressed in sections 3, 4 and 5 of the report.

- **Involvement of the non-oncology workforce:** Much of the ongoing care for women with gynaecological cancers is provided by workers who do not necessarily have a career-defining role in gynaecological cancer care. This is particularly so for most nurses, primary health care and allied health care professionals. Issues regarding their roles (and any changes), their needs re knowledge, skills and training and how to integrate them into management plans are addressed in sections 3, 4 and 5 of the report.

In concluding this introduction, we highlight some broader developments relating to health workforce planning. Workforce strategies for various sections of the health workforce are being developed within an active policy framework which has undergone substantial change over the last five years. Reports from the Productivity Commission (2005), The National Health Workforce Taskforce (2008) and The Australian Health Minister’s Conference (2004) indicate that a strategic, national approach is required. This is currently in its development stage and will undoubtedly shape the future of the health workforce. It will also influence the ways in which workforce data are collected and how workforce projections are estimated. There is, however, an alternative way of thinking about workforce planning called the ‘models of care’ (AHWAC et al 2005) or ‘skills mix’ (AHWAC 2004) approach.
This approach is thought to be most suited for a particular care group in which multidisciplinary models of care are prevalent and where workforce redevelopment might be necessary. In brief, this kind of workforce planning, ‘begins with identifying patient needs and determining the best skill mix of health care workers to provide the care (assessing competencies, reviewing skill mix and planning for teams)’ (AHWAC 2004, p73). The ‘models of care’ approach is still in the development stage, although there has been some movement toward its adoption in the nursing workforce (AHWAC 2004). It is presented here as a potential tool for use by Cancer Australia in thinking through what the impact of changing models of cancer care might be for the gynaecological cancers workforce.
2. Review of Existing Data on the Gynaecological Cancers Workforce

In this section we focus on published and unpublished data for future workforce planning, such as demographic characteristics, skills, type of employment, workforce histories and intentions and attitudes of health professionals about their jobs. The sources of these data include government departments, professional colleges, registration bodies, medical societies and associations, research centres and universities. The terms of reference for the study define the workforce as those who have ‘a designated role in caring for women with any type of gynaecological cancer.’

Existing data sets are generally not specific enough to provide useful information for workforce planning. Data on the characteristics of the Australian medical workforce are collected by the Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW). ABS uses the 6 digit codes in the Australian Standard Classification of Occupations (ASCO), which give the most detailed classification of occupations. However, even at the 6-digit level, the sub-categories are too broad to identify a specific workforce sub-group such as gynaecological oncologist. AIHW datasets contain a more detailed classification of the specialty areas of health workers, and constitute the most reliable source. National and state health departments were not able to provide suitable data.

Professional colleges usually maintain an internal database of their members, and some of them have conducted surveys in recent years. They tend to use more detailed specialisation or sub-specialisation categories (e.g. gynaecological oncologist, instead of ob-gyn specialist), however, the data on the characteristics of the workforce are limited.

Data on current students are potentially important in providing insights on the future supply of health professionals. However, relevant data on the current students entering occupations specifically relating to the designated gynaecological cancers workforce are similarly not available even at the most detailed coding level under the Australian Standard Classification of Education (ASCED) 2001. This is consistent with current models of health professional education, which prepare students for broad professional roles.

We review the available data for medical specialists, nurses and allied health professionals below.

2.1 Medical Specialists

As well as AIHW and the Department of Health and Ageing (DoHA), data were sought from Health Workforce Australia, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Royal Australian and New Zealand College of Radiologists (RANZCR). Several research fellows from universities were also contacted to seek advice on the data sources that may contain information of our interest. Of all these sources, RANZCOG, RANZCR and AIHW held the most relevant data on relevant medical specialisations.
It proved difficult to isolate medical professionals who can be explicitly defined as having a designated role in the gynaecological cancers workforce. The treatment of gynaecological cancers requires a medical team including gynaecological oncologists, medical oncologists, radiation oncologists, and anatomical pathologists, each with a specific role and each involved in treatment for different proportions of their clinical time. This makes it very difficult to identify the extent of their designated role in the gynaecological cancer workforce, including the actual hours they spend in treating women with gynaecological cancers.

With these limitations in mind, we use data from RANZCOG to provide details of the characteristics of gynaecological oncologists, RANZCR for statistics on radiologists who have gynaecological cancer as their subspecialty; the AIHW Medical Labour Force Survey 2005 for data on medical oncologists; and the Royal College of Pathologists of Australasia (RCPA) for data on anatomical pathologists.

### 2.1.1 Gynaecological Oncologists

RANZCOG trains and accredits obstetricians and gynaecologists throughout Australia and New Zealand. The College maintains an internal database of information on the demographic and employment characteristics of obstetricians and gynaecologists who specialise in gynaecological oncology, as well as data for specialists from other subspecialties. This internal database is updated regularly and contains the most current, useful and complete data on gynaecological oncologists.

According to the RANZCOG definition, a gynaecological oncologist is required to have completed a formal three year training program in gynaecological cancer care, have passed the examination as a Certified Gynaecological Oncologist, and spend at least 66 per cent of their time specifically in gynaecological oncology practise. The RANZCOG data enables us to perform a descriptive analysis of Fellows who are in active practise.

According to RANZCOG’s annual statistics from 2008, there are currently 1,288 ob-gyn specialists in Australia. Of these specialists, 175 (14 per cent) have completed a subspecialty in ob-gyn, of which 36 have a subspecialty in gynaecological oncology. As indicated in Table 2.1, the number of (sub)specialists is not distributed evenly between genders, and this is especially true for gynaecological oncologists with 31 out of 36 (86 per cent) of gynaecological oncologists being male, compared to approximately two thirds (66 per cent) of practitioners in the rest of the ob-gyn areas.

No gynaecological oncologist is aged below 35 years. This is largely due to the number of years of training required before registration. There are 8 (22 per cent) gynaecological oncologists in the 35-44 age group, 18 (50 per cent) aged 45-54, 8 (22 per cent) aged 55-64, and 2 (6 per cent) are aged 65 or over.

---

1 This is not a comprehensive list and the team may also include haematologists, geneticists and other similarly specialised areas.
2 RANZCOG offers training in five different subspecialties, including gynaecological oncology, obstetrical and gynaecological ultrasound, maternal-fetal medicine, reproductive endocrinology and infertility and urogynaecology.
3 Approximately 92 percent of all ob-gyn specialists have provided information on their date of birth.
Table 2.1: Number of RANZCOG Fellows by Gender and Age by Subspecialty

<table>
<thead>
<tr>
<th></th>
<th>With Completed Sub-Speciality</th>
<th>Without a Sub-Speciality and not in Training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gynaecological Oncology</td>
<td>All Other Areas</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 35</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>35-44</td>
<td>7</td>
<td>25</td>
<td>144</td>
</tr>
<tr>
<td>45-54</td>
<td>15</td>
<td>33</td>
<td>213</td>
</tr>
<tr>
<td>55-64</td>
<td>7</td>
<td>26</td>
<td>278</td>
</tr>
<tr>
<td>65+</td>
<td>2</td>
<td>8</td>
<td>129</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 35</td>
<td>-</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>35-44</td>
<td>1</td>
<td>22</td>
<td>63</td>
</tr>
<tr>
<td>45-54</td>
<td>3</td>
<td>21</td>
<td>121</td>
</tr>
<tr>
<td>55-64</td>
<td>1</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td>65+</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
<td><strong>139</strong></td>
<td><strong>1013</strong>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>1188</strong>*</td>
</tr>
</tbody>
</table>

* Note: date of birth missing from some records
Source: RANZCOG annual statistics 2008

Compared with the whole ob-gyn workforce, the gynaecological oncologist workforce is younger, with 28 per cent of practising gynaecological oncologists aged over 55 years compared to 42 per cent of the total ob-gyn workforce. The vast majority (99 per cent) of ob-gyn subspecialists work in metropolitan areas\textsuperscript{4} compared to 86 per cent for the whole ob-gyn workforce. No information was available on the level of outreach services provided.

NSW had the highest proportion of gynaecological oncologists with 42 per cent, followed by Victoria, Queensland and WA, with 22 per cent, 14 per cent and 11 per cent respectively. There are no gynaecological oncologists in the ACT or NT. This distribution is slightly different to that of the ob-gyn workforce as a whole which is more proportionally spread across states. NSW had the highest proportion of ob-gyn specialists with 32 per cent, followed by Victoria and Queensland 27 per cent and 19 per cent, while ACT and NT had 2 per cent and 1 per cent of the workforce respectively.

\textsuperscript{4} Approximately 94 percent of the specialists have provided information on their geographic location by the Rural, Remote and Metropolitan Areas (RRMA) classification.
Table 2.2: Number of RANZCOG Fellows by State by Subspeciality

<table>
<thead>
<tr>
<th></th>
<th>With Completed Sub-Speciality</th>
<th>Without a Sub-Speciality and not in Training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Gynaecological Oncology</td>
<td>In all Other Areas</td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>-</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>NSW</td>
<td>15</td>
<td>60</td>
<td>342</td>
</tr>
<tr>
<td>VIC</td>
<td>8</td>
<td>42</td>
<td>300</td>
</tr>
<tr>
<td>QLD</td>
<td>5</td>
<td>15</td>
<td>226</td>
</tr>
<tr>
<td>SA</td>
<td>3</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>WA</td>
<td>4</td>
<td>11</td>
<td>89</td>
</tr>
<tr>
<td>NT</td>
<td>-</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>TAS</td>
<td>1</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
<td><strong>139</strong></td>
<td><strong>1112</strong>*</td>
</tr>
</tbody>
</table>

* Note: location information missing from one record
Source: RANZCOG annual statistics 2008

In proportion to population, NSW has a relatively larger number of gynaecological oncologists; SA, WA and Tasmania have roughly proportionate numbers while Queensland and Victoria appear to be under-supplied by gynaecological oncologists. Table 2.3 provides the place of usual residence by states and territories in 2006 (ABS Census data). Please note that no adjustment has been made for any differences in demand for services, and neither are we commenting on the adequacy of the total workforce supply.

Table 2.3: State of Residence Compared to Location of Gynaecological Oncologists, by States and Territories

<table>
<thead>
<tr>
<th></th>
<th>No. of Persons*</th>
<th>Percentage of population</th>
<th>Percentage of gynaecological oncologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>6,549,177</td>
<td>32.98</td>
<td>41.7</td>
</tr>
<tr>
<td>VIC</td>
<td>4,932,422</td>
<td>24.84</td>
<td>22.2</td>
</tr>
<tr>
<td>QLD</td>
<td>3,904,532</td>
<td>19.66</td>
<td>13.9</td>
</tr>
<tr>
<td>SA</td>
<td>1,514,337</td>
<td>7.63</td>
<td>8.3</td>
</tr>
<tr>
<td>WA</td>
<td>1,959,088</td>
<td>9.87</td>
<td>11.1</td>
</tr>
<tr>
<td>TAS</td>
<td>476,481</td>
<td>2.40</td>
<td>2.8</td>
</tr>
<tr>
<td>NT</td>
<td>192,898</td>
<td>0.97</td>
<td>0</td>
</tr>
<tr>
<td>ACT</td>
<td>324,034</td>
<td>1.63</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>2,319</td>
<td>0.01</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,855,288</strong></td>
<td><strong>100.00</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

* Source: ABS 2006 Census QuickStats
2.1.2 Radiation Oncologists

The Faculty of Radiation Oncology in the Royal Australian and New Zealand College of Radiologists (RANZCR) provided us with statistics on radiation oncologists from their internal database and a workforce survey conducted in 2006. The internal database covers all members in RANZCR and records characteristics such as age group, state and territory of residence and full-time/part-time status. The workforce survey was tailored to obtain information on work conditions and attitudes, and also collected information on hours worked, regions, and work arrangement (e.g. public/private sector).

Unlike other data collections on radiation oncologists, the RANZCR data provided information based on the total population of radiation oncologists (as opposed to a sample from a survey), and contained detailed information on numbers and characteristics of subspecialists.

There are currently 242 radiation oncologists practising in Australia. The profession is male dominated, with 67 per cent (162) of radiation oncologists being male. As shown in Table 2.4, the gender imbalance is particularly evident in the age groups 45-54, 55-64 and >65, where the percentage of male radiation oncologists is 71 per cent, 83 per cent and 88 per cent respectively. In contrast, 40 per cent of the 35-44 age group is female, and 77 per cent in the <35 age group.

Table 2.4: Number of Radiation Oncologists by Sex and Age

<table>
<thead>
<tr>
<th>Age Category</th>
<th>&lt;35</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>&gt;65</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male*</td>
<td>5</td>
<td>59</td>
<td>55</td>
<td>35</td>
<td>7</td>
<td>161*</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>39</td>
<td>23</td>
<td>7</td>
<td>1</td>
<td>80</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>98</td>
<td>78</td>
<td>42</td>
<td>8</td>
<td>241</td>
</tr>
</tbody>
</table>

* Note: date of birth missing from one record

Source: RANZCR Database, 2008

More than 60 per cent of the women in this field are under 45, compared to 40 per cent of the men. The vast majority (89 per cent) of radiation oncologists are working full-time, with women slightly more likely to work part-time (17 per cent compared to 8 per cent).

Table 2.5 shows the distribution of radiation oncologists by state, relative to population share. Victoria has a higher proportion of radiation oncologists than its population might suggest, while SA and WA have a slightly lower proportion. For other states and territories the difference is less than two per cent.
Table 2.5: Location of Radiation Oncologists Compared to State of Residence of Population, by States and Territories

<table>
<thead>
<tr>
<th></th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Radiation oncologists</td>
<td>7</td>
<td>79</td>
<td>0</td>
<td>53</td>
<td>10</td>
<td>5</td>
<td>72</td>
<td>16</td>
<td>242</td>
</tr>
<tr>
<td>% Radiation oncologists</td>
<td>2.9</td>
<td>32.6</td>
<td>0</td>
<td>21.9</td>
<td>4.1</td>
<td>2.1</td>
<td>29.8</td>
<td>6.6</td>
<td>100</td>
</tr>
<tr>
<td>% Population</td>
<td>1.6</td>
<td>33.0</td>
<td>1.0</td>
<td>19.7</td>
<td>7.6</td>
<td>2.4</td>
<td>24.8</td>
<td>9.9</td>
<td>100</td>
</tr>
</tbody>
</table>

* Source: RANZCR Database, 2008

RANZCR list gynaecology as one of their areas of special interest. This option was selected by 10 Australian radiation oncologists, of whom five have a practise in NSW, four in Queensland and one in Victoria.

In 2006, the Faculty of Radiation Oncology in RANZCR conducted a survey of Fellows’ work conditions and attitudes. This workforce survey provides the most up to date data on radiation oncologists, including those who have a subspecialty in gynaecology.

There were 111 respondents to the survey, 54 of whom identified themselves as subspecialists in radiation oncology. Six identified gynaecology as one of their subspecialties, and 1 person identified gynaecology as their only subspecialty. Of these 7, 6 were male. As defined in the survey, a radiation oncologist can claim a clinical practice as a subspecialty when they spend 50 per cent or more of their working time on it. As some radiation oncologists named two or more subspecialties, the responses may not be perfectly reliable, but can be used as a guide.

Gynaecology subspecialists were located in only two states, with 6 of them based in NSW and one in Victoria. All seven gynaecology subspecialists worked primarily in the public sector, and resided and worked in capital cities for the majority of their time. Two of the gynaecology subspecialists also worked in rural areas. Two worked part-time, with 30 clinical hours per week. The other five subspecialists worked full-time, with four working 40-50 clinical hours weekly and one working 60 clinical hours per week.

2.1.3 Medical Oncologists

AIHW publishes the national Medical Labour Force Survey which is conducted annually by state and territory health departments utilising the Medical Boards’ registration renewal process for distribution. It includes a range of demographic and employment characteristics that are essential for workforce planning. The report of the 2005 survey provides the most recent and relevant information on the number of medical oncologists by state and territory, age and weekly clinical hours.

AIHW estimates that there were 259 medical oncology clinicians in 2005. Their average age was 44.4 years with nearly half (47 per cent) aged 35-44, and 31 per cent aged 45-54 years. This suggests that any shortages of medical oncologists are unlikely to be due to a cohort of (age-related) retirements. The gender distribution is
similar to that of radiation oncologists with 66 per cent being male and 34 per cent female. Further breakdown of these statistics into age-groups was not possible.

As illustrated in Table 2.6, medical oncologists worked an average of 39.6 clinical hours per week, with 35 per cent working part-time (fewer than 35 clinical hours per week). Approximately one quarter (26 per cent) of medical oncologists worked more than 50 clinical hours per week, 7 of whom worked 65-79 hours, with 4 stating that they worked over 80 clinical hours per week.

Table 2.6: Number of Clinical Hours Worked Per Week by Medical Oncologists, 2005

<table>
<thead>
<tr>
<th>Clinical hours worked per week</th>
<th>1-19</th>
<th>20-34</th>
<th>35-49</th>
<th>50-64</th>
<th>65-79</th>
<th>80+</th>
<th>Not stated</th>
<th>Total</th>
<th>Average clinical hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical oncology</td>
<td>11</td>
<td>80</td>
<td>89</td>
<td>58</td>
<td>7</td>
<td>4</td>
<td>10</td>
<td>259</td>
<td>39.6</td>
</tr>
</tbody>
</table>

Source: AIHW Medical Labour Force Survey 2005

As Table 2.7 shows the distribution of medical oncologists is somewhat more uneven than that of radiation oncologists. Once again Victoria has a higher proportion of medical oncologists than its population might suggest. In contrast NSW has a relatively lower proportion. Queensland, WA and NT also have slightly lower proportion of medical oncologists in relation to population, while the ACT, SA and Tasmania have a slightly higher proportion.

Table 2.7: Number of Medical Oncologists (Clinicians Only) Compared to State of Residence of Population, by States and Territories

<table>
<thead>
<tr>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Medical oncologists</td>
<td>6</td>
<td>71</td>
<td>-</td>
<td>41</td>
<td>25</td>
<td>8</td>
<td>90</td>
<td>18</td>
</tr>
<tr>
<td>% Medical oncologists</td>
<td>2.3</td>
<td>27.4</td>
<td>0</td>
<td>15.8</td>
<td>9.7</td>
<td>3.1</td>
<td>34.8</td>
<td>6.9</td>
</tr>
<tr>
<td>% Population</td>
<td>1.6</td>
<td>33.0</td>
<td>1.0</td>
<td>19.7</td>
<td>7.6</td>
<td>2.4</td>
<td>24.8</td>
<td>9.9</td>
</tr>
</tbody>
</table>

* Source: AIHW Medical Labour Force Survey 2005

2.1.4 Pathologists

Anatomical pathologists form the main group of pathologists who take part in the diagnosis and treatment of gynaecological cancers. Nevertheless, anatomical pathologists can work in a range of cancer areas and gynaecological cancers are likely to count as only a small proportion of their work. Whilst data on those significantly engaged in gynaecological work are not available, both AIHW and the Royal College of Pathologists (RCPA) hold some statistical information on pathologists who would be suitably trained to work in this area.
According to the most recent data (2008) from RCPA, there are 598 anatomical pathologists in Australia, with more than half (58 per cent) being male. Of all the anatomical pathologists, 123 explicitly listed either gynaecology (18) or cytology (105) as their special interest. Of these, 53 (43 per cent) are male indicating that this is a more female dominated area than anatomical pathology more generally.

As Table 2.8 shows the workforce for anatomical pathology is ageing, with nearly one quarter (22 per cent) of practising anatomical pathologists aged between 55 and 64 years, and 12 per cent being 65 years of age or over. The ageing problem is more serious among male anatomical pathologists, with 26 per cent in the 55-64 age group and 17 per cent in the 65 and over age group.

<table>
<thead>
<tr>
<th>Table 2.8: Number of Anatomical Pathologists by Age Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;35</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Source: RCPA, College Database, 2008

The number and characteristics of new fellows in anatomical pathology has changed in the past five years. Between 2003 and 2007, RCPA recruited 126 fellows: 59 males and 67 females. During these five years, the number of female anatomical pathologists grew at a higher rate than male anatomical pathologists with the number of male specialists increasing by 21 per cent, and the number of female specialists increasing by 36 per cent (Table 2.9).

<table>
<thead>
<tr>
<th>Table 2.9: Number of New Fellows in Anatomical Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Source: RCPA, College Database, 2008

Data from AIHW Medical Labour Force Survey 2005 included anatomical pathology as one of the specialties under pathology and incorporated the distribution of anatomical pathologists by state and territory. AIHW estimated the total number of anatomical pathologists (clinicians only) to be 562 in 2005. NSW had nearly 41 per cent of all anatomical pathologists, a high proportion in comparison to population share. Queensland and Victoria have fewer anatomical pathologists than might be expected, while the other states and territories were, by and large, proportionally represented.
Table 2.10: Number of Anatomical Pathologists (Clinicians Only) Compared to State of Residence of Population, by States and Territories

<table>
<thead>
<tr>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Anatomical pathologists</td>
<td>15</td>
<td>230</td>
<td>(2)*</td>
<td>83</td>
<td>46</td>
<td>16</td>
<td>117</td>
<td>53</td>
</tr>
<tr>
<td>% Anatomical pathologists</td>
<td>2.7</td>
<td>40.9</td>
<td>0.4</td>
<td>14.8</td>
<td>8.2</td>
<td>2.8</td>
<td>20.8</td>
<td>9.4</td>
</tr>
<tr>
<td>% Population</td>
<td>1.6</td>
<td>33.0</td>
<td>1.0</td>
<td>19.7</td>
<td>7.6</td>
<td>2.4</td>
<td>24.8</td>
<td>9.9</td>
</tr>
</tbody>
</table>

* Source: AIHW Medical Labour Force Survey 2005
# Numbers for NT were not published by AIHW, however to get a total of 562 pathologists, NT would need to have 2. All other data are replicated from the AIHW source above.

2.2 Nurses

Over the course of this research we contacted various nursing bodies seeking data on those nurses who provide care for women receiving treatment for gynaecological cancers. This included the Cancer Nurses’ Society of Australia, the Australian Nursing Federation, the Royal College of Nursing Australia, and representatives of several State-based nursing and midwifery boards. We also contacted nursing researchers in teaching hospitals, academia, and other clinical settings, seeking their advice about where to look for information relevant to our investigation. None of these contacts yielded systematic workforce data of a kind suitable for the current interests and workforce planning needs of Cancer Australia. 

The most comprehensive existing national data on the nursing workforce are those collected by the Australian Institute of Health and Welfare (AIHW), and presented in its annual ‘Nursing and Midwifery Labour Force’ reports. These reports describe nurses’ main areas of clinical practice, and include relevant demographic and employment-related information, such as age, sex, and working hours. The AIHW reports indicate that the surveys on which they are based have had a declining response rate. The data are collected by sending questionnaires to nurses renewing registration or enrolment with one of the state-based nursing and midwifery boards. Between 1999 and 2004, the proportion of all nurses (registered and enrolled) who returned the AIHW survey nationally fell by 18 percentage points, to 60 per cent. The final data presented in the AIHW reports are therefore estimates of the size and attributes of the nursing labour force, rather than the results of a formal workforce audit or census. However, in light of the lack of alternative workforce data, and the fact that the response rate to recent AIHW surveys remains well above 50 per cent, we believe that the AIHW data offer the most reliable contemporary picture of nurses with a designated role in caring for women with gynaecological cancers.

2.2.1 AIHW Nursing Labour Force Survey

AIHW reports data about ‘principal area of practice’ for employed clinical nurses in their main job separately by State and Territory, and cross-tabulates the estimated number of nurses in each practice area against other characteristics such as their age and average hours of work. By combining the state-based clinical practice data we
can build a national picture of nurses’ distribution across the main areas of clinical practice.

The areas of clinical practice shown in the published AIHW reports are too broad to enable the identification of gynaecological cancer nurses. However, a number of the accompanying data tables available from the AIHW website show a more detailed breakdown of clinical practice areas, including oncology/haematology and gynaecology, the most relevant categories. The most recently released data are from the 2004 nursing labour force survey.

Unfortunately there is no single professional category in which all of the nurses caring for women with gynaecological cancers are grouped. Women receiving treatment for these cancers are seen by a diverse group of nurses, depending on their physical location, insurance status, age, and progression of the disease. Among the categories of nurses who may come into contact with women affected by gynaecological cancers are oncology nurses, general surgical nurses, women’s health nurses, community health nurses, and palliative care nurses. None of these groups of nurses can be explicitly defined as part of the designated ‘gynaecological cancers’ workforce.

For this reason we focus only on oncology/haematology nurses and surgical nurses who specialise in gynaecology. While it will also be the case that some nurses in these two sub-groups have no substantial exposure to women with gynaecological cancers, by focusing on these two groups only, the analysis gets as close as possible to the nurses with a designated role in gynaecological cancer.

Across Australia, an estimated 4179 employed clinical nurses had a medical speciality in oncology and haematology in 2004, or 2 per cent of the total employed clinical nursing workforce of 218,000. A smaller number – 826 nurses – specialised in surgical gynaecology (less than 0.5 per cent of the total). The estimate for surgical gynaecology nursing understates the true number of nurses working in this area, because the relevant data are not collected in every jurisdiction. Surgical gynaecology is not defined as a specific area of clinical practice in South Australia, the Northern Territory, or the ACT. Accordingly, the data we provide on surgical gynaecology nurses in this section refer only to the five States of New South Wales, Victoria, Queensland, Western Australia, and Tasmania.

Medical oncology nursing and surgical gynaecology nursing are small components of the whole clinical nursing workforce. The AIHW data tell us that, in 2004, there were nearly 218,000 employed clinical nurses across Australia. Nurses whose primary practice area was in oncology/haematology represented 2 per cent of this total, while nurses primarily practising surgical gynaecology represented less than half of one per cent of all nurses. In describing the attributes of nurses with the greatest exposure to women with gynaecological cancers, we are therefore reporting on a small subset of the whole nursing workforce.

To obtain Australia-wide estimates of the demographic and other attributes of nurses with specialities closest to ‘designated roles’ in gynaecological cancer treatment, we have combined the state-level estimates from the 2004 AIHW nursing labour force data tables into a synthetic national dataset. Table 2.11 shows the results of our
analysis for selected characteristics of the medical oncology and surgical gynaecology nursing workforces. For comparison, we have also shown the data for all nurses irrespective of their primary practice area.

Table 2.11: Demographic and Employment Attributes of Selected Nurses, 2004 (Per Cent)

<table>
<thead>
<tr>
<th>Primary area of clinical nursing</th>
<th>Aged 55+</th>
<th>Male</th>
<th>Registered</th>
<th>Part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical: Oncology/haematology</td>
<td>9</td>
<td>7</td>
<td>90</td>
<td>42</td>
</tr>
<tr>
<td>Surgical: Gynaecology</td>
<td>13</td>
<td>n/a</td>
<td>85</td>
<td>55</td>
</tr>
<tr>
<td>All nurses</td>
<td>15</td>
<td>8</td>
<td>78</td>
<td>51</td>
</tr>
</tbody>
</table>

Note: Estimates shown for medical oncology/haematology nurses exclude the Northern Territory. The estimates for surgical gynaecology nurses exclude three jurisdictions – South Australia, the Northern Territory, and the Australian Capital Territory – because the relevant information is not collected.

Source: AIHW Nursing Labour Force Survey, 2004

The estimates shown in Table 2.11 indicate that nurses who practice primarily in medical oncology/haematology are younger, more likely to be registered, and less likely to be working part-time, than nurses on average. However they are no different in terms of gender – like the majority of nurses, those practicing in the area of medical oncology are overwhelmingly female. No specific data are available at the national level on the gender composition of surgical nurses primarily practising in the area of gynaecology. Where data are available at state level, however, they show that surgical gynaecology nurses are almost always women. In NSW and QLD, 99 per cent of the nurses practising in this area were women. In Tasmania the figure is somewhat lower – 90 per cent – but this estimate is based on a very small number of observations. Surgical gynaecology nurses have a similar age profile to nurses generally, although they are older on average than oncology/haematology nurses. The attribute which most distinguishes surgical gynaecology nurses is their propensity to work part-time. Over half of these nurses work on a part-time basis, which is slightly above the average rate for all nurses, but well above the rate for nurses specialising in oncology/haematology. These differences in part-time employment rates may suggest that nurses with specialised skills in medical oncology/haematology are in greater demand than nurses practising in surgical gynaecology settings, or may reflect choices made by these nurses or the requirements of their clinical roles.

Data on average weekly working hours are also available. Figure 2.1 graphs average weekly working hours for employed clinical nurses, in each jurisdiction in 2004. As expected, average hours are generally longer for nurses practising in the area of medical oncology/haematology than for those whose focus is surgical gynaecology. The exception to this rule is Victoria, where the two groups of nurses have very similar average hours. The longest working hours for medical nurses practising in oncology/haematology are in the ACT (39), and the shortest hours are in South Australia (32). The longest working hours for surgical gynaecology nurses are in Victoria (33), while the shortest hours are in Western Australia (28).
AIHW has also published a limited time series of data on the number and attributes of registered and enrolled nurses whose principal work area is oncology. The data cover the period 1997 to 2001. It is not possible with these data to specifically identify the nurses who work in gynaecological cancer settings. In practice, women undergoing treatment for gynaecological cancer will see a diverse range of nurses, including some who would not be classified by the AIHW as ‘oncology’ nurses. These include nurses working primarily in surgical, medical, palliative care and community roles, all of which are separate from the oncology sub-group. However, nurses who self-identify as oncology practitioners are most likely to be working in cancer centres, and this is where a large part of the treatment provided to women with gynaecological cancers occurs. It is for this reason that we focus on oncology nurses in the following analysis of changes in the workforce over time.

Between 1997 and 2001, the estimated number of clinical nurses across Australia with oncology as the principal area of work in their main job increased from 2663 to 3681. This represents an increase of just over one thousand nurses, or 38 per cent, in the space of four years, compared to a 21 per cent increase in the total number of clinical nurses. These figures suggest that oncology has been an area of exceptional growth in nursing employment over recent years. Note, however, that these estimates refer only to the numbers of nurses employed in oncology. In further analysis (below), we consider changes in workforce supply by reference to the hours worked by nurses in clinical settings.

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5 The time series actually extends back to 1995, but the data for oncology nursing that we use in this section are only available from 1997.
In both 1997 and 2001, nine out of ten nurses who nominated oncology as their main area of practice were registered. This proportion is substantially higher than the share of registered nurses in the whole clinical nursing workforce, which was 78 per cent in 1997 and 79 per cent in 2001, which may be indicative of the complexity of oncology nursing. It should be noted that although the field of oncology nursing is growing relative to the total nursing workforce, oncology nursing represents only a small component of the care delivered by nurses.

The AIHW time series data also show the age profile, geographic distribution, and working hours of nurses who spent most of their time working in oncology settings. The AIHW data indicate that registered oncology nurses are generally younger than other registered nurses. This youthful profile has become slightly more pronounced as the oncology nursing workforce has expanded. In 1997, registered nurses mainly working in oncology settings had an average age of 37 years, compared to an average of 40 years for all registered nurses. By 2001, the average age of an oncology nurse was 38 years, compared to an average of 42 for all other clinical registered nurses. In all, 41 per cent of oncology nurses were under 35 years of age (in 2001), compared to only 28 per cent of all registered nurses.

Oncology nurses are also more heavily concentrated in metropolitan areas. In 1997, three quarters of oncology nurses were based in a major city for most of their clinical working time. This metropolitan concentration increased slightly (to 76 per cent) in the four years to 2001. The rest of the registered nursing workforce is more evenly distributed throughout regional and remote parts of Australia. In 2001, oncology nurses were about half as likely to hold jobs based in regional areas as registered nurses generally. More than one quarter of all registered clinical nurses were based in inner or outer regional areas, compared to 13 per cent of the nurses who identified oncology as their main area of clinical work. Some of the nurses who spend the bulk of their time in city areas may also contribute occasional care in regional or remote locations, but the AIHW estimates show only the primary work location, based on where most clinical hours were worked. However, there is clearly a tendency for cancer services to be situated in metropolitan areas, and this pattern is consistent with the evidence that the oncology nursing workforce is over-represented in major cities, relative to other parts of the nursing profession.

Average working hours for oncology nurses are longer than for all registered nurses, but appear, on the limited evidence available, to be falling slightly over time. In 1997, the average oncology nurse worked a total of 33 hours, compared to an average of 31 hours for registered nurses generally. The average working week fell by one hour for oncology nurses between 1997 and 2001, while the average for all registered nurses was unchanged. In 2001, just over half of oncology nurses (52 per cent) were full-time (working 35 hours or more), compared to 44 per cent of all registered nurses. Given the rapid growth in the number of nurses employed in oncology settings it is perhaps surprising that the average length of the oncology nursing week has not fallen further. The fact that the number of oncology nurses has expanded by 38 per cent, with only a slight reduction in average total working hours, suggests that there is strong and expanding demand for oncology nursing services in the Australian community.

6 These figures include in the total numbers employed those nurses for whom the main geographic location could not be determined. The concentration of oncology nurses in major cities would be even stronger if those with indeterminate locations were excluded from the calculations.
2.3 Allied Health Workers

Allied health workers are part of the multidisciplinary teams that care for women with gynaecological cancers, including social workers, pharmacists, physiotherapists, psychologists, dieticians and genetic counsellors.

We contacted a number of professional bodies and organisations which we anticipated might hold relevant data on allied health workers, such as the Australian Psychological Society (APS), Allied Health Professions of Australia (AHPA) and the Mental Health and Workforce Division in DoHA. However, these organisations did not have the level of detailed data necessary for our purpose, and referred us to other sources or contact persons few of which yielded systematically collected data at the level of detail required. Psychologists are the sole exception.

2.3.1 Psychologists

The Australian Psychological Society (APS) has nine Colleges, each representing a specialist area in psychology, one of which is defined by the APS as health psychology. The College of Health Psychologists currently has 281 members in Australia. Apart from the number of members by state and territory there is no other available data on their membership. While APS does have more detailed data on their members, they indicated to us that the data they could provide would be only rough estimates and would not tell us whether a psychologist was involved in the treatment of gynaecological cancers patients. Since the APS data would not be of high quality and relevance, we have decided not to proceed with a request for more detailed data.

Almost half of the 281 members of the College of Health Psychologists are located in Victoria (45 per cent). This is nearly double what might be expected from comparison with the proportion of their population. In contrast, NSW, Qld and WA have fewer health psychologists than would be expected, while ACT, NT, SA and Tasmania are roughly proportional with their population.

Table 2.12: Number of Health Psychologists by State of Residence and Population

<table>
<thead>
<tr>
<th></th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Health psychologists</td>
<td>6</td>
<td>61</td>
<td>2</td>
<td>41</td>
<td>25</td>
<td>13</td>
<td>127</td>
<td>6</td>
<td>281</td>
</tr>
<tr>
<td>% Health psychologists</td>
<td>2.1</td>
<td>21.7</td>
<td>0.7</td>
<td>14.6</td>
<td>8.9</td>
<td>4.6</td>
<td>45.2</td>
<td>2.1</td>
<td>99.9</td>
</tr>
<tr>
<td>% Population</td>
<td>1.6</td>
<td>33.0</td>
<td>1.0</td>
<td>19.7</td>
<td>7.6</td>
<td>2.4</td>
<td>24.8</td>
<td>9.9</td>
<td>100</td>
</tr>
</tbody>
</table>

* Source: The College of Health Psychologists website, 2008

7 The discrepancy may be related to the differences between states in the requirements for registration
2.4 Conclusion

We conducted an extensive search for published and unpublished data that would be useful for workforce planning in the gynaecological cancers workforce. We found no data that would provide the level of detail about the characteristics of the workforce requested by Cancer Australia. Most large-scale reliable data sets did not have fine enough codes to identify workers with a specialisation in gynaecological cancer. The data that were available have been presented in this section of the report; however, these data are from different sources, were collected in different years and have used different questionnaires and methodologies. Comparability is therefore limited.

The limited data on gynaecological oncologists is likely to be the most accurate in reflecting those working in the designated gynaecological cancer workforce. There are 36 gynaecological oncologists in Australia (excluding trainees); they are predominantly male, aged between 45-54 years and are based in metropolitan areas. They are required to spend at least two-thirds of their clinical time in gynaecological oncology. Data on other medical professionals are more general and do not necessarily reflect the amount of work done on the treatment and care of women with gynaecological cancers. Nevertheless, the analysis provides information about the pool of potential medical professionals that can be drawn upon for the treatment of gynaecological cancers. As a state-based analysis of each of the medical professions was available, their distribution was reported (although some caution is required). Proportionally, NSW has a higher supply of gynaecological oncologists and anatomical pathologists, and a lower supply of medical oncologists than would be expected based on population share. Victoria has a higher supply of radiation oncologists and medical oncologists, and a lower supply of gynaecological oncologists and anatomical pathologists. Queensland has a lower supply of all relevant medical professionals except radiation oncologists. South Australia and Western Australia have a lower supply of radiation oncologists, with WA also being slightly low in medical oncologists. These distributional patterns may provide some indication of shortages in particular areas, although this would be stronger with better evidence about the optimum levels of service provision for the population.

Although oncology nurses could be identified from one of the data sources, the proportion working in designated gynaecological cancer roles could not be delineated. Overall the number of oncology nurses is increasing more rapidly than the clinical nursing workforce generally, perhaps reflecting increasing incidence of cancer and expanding treatment options. Nurses working in this specialty are more likely than their clinical nurse counterparts to be RNs, younger, located in metropolitan areas, work full-time and work slightly longer hours per week.

Unfortunately, none of the allied health professions collect data with the level of detail required to identify those working in gynaecological cancer care, or even general cancer-related roles. Some very general data on health psychologists were reported.

To be useful for workforce planning, data should be systematically collected with a level of detail that permits analysis of particular specialisations such as the gynaecological cancer workforce. While NILS has experience in conducting these types of workforce surveys, there are likely to be difficulties in constructing one that captures only the gynaecological cancer workforce. This raises questions about how existing data could be made more useful for gynaecological cancer workforce planning. Where gynaecological cancer/oncology is a clearly defined subspecialty within particular occupations, then it could be appropriate to collect data on gynaecological cancer subspecialties via registration bodies or the AIHW and ABS. However, for occupations in which the
numbers of health professionals working in designated gynaecological cancer roles are small this would be an inappropriate course of action. It would not be worth the effort to collect the data, especially as any data that resulted would have problems with reliability. The workforce planning issue for those occupations that have a designated role – but not a career-defining role – in gynaecological cancers, is slightly different. For these occupations the key is to have enough workers in these roles more generally, as this would help ensure that there were enough to perform roles in the treatment of gynaecological cancer. Finally, if a more comprehensive view of the workforce with a role in the treatment of gynaecological cancers is required this would involve collecting new data. This data is likely to be more useful if it had a focus on the oncology workforce more broadly, with the capacity to identify workers with roles in the different tumour/disease streams.

The problems that made this review of existing data difficult are firstly, there is no clear definition of the gynaecological cancers workforce except for gynaecological oncologists. Most health professionals with a role in the treatment and care of women with gynaecological cancers do so as part of their broader responsibilities. Most of the gynaecological cancers workforce would fall into this category: including radiation oncologists, medical oncologists, and some nurses and allied health professionals.

Secondly, there is a need to get a clearer understanding of what roles these professions have in gynaecological cancers and what proportion of clinical time would be dedicated to treating women with gynaecological cancers. This would provide a more accurate picture of how many people are involved in the designated gynaecological cancer workforce, their role, their characteristics and their location.

Thirdly, there is a much larger group of health professionals who are integral to the treatment and care of women with gynaecological cancers, but who do so as only a minor part of their work. This would include general practitioners, general clinical and community nurses, palliative care nurses, and a range of allied health professionals. Capturing the contribution these workers make to the gynaecological cancers workforce is more challenging, but nevertheless important.

Finally, it was evident from the data that most of the gynaecological cancers workforce is based in metropolitan areas. No systematic data was available on the outreach roles of various health professions, nor on the geographical coverage (beyond state or territory) of service provision.
3. Consultations with People Affected by Gynaecological Cancers on the Roles and Activities of the Workforce

The aim of this section is to report on the views of women, their families and carers using the following framework:

1. Satisfaction with their experiences and interactions with the ranges of gynaecological cancer workforce members;
2. Themes arising from different elements of the models of care they experienced at various stages in their cancer trajectory; and
3. Suggestions from patients and carers for improvement in care.

We firstly outline methods of gathering and analysing data, as well as providing demographic information on the women we interviewed.

3.1 Method

Five cancer treatment centres in four Australian states (Victoria, New South Wales, South Australia and Northern Territory) participated in the consultations. These were Monash Medical Centre (public, VIC), Border Medical Oncology (private, NSW), the Royal Adelaide Hospital (public and private, SA), Flinders Private (private, SA), and the Royal Darwin Hospital (public and private, NT).

Twenty-five women with a diagnosis of gynaecological cancer and 6 carers of women affected by gynaecological cancer in four states - Victoria (urban and rural), New South Wales (rural), South Australia (urban and rural) and Northern Territory (rural) - were interviewed with the permission of the ethics committee of participating hospitals and Human Research Ethics Committees of participating Universities. The group includes 3 Aboriginal women. Women who did not have a diagnosis of gynaecological cancer; were too ill and unable to participate in an interview; or who were unable to provide informed consent were excluded from participating in the study. One non-English speaking woman took part through an interview with her daughter. Quotes from the interviews given below are coded with letters, R=rural, U=urban or C=carer, and a number.

We make no claim to have achieved a comprehensive overview of the field. We did not set out to construct a representative sample of women, stratified according to age, ethnicity or other variables. Rather women were recruited in outpatient settings at the 5 clinical centres. Table 3.1 below provides a snapshot of the characteristics of women interviewed:

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*The ethics committees included the Southern Health Human Research Ethics Committee (Project No. 08079L, approved 27th May 08); Monash University Standing Committee on Ethics in Research Involving Humans (SCERH) (Project No. CF08/0560-200800270 approved 14th April 2008); Joint Hospital’s Ethics Committee, Wodonga Regional Health Service (approved 23rd April 2008); Flinders University and Southern Adelaide Health Service Social and Behavioral Research Ethics Committee (Project No.4104. approved 3rd March 08); Human Research Ethics Committee of NT Department of Health and Community Services and Menzies School of Health Research (Project No. 08/29. approved 16th May 2008).*
Table 3.1: Demographic Characteristics of the Patients (N=25)

<table>
<thead>
<tr>
<th>Variable</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (mean age=57.8)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>31-40</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>41-50</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>51-60</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>61-70</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>71-85</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td><strong>Gynaecological cancer type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Uterine</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Ovarian</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td><strong>First diagnosed with cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 5 years ago</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>1 – 5 years ago</td>
<td>16</td>
<td>64</td>
</tr>
<tr>
<td>1 – 12 months ago</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
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<tr>
<td>Married</td>
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<td>64</td>
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<tr>
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<td>20</td>
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<td>Widowed</td>
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</tr>
<tr>
<td>Single</td>
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<td>4</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 4</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>44</td>
</tr>
<tr>
<td>1</td>
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</tr>
<tr>
<td>No children</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td><strong>Highest level of education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed postgraduate</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Completed undergraduate</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Some post-school training</td>
<td>2</td>
<td>8</td>
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<tr>
<td>Some secondary</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Grade 8 or less</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>N/A</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td><strong>Household status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living alone</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Living with other</td>
<td>17</td>
<td>68</td>
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<tr>
<td><strong>Employment status</strong></td>
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</tr>
<tr>
<td>Paid full-time</td>
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<td>16</td>
</tr>
<tr>
<td>Paid part-time or casual</td>
<td>4</td>
<td>16</td>
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<tr>
<td>Retired</td>
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<td>60</td>
</tr>
<tr>
<td>On a pension</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>
Table 3.2 compares the site of cancer with the epidemiology of gynaecological cancer in Australian women. Women in this study were more likely to have cancer of the cervix and less likely to have ‘other’ gynaecological cancers than the general population of women with gynaecological cancer.

### Table 3.2: Site of Cancer in Study Group Compared with Incidence in Australia

<table>
<thead>
<tr>
<th>Site</th>
<th>Study Group</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Cervix</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Uterus</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>Ovary</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Uterus other</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>


Interviewing patients about the quality of care they receive either from their treating doctor, other health professionals or hospital is a delicate exercise. It is important to ensure that patients are secure in the knowledge that their engagement in the research will in no way jeopardise their on-going care. Health professionals (doctors and nurses) were asked to hand out an information sheet/flyer outlining the project to women who attended the various clinics on the days chosen for recruitment. The flyer briefly explained the project and invited the women to make direct contact with the research team. The flyers were also distributed to women in the out-patient waiting rooms with assistance from a health professional or receptionist.

Of the 30 women at the Monash Medical Centre who were approached, 8 women agreed to an interview, 3 women were ineligible due to sickness, one due to impending surgery, and one did not have a gynaecological cancer leaving 5 women recruited to the project. Of 22 women at Border Medical Oncology who were approached, in total 8 women were contacted. Of these 8, one woman withdrew from the interview due to impending surgery and one could not participate in an interview because of time constraints on the project. For the South Australian component of the study, 6 women were approached from Flinders Private Hospital, and interviews were arranged with 4. For the Royal Adelaide Hospital 5 women were approached, 3 agreed to an interview, but time constraints on the project meant that only 2 interviews were completed. In Darwin, 8 women were approached and 4 agreed to an interview. The 4 other women were unavailable on the dates the research team were in Darwin (3) or could not be contacted (1).

In order to facilitate timely and sensitive interviews with Aboriginal women contact was made with a Nunga Women’s Cancer Group who meet to discuss their own or their family’s health issues. This contact was negotiated by an Aboriginal researcher associated with Flinders University. Three women agreed to be interviewed. One woman was interviewed via phone and the other two were interviewed together.
Women who consented to contact were telephoned by a member of the research team with a request that they take part in an interview. They were given a detailed explanation of the purpose of the research, with its focus on workforce, what was involved, such as time requirements, and the topics to be covered in the interview.

Carers were recruited by asking the women who agreed to take part in this study to discuss the research with a family member or carer with a request for interview. If the family member or carer agreed, the women were invited to provide the researchers with the contact details of these family members or carers.

Interviews were conducted face-to-face for the most part, and five were done by telephone. They took between 60 to 90 minutes. Interviews were semi-structured. Women were asked to recall their cancer journey beginning with the story of how they found out about their cancer and what happened in terms of cancer care. The women were asked about their experiences of, and thoughts about, the care that was provided for them by medical, nursing and allied health professionals. They were also asked to comment on care provided by family, friends and volunteer services and to reflect on what had been the best part of their care or what could have been improved.

All interviews were audio recorded with permission of the women/carers and were transcribed by a professional service contracted to the National Institute for Labour Studies. The four members of the research team read the transcripts to acquire a sense of the overall story being told by each participant. Transcripts were analysed using NVivo8 which is a computerised software program for the management of interview data (QSR 2008) in order to ensure a high level of accuracy in identifying themes.

The themes are divided into three sections. The first section reports on the women’s satisfaction with their experiences and interactions with the range of gynaecological workforce members. The experiences of the Aboriginal women interviewed are discussed separately. Sub themes in this section pick up on the women’s illness trajectory, their views on the quality of care they received from their oncologist, surgeon, nurse or allied health professional, their views on how information should be provided and implications for the workforce. The second section follows up on a number of themes arising from the models of care experienced by women at various stages in their cancer journey. The first theme explores the women’s views of multidisciplinary care, and the role of the general practitioner, the challenges facing women from remote and rural areas; what happens when something goes wrong, pain management, issues related to gender, and financial issues. The experience of carers is discussed in the third section.

3.2 Limitations of the Analysis

The aim was to gain a detailed insight into each participant’s personal experiences with the workforce and the model of care they experienced during their cancer journey. It was not possible to interview sufficient numbers of women, their families and carers to adequately explore each population and patient group, or to make judgments on difference in experiences for women according to cultural or geographical location. The qualitative nature of this component of the investigation has restricted the sample size of participants and as a consequence, any claim to generalisability. However, distinct patterns emerged from the interviews which make us confident that the experiences of the women quoted in this report are a reliable and valid portrayal of the clinical
management of gynaecological cancer, and likely to resonate with other women similarly placed in the various urban, rural and remote regions of Australia.

This study is also limited by the fact that the focus was on the experiences of women who were undergoing follow-up treatment. As a consequence there is a survivor bias in this report. We did not interview those patients who were too sick, those undergoing surgery or currently in hospital. These women may have a different perspective on the issues explored in the study. Many women will have died despite their treatment. Despite this, recruitment of the sample from a variety of treatment centres enabled a mix of rural and urban areas as well as women with a range of experiences, and this enhances its generalisability.

### 3.3 Women’s Satisfaction with their Experiences

Overall the women felt the quality of the care they received was excellent. Much of this had to do with the special relationship they developed with their surgeon or oncologist. In presenting the themes relevant to quality of care we discuss positive aspects of care as well as highlighting possible areas for improvement. The themes are:

1. The patient journey
2. Time and service accessibility
3. Timely information
4. Quality of the care provided by workforce

#### 3.3.1 The Patient Journey

In this section we present a skeleton outline of the women’s journey from initial symptoms through to diagnosis and from doctor to doctor or treatment mode to treatment mode. One of the major difficulties for women with a gynaecological cancer is recognising the symptoms and having her health professional respond appropriately. The 25 women interviewed for this study ranged from those diagnosed during routine surveillance, to those who acted in response to symptoms, and included some who took years to obtain a diagnosis. The majority of the women sought help from the health professionals mainly because they experienced symptoms such as bleeding or pain. Symptoms which were described during the interviews are shown in Table 3.3.
### Table 3.3: Recognition of Symptoms of Gynaecological Cancer (N=25)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Number</th>
<th>How they sought help</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding</td>
<td>8</td>
<td>Straight to the GP</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waited for 4 months</td>
<td>1</td>
</tr>
<tr>
<td>Pain and bleeding</td>
<td>3</td>
<td>Straight to the GP</td>
<td>3</td>
</tr>
<tr>
<td>Pain in bladder</td>
<td>1</td>
<td>Straight to the GP</td>
<td>1</td>
</tr>
<tr>
<td>Pain in the lower abdomen</td>
<td>1</td>
<td>Waited for 2 months</td>
<td>1</td>
</tr>
<tr>
<td>Pain</td>
<td>1</td>
<td>Straight to the GP</td>
<td>1</td>
</tr>
<tr>
<td>Stomach swelling</td>
<td>2</td>
<td>Straight to the GP</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waited for 2 weeks.</td>
<td>1</td>
</tr>
<tr>
<td>Regular pap smear tests – abnormal pap smear</td>
<td>4</td>
<td>Detected through a regular</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pap smear test.</td>
<td></td>
</tr>
<tr>
<td>A bowel problem</td>
<td>1</td>
<td>A check up with a gastroenterologist.</td>
<td>1</td>
</tr>
<tr>
<td>Had lumps appear on both sides of groin</td>
<td>1</td>
<td>Straight to the GP</td>
<td>1</td>
</tr>
<tr>
<td>Thought she had a urinary tract infection</td>
<td>1</td>
<td>Straight to the GP</td>
<td>1</td>
</tr>
<tr>
<td>Feeling unwell and legs ached “strange symptoms”</td>
<td>1</td>
<td>Straight to the GP</td>
<td>1</td>
</tr>
<tr>
<td>Thought she was having a heart attack and her abdomen swelled up</td>
<td>1</td>
<td>To hospital emergency</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>department</td>
<td></td>
</tr>
</tbody>
</table>

The most common pattern was to attend a general practitioner with the symptom of irregular vaginal bleeding or pain, or to have the cancer found during a routine Pap smear.

#### 3.3.2 Time and Service Accessibility

The time between the appearance of symptoms to diagnosis was short for most women. Thirty six per cent of women were diagnosed within 2 days and 28 per cent were informed of their diagnosis within 2 weeks of attending their doctor. Reasons for delayed diagnosis included waiting for their test result; misdiagnosed/ the doctor was unable to diagnose their non-specific symptoms of gynaecological cancer; own choice to delay having their test done.

A rural woman described the delay in diagnosis that resulted from her doctor misreading the signs:

> Went to Family Planning at the time, then I had an IUD put in and I thought ‘Oh, the IUD is causing my bleeding’, ‘the IUD is causing my irritation’ and this sort of stuff. So for several years there was something there and it went undiagnosed. I was bleeding very heavily and sex - intercourse – was painful and I had bad pains in my stomach and stuff and I was 47 kilos, like I’m probably 58 now, so I wasn’t well at all and I just kept going back to the doctor and back to the doctor going ‘something’s wrong; something’s wrong’ (R7).
The time between when patients were informed of the diagnosis and when they received
treatment was short. About 70 per cent of women had surgery within 2 weeks of
diagnosis. For the remaining women, the major reasons mentioned for the delay were; 1) she
needed to wait for the ultrasound and the team meeting; 2) took the holiday she had
organised; 3) underwent pre-operative chemo or radiation therapy to reduce the size of
the tumours.

Table 3.4 summarises the time of the journey of women from symptom to diagnosis to
intervention, and their outcomes, as described by individual women. ‘R’ designates a
rural woman.

<table>
<thead>
<tr>
<th>Time: symptom to diagnosis, year</th>
<th>Diagnosis</th>
<th>Time: diagnosis to intervention</th>
<th>Outcome May 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day 2003 (R)</td>
<td>Uterine</td>
<td>1 week</td>
<td>Well (no secondary cancer)</td>
</tr>
<tr>
<td>N/A 1986 (R)</td>
<td>Cervical</td>
<td>12 months</td>
<td>Well</td>
</tr>
<tr>
<td>Within 1 week 1996 (R)</td>
<td>Cervical</td>
<td>12 months</td>
<td>Well</td>
</tr>
<tr>
<td>3 years 2004 (R)</td>
<td>Cervical</td>
<td>3 days</td>
<td>Tumour found – due for surgery</td>
</tr>
<tr>
<td>1 day 2005 (R)</td>
<td>Cervical</td>
<td>1 week</td>
<td>Well</td>
</tr>
<tr>
<td>3 months 2004 (R)</td>
<td>Ovarian</td>
<td>2-3 days</td>
<td>Well</td>
</tr>
<tr>
<td>1 day 2003 (R)</td>
<td>Ovarian</td>
<td>2 weeks</td>
<td>Well</td>
</tr>
<tr>
<td>8 days, 2007</td>
<td>Uterine</td>
<td>3 days</td>
<td>Well</td>
</tr>
<tr>
<td>1 day, 2007</td>
<td>Uterine</td>
<td>1 week</td>
<td>Well</td>
</tr>
<tr>
<td>1 day, 2007</td>
<td>Uterine</td>
<td>1 week</td>
<td>Well</td>
</tr>
<tr>
<td>1 week, 2007</td>
<td>Ovarian</td>
<td>4 weeks</td>
<td>Well</td>
</tr>
<tr>
<td>1 month, 2004</td>
<td>Ovarian</td>
<td>6 months</td>
<td>Active treatment</td>
</tr>
<tr>
<td>2 weeks, 2004</td>
<td>Cervical</td>
<td>3 weeks</td>
<td>Well</td>
</tr>
<tr>
<td>1 month 2004 (R)</td>
<td>Uterine</td>
<td>3 days</td>
<td>Well</td>
</tr>
<tr>
<td>6 years 1999 (R)</td>
<td>Ovarian</td>
<td>3 weeks</td>
<td>Well</td>
</tr>
<tr>
<td>Within week 2004 (R)</td>
<td>Uterine</td>
<td>2 weeks</td>
<td>Well</td>
</tr>
<tr>
<td>1 week 2007 (R)</td>
<td>Uterine</td>
<td>2 weeks</td>
<td>Well</td>
</tr>
<tr>
<td>2 days 1999 (R)</td>
<td>Ovarian</td>
<td>2 days</td>
<td>Well</td>
</tr>
<tr>
<td>Within week 2007 (R)</td>
<td>Ovarian</td>
<td>2 months</td>
<td>Well</td>
</tr>
<tr>
<td>1 day 2003</td>
<td>Uterine</td>
<td>1 day</td>
<td>Well</td>
</tr>
<tr>
<td>1 day 2007</td>
<td>Cervical</td>
<td>Within 30 days</td>
<td>Ongoing monitoring for recurrence</td>
</tr>
<tr>
<td>2 days 2006</td>
<td>Uterine</td>
<td>1 week</td>
<td>Well</td>
</tr>
<tr>
<td>8 months 2007</td>
<td>Cervical</td>
<td>2 weeks</td>
<td>Ongoing pain from surgery</td>
</tr>
<tr>
<td>N/A 2007</td>
<td>Uterine</td>
<td>N/A</td>
<td>Ongoing monitoring for recurrence</td>
</tr>
<tr>
<td>3 weeks 2001</td>
<td>Cervical</td>
<td>6 days</td>
<td>Well</td>
</tr>
</tbody>
</table>

While most women commented favourably on the timeliness of care some women
thought it was too quick and found it difficult to assess the benefits of suggested
therapies or surgery in the short time they were given. Some women indicated that they
were impressed with the fact that following a speedy diagnosis, the necessary surgery was organised quickly.

It’s just too quick. I had two weeks to decide about this hysterectomy and I had to ask for that two weeks. I said ‘I can’t make this decision now’ and she said ‘I’ll give you two weeks to decide’. .. Since then I’ve just wondered was it really necessary to go ahead and do all that. But hindsight is a wonderful thing. Look, at the time I was impressed with the fact that within 2 weeks I had a date for surgery and I was seeing these guys who were meant to be very – I’m sure they are excellent. At the time I was thinking this was happening very quickly (U8).

However, there were also problems with timeliness, including those caused by unavailability of a key team member, and waiting times in public hospitals:

3.3.3 Access to Timely Information

The amount of information needed by a cancer patient is difficult to gauge. Getting this right is particularly important given the speed with which women needed to make decisions about what is a life or death situation. Many of the women we interviewed were unsure of the extent of their cancer, for example, whether lymph nodes were involved, or the extent of the surgery. For example, one woman commented that she had no idea that her surgeon was going to move her ovary to the front of her abdomen. However, most women had picked up the appropriate medical terminology and reported that the information they received was adequate.

There was considerable variation in the standards which women applied to information and decision making in health care. Some felt the need for more information and indicated their willingness to look for it elsewhere (e.g. from general practitioners or on the Internet). Some women stated that they were always happy to let the health professionals take the lead and make the decisions. Others required more information, and more questions answered. The differences here were subtle. Women tended to take the word of their doctor at the initial stage of diagnosis, but in some cases wonder in hindsight if the process and decision making were right for them. Once they began the cancer journey, especially in the recovery and remission stages, they wanted more information on their prognosis and test results. This was particularly pertinent to women who had reached the twelve month to 4 year mark who might only have an annual check up, as the following quote demonstrates:

Yes. I’m finding now that it’s getting a bit iffy. They give me the results of the test but I don’t feel that they’re telling me enough now. Although it’s been 2 years since I had the chemo for the ovarian cancer I don’t feel that Dr X is giving me enough information now. Dr X just goes on the fact that I look good so I should be well…. the first time I walked in there Dr X said ‘how are you feeling?’ and - when you’re out talking to people, like I am now [you can feel ok], but when I’m at home it can be totally different (R9).

The women also offered suggestions about improving information available to patients, including information on prevention, treatment options, and to alert them to the fact that symptoms may be ‘vague’. There were several comments about the anxiety caused by not knowing what was going on:
The unknown is probably the scariest bit (U12).

Some also felt that more personal communication would assist with fear and anxiety, but in presenting this data we are clear that there is no standard answer to how much information should be provided:

I just found I was very confused and I just had to put myself in their hands and hope I was doing the right thing (U5).

One possible solution here that would facilitate the careful staging of information at a pace the woman and her family could absorb is to provide an information service at the site of care.

3.3.4 Quality of Care

In analysing the interviews we were mindful to tease out what qualities the women valued in the workforce. Quality care was defined as care that the women could be confident in. This was a mixture of a positive attitude, giving the women hope of a good outcome, and confidence that the team was efficient and knew what they were doing.

The women appreciated the sense of safety that came with trust in their surgeon and the team that took care of them. The women responded well to staff who kept their hope alive. Overall the gynaecological workforce was seen to offer quality patient-centred care. Staff were reported to be compassionate and to work as a team.

He said to me ‘if you were my wife there’s only one bloke that would look at you’ and I reckon that was the best thing that ever happened (R2).

High quality care included personal support, appropriate information and smooth transitions from one aspect of care to another so that the women felt their team knew what they were doing and communicated both with each other and with them.

The support was just fantastic (U9).

…..one of the nurse educators really told [us] what we could do when I returned home (R11).

Women described some of their best experiences as flowing from interactions with their care team that put them at the centre of the treatment team, and included their husbands. This meant doctors and nurses took time to help them understand what was going on and what was happening. They appreciated medical staff who managed to appear relaxed and confident rather than hurried or rushed, and those who included their family members in the management plans.

They kept [husband] in the loop (R4).

I always felt that I was treated as an individual (U1).

It was a relief to some women that the staff appeared to work as a team.
A number of women valued the quality of caring relationships established between them, their carer and the treating medical team. This was especially so for their surgeon and oncologist, but extended to the nursing team. Comments included the following:

The best thing that stands out for me is the way the doctors took the time to go through it with us, explaining in detail what the procedure was going to be with mum’s follow up...it wasn’t like they were rushed. I’m sure they had to be places but they never gave the impression that they were in a hurry and couldn’t talk. They always took the time to answer whatever queries we had. The support was just fantastic (CU9).

This friendliness and assistance was extended to carers, and was appreciated by the women. The women noted that nurses and receptionists extended care and concern as well as doctors. The role of the nurse in coordinating care was picked up in this theme. A number of women commented on the high quality of care provided by nursing staff in oncology units when they went for chemotherapy treatment.

I saw the doctor first and you were reviewed by a doctor and then they wrote out your prescription for your treatment and then you took that to the nurses and they went and got your stuff from the pharmacy and set you up. They were just very loving, very friendly and cheerful. They were nice. Nothing was too much trouble for them so it was good (U5).

The quality of nursing and medical care is summed up in the following quote:

…… She nursed me like a mother, she was beautiful. I think I was in intensive care two days and I had her for two days and then I just had the ordinary nurses and it was – I was so spoilt by her that the other was adequate......I am a diabetic and they actually appointed a doctor for me. She was lovely and I can’t remember her name (U5).

Women tended to develop a more intense therapeutic relationship with their doctor than with nurses or allied health professionals. Women spoke of their doctor, knew his or her name and had an opinion on the quality of care they received from their doctor. Nurses were spoken about in very general terms with the exception of those nurses who specialised in cancer care either working directly with a surgeon or as a community-based cancer nurse. While the majority of nursing care was reportedly given in a caring and compassionate manner it needs to be noted that a number of women reported that the nurses were caring but busy:

I know for a fact that nurses are run off their feet, they are very busy, but I think we underestimate the value of that communication process, of having 3 seconds to stop and just talk. It is so uplifting when you’re feeling really, really sick. Hugely therapeutic (U3).

### 3.4 Models of Care

The primary focus of the interviews was to ascertain overall satisfaction with the quality of care provided for the women in the light of the pressures on the health workforce and the shift to multidisciplinary teamwork. In this section we pick up on themes that emerged from the interviews that impact on quality care. These are:
3.4.1 Multidisciplinary Care

The women were asked questions about their experience of care provided by the different professions they encountered. They were also asked about their experiences of their health care providers as teams, with a particular focus on whether they knew who to talk to, whether the messages from members of their team were consistent, as well as general comments on how the care providers worked together. Themes arising from this material are reported here, followed by a commentary on the implications of this material for models of care.

Women were asked to nominate the members of their treating team, and their lists included all relevant medical specialists, nurses, allied health staff, and less commonly others including the chaplain, the ward clerk or receptionist, volunteers, and the hairdresser (who helped a woman choose a wig).

The medical teams varied from the simplest to the complex. At a minimum, women saw their GP and were referred either directly to a gynaecological oncologist, or to a gynaecologist for diagnosis. From there they were managed by the gynaecological oncologist and anaesthetist. Post operative follow-up was from the gynaecological oncologist and the GP may have been involved. More complex pathways involved multiple GP visits before a diagnosis, referral to a gynaecologist, investigations, various types of treatment, radical hysterectomy by a gynaecological oncologist with anaesthetic support and the involvement of a bowel surgeon. This may be followed up with chemotherapy, radiotherapy, or both. Women with post-operative complications required further management with other specialists including bowel surgeon and surgical oncologists with additional skills. Frequent follow-up monitoring by both the operating gynaecologist and GP was usual.

The diagnostic stage of involvement with doctors included general practice, general gynaecology, family planning services, gynaecological oncology, gastroenterologist, emergency department. The most common pathway was from general practice to gynaecologist. This was the team that made the diagnosis for nine women, half of whom were rural and half were urban. Urban women were more likely than rural women to be referred directly to a gynaecological oncologist.

The treatment team was consistent for most women. Pre-operative, surgical and post-operative care was provided by a team of doctors made up of gynaecological oncologist, surgeon, anaesthetist, medical oncologist and radiotherapist. Follow up care was provided by many of the same doctors, including the general practitioner, gynaecological oncologist, medical oncologist and radiotherapist if chemotherapy and radiation were
part of the management. Usual care included a six week post-operative review by the
surgeon, then three monthly review, and if no recurrence, six monthly review. A majority
of women (16) included general practitioners in the follow-up team; the others relied on
scheduled visits with the gynaecological oncologist.

Nurses were part of the care team while the women were in hospital, and when they
attended for chemotherapy or radiotherapy. Other health practitioners were rarely
named as part of the treatment team.

Overall, the women reported mostly positive experiences. There were five main areas of
comment and these are discussed below:

1. Good coordination among team members
2. Working with her general practitioner
3. Problems with follow-up care after discharge from hospital
4. Bringing the general practitioner into the team
5. Other issues relating to multidisciplinary care

3.4.1.1 Good Coordination Among Team Members

The women were more confident about their care and their prognosis when they sensed
that everyone was working together, that everyone knew what everyone else was doing,
and that care was focused on them as people:

They always knew what each other was going to do and all those doctors, they
were like ‘that’ together and the nurses around them, they knew what they were
doing too (R11).

The women were alert to communication among team members, and several commented
on good communication:

I saw about 5 different doctors on five separate visits to … and they were in a
group and they’d work out what was the best procedure to take (R2).

Positive comments were also made about non medical staff, from receptionist through to
allied health professionals:

They all are there to care for you in whatever way, The ward clerk was
marvellous, … the domestic staff, … they were all marvellous (R11).

When women felt teamwork was lacking, it worried them. For example one woman
noted a general lack of team work in relation to the anaesthetist:

You see them briefly, you get a few questions answered, off they go. You see them
as you get on the operating table and that’s it. No, I have had no sense of team
(U3).

There was also concern about receiving different messages from different team members.
In the case quoted below the woman had moved from receiving care in a private hospital
to a large public hospital and found the fact that she saw a different doctor at each visit distressing:

I just found each time I went it was different news (U5).

3.4.1.2 Working with her General Practitioner

In the Australian health system the primary relationship with the medical profession is through a general practitioner (GP). The GP is the doctor who works with the patient to manage their health care. The GP traditionally makes referrals to other specialists when specific types of care are needed, and the patient is returned to the GP for on-going care once the particular episode of care is completed. Our study has identified that this formal system of primary care worked for some women, and for others it was fractured. Women were asked about their experience of working with doctors. They were not asked specifically about general practitioners, so we are only able to report their experience when women spontaneously mentioned general practitioners.

The smoothest pathways to care occurred when women either went for a routine Pap smear and the smear revealed cancer, or they experienced some symptom that prompted them to consult their general practitioner. GPs either examined the women and found signs that prompted a referral to a gynaecologist for further diagnosis, or made a provisional diagnosis and referred them to a gynaecologist for management.

Women talked about their GPs being ‘very thorough’, ‘wonderful’, ‘brilliant’, ‘very supportive’ and ‘marvellous’.

He’s brilliant. He got my diagnosis right from the beginning (U8).

I have a marvellous GP here who picked it up straightaway (R11).

More than half the women (15/24) described how their GP made the diagnosis and referred them for further management. Their general practitioners were included in the management team and contributed to their post-operative care, pain management and future cancer surveillance. Two women described how their GPs diagnosed and managed their depression and anxiety resulting from the cancer experience. Half the women described how their general practitioners contribute to their on-going care, whether this was for a general medical condition such as elevated blood pressure or diabetes, or support with their cancer treatment. There were equal numbers of women from urban and rural environments who named a GP as part of their team.

Some felt very supported by their GPs, describing how they went out of their way to stay in touch with them during their recovery from surgery, chemotherapy and radiotherapy. Where the system worked well the general practitioner was part of the management team.

I know that my oncologist, he keeps my GP informed all the time. When I go to my GP he’s got the latest report. I also visit the pain management clinic, he keeps the professor in charge of the pain management unit up to date with what’s happening (U4).
The general practitioner was not always brought into the treatment team. The most significant teamwork problem women experienced was lack of communication and coordination with their GPs. A woman from a regional community said in relation to her GP:

... [metro hospital] didn’t talk at all with my GP ... I had to ask them to make sure that they were sending information to my doctor (U8).

3.4.1.3 Problems with Follow-Up Care After Discharge from Hospital

The most serious problem women commented on was a lack of coordination and follow-up on discharge from hospital, and the weaknesses in the relationship with GPs contributed to this problem:

It was just that awful week where there was no help. There was no follow-up. There was nothing. I gather it was just a young intern on the Saturday that said ‘right, you’re gone. You have nothing more to do with this hospital. Don’t bother ringing if you have a problem, ring your GP’. I rang my GP he promptly informed me that he had no idea what I’d had done. There was no paperwork. There was no follow-up and he wouldn’t make a house call and I was too sick to get out of bed ... there should have been somebody that could have seen me that first week. But nothing was offered (R2).

Some women were concerned when care providers completed their roles and ‘dropped’ from view:

I was upset because I got to like this main surgeon but suddenly he dropped me and referred me to another doctor (R1).

A few women (4) did not mention their general practitioner and did not include them in their accounts of the medical team which managed their care. Some of these women were dealing with complex medical conditions which were being managed through a tertiary hospital and their focus was on their interactions with those teams. This included a woman who was managing organ transplantation as well as cancer, another with ovarian cancer followed by breast cancer in the same year, and another who had repeated recurrences of cancer managed within the hospital system with repeated chemotherapy.

In a few instances women felt let down by their general practitioner, either at the point of diagnosis, or in post-operative management. One woman was relying on her family planning doctor for women’s health care and experienced a delay in diagnosis of uterine cancer by some years. One woman was managed for years with irritable bowel syndrome and was finally diagnosed with extensive abdominal cancer. Her management story focused on the hospital team and her GP was not mentioned after he had referred her to a gynaecologist. One woman said she was diagnosed with Ross River fever when she sought advice from her GP about why she was feeling unwell. It took her massage therapist and an extended family member to tell her she needed another opinion. She was diagnosed with multiple cancers, including lymphoma, Hodgkins disease and ovarian cancer.

Two women did not get the post-operative care they needed from their general practitioner. One needed immediate and significant post-operative care and the general
practice she had attended since age 14 did not respond to her requests for a home visit. She was too sick to attend the practice and was without medical support for 10 days until her appointment for chemotherapy. Another had to learn to self-catheterise her bladder and became severely depressed. The depression was eventually diagnosed and treated by her GP, yet she and her husband both felt they did not get the counselling and support they needed at that time.

saw my GP and did that but I had ongoing issues with my bladder and there was never any counselling offered to me (R7).

A carer also needed better access to general practice support. He and his wife had been dealing with recurrent cancer over a ten year period. There were times when he needed medical support and had to fight to get it.

I haven’t had a problem with her medical practitioner; it was only getting in to see him when she needed to. I think in her condition it’s sort of special and they ought to be considering her a special case from the first phone call (CR1).

He was very happy with the quality of his wife’s general practitioner’s care and referral when they had sorted out the access problems.

3.4.1.4 Bringing the General Practitioner into the Team

It would appear that where the GP was included in the management of the woman’s illness, particularly post-surgery and during the chemotherapy and radiotherapy stages distressing events, such as pain, that occurred between visits to specialists were better managed. It would also appear that some of the more traumatic events recorded below under adverse events could be better dealt with if GPs were an integral member of the gynaecological cancer team. This is especially so for rural women who may have to wait considerable time before their post-surgery appointment. A more integrated discharge to their local GP would assist in tiding them over until their first chemotherapy appointment or post-surgery 6 week visit. This could be achieved by ensuring women are discharged to an appointment that has been made with her local GP, taking with her a discharge summary that includes guidelines for continuing care until her next appointment with the cancer care team.

3.4.1.5 Other Issues Related to Multidisciplinary Care

There were a small number of women and carers who expressed concern about professional relationships among doctors:

We’ve found out that it was no good us going to any other surgeon in [capital city] for a second opinion because there’s a little loop down there, a little group ... that if one decides there’s nothing more that can be done, then that’s it. That’s why we’re down in [another capital city]. But I’m not going to say any more about that because I find it very hard to believe. (R1)

On the other hand, several women noted and appreciated their doctor’s honesty about expertise:
Dr --- said my expertise doesn’t go as far as you need’ so [the doctor] made this arrangement. (U11).

Multidisciplinary care includes professionals in addition to doctors. Women were nursed by general and specialist nurses both as in-patients and when receiving chemotherapy and radiotherapy. On the whole their experience of nursing care was excellent, with the nurses being competent, doing their best to attend to the women as individuals, and making them as comfortable and hopeful as possible.

There were instances with individual nurses when this did not apply and they are detailed elsewhere. Others involved in care who the women encountered while in hospital included physiotherapists, occupational therapists, a chaplain, and trainee nurses, doctors and paramedics.

3.4.2 Treatment and Care of Aboriginal Women with Gynaecological Cancer

The research team and Cancer Australia were acutely aware of the special needs of Aboriginal women. Negotiations resulted in interviews being conducted with three women. All three were from rural towns in South Australia. Two of the women were health professionals; one was a registered nurse who had recently had cancer of the uterus, the other was an experienced health worker. Two women received their care through the public system in 1986 and 1995 and were able to reflect on changes to the health care system in the past twenty years from hospital admissions related to subsequent illnesses and to their on-going work in the public health care system.

No women from remote regions could be interviewed within the timeframe of the project. However, a number of health professionals interviewed in Darwin provided valuable insight into the range of issues confronting Aboriginal women in remote regions of the Northern Territory. Their observations have been incorporated into this segment of the report to provide a more comprehensive commentary. We also conducted a literature review on Aboriginal women and gynaecological cancer in order to more accurately discern the range of issues needing to be addressed. The literature is reported here in order to round out the report.

The three women interviewed were asked the same questions as other women in the study, but special attention was given to questions about:

1. Access to health services
2. Culturally appropriate care and information.

3.4.2.1 Access to Health Services

All three women reported timely access to services both in terms of initial diagnosis, surgery and on-going treatment. Two women were diagnosed through an Aboriginal or community health service, the third by her GP. She regarded her GP as

.... marvellous GP here who picked it up straightaway. I went in and told her the symptoms and she did a – what’s that test? ... That was on the Tuesday and she was ringing me at – Thursday lunch time she got the results. My GP here is marvellous (R13).
Despite these excellent examples of timely care the high rate of cervical and ovarian cancers among Aboriginal women has been attributed to a lack of accessible primary health care services and cancer specialists, particularly in rural and remote locations. This makes it difficult for Aboriginal women to receive screening, diagnosis and treatment for gynaecological cancers (O’Brien et al. 2000; Condon et al 2005). It also contributes to delayed diagnosis, a factor linked with increased mortality (Condon et al. 2005). The lack of access to health services is recognised by community women and health professionals alike (Hunt & Geia 2002; Kirk 1998).

Services need to be not only accessible, but also effective. The literature suggests that locally based health services are in an ideal position to provide high quality care. This is because local staff are more likely to be aware of family and socioeconomic issues facing their clients (McGrath et al. 2007; Olver et al. 2005). However, the provision of local health services is hampered by a lack of resources. Several authors argued that the majority of local primary health services require increased funding in order to provide cancer treatment and palliative care (McGrath et al. 2007; Prior 2005).

Low availability of health services presents several barriers to Aboriginal women (Kirk 1998). Having to travel or relocate to seek treatment has been associated with emotional, social and financial stress, not only for patients, but also for family members (McGrath & Patton 2006). Added to this are feelings of isolation when patients are separated from their land and community, in a time of both physical and emotional uncertainty (McGrath & Patton 2006).

Interviews with health professionals working directly with Aboriginal women in remote regions reiterated the difficulties of providing quality and timely care for this population group. Major difficulties included synchronising appointments for women from remote communities with visiting specialists, given the distances, and communication issues and travel difficulties during the wet season. The following comment from a nurse sums up this dilemma;

The system lets them down sometimes because – for instance this morning one Aboriginal woman had an appointment at 10am and they ring me up at 1.30, the Aboriginal liaison people, ‘the bus has just brought her in now for her appointment’. ‘I’m sorry, the doctors have gone, the clinic finished an hour and a half ago’. We have to rebook her to next week then the problem with that is, will she comply next week? Will she be in town? So that’s our biggest problem. If we could get them here we could do a lot more for them (RDH health worker).

3.4.2.2 Culturally Appropriate Health Care and Information

The most prominent experience reported in the literature in the area of gynaecological cancer in Aboriginal women appears to be the cultural inappropriateness of health services. This is claimed to be a major cause of the poor levels of Indigenous health (McGrath et al. 2007). Health services are described as being alienating and threatening to Aboriginal people by several authors including McGrath, Holewa and Kail-Buckley (2007), highlighting the importance of overcoming cultural barriers. One way of dealing with this is through the employment of Aboriginal staff.
The following exchange during the interview with two Aboriginal women for this study highlights the value of employing Aboriginal health and liaison workers in public hospitals to ensure patients feel comfortable:

Remember old X who used to be an Aboriginal Liaison Officer? He did – he actually supported me through mine. And he was a male. Where was the cultural gender balance inappropriateness there? … he done good for me anyway…Just because he knew the family couldn’t come in and I couldn’t come out, he’d actually – even though he wasn’t allowed to come into the room he’d be having a chat to me and having a laugh. ‘Do you want me to give Uncle B a ring and see whether blah blah?’ He was good. But it was just that little thing that a doctor or a nurse wouldn’t have even thought of, to have that communication with you (R11).

The importance of Aboriginal Health Workers, Liaison officers and other Indigenous staff cannot be overstressed. In remote regions Aboriginal staff work closely with doctors and nurses to ensure appointments and treatment protocols go smoothly. As one nurse working in a rural region noted:

For instance I just spent three months looking for this particular lady and I kept ringing X. Finally I got onto someone that said there was an interpreter there so they would speak to the sister. Anyway, I finally get this lady in and she has the surgery and then we lose her for follow up chemotherapy. To cut a long story short, through all my enquiries I’ve found out that her [relative] is in our Aboriginal Liaison office here in the hospital the whole time and he knew exactly where she was and how we could get her in (RDH doctor).

Attention to cultural issues is especially relevant in terms of gynaecological cancer treatment and care as culturally inappropriate health care has been attributed to poor screening participation rates (Wray et al. 2007), and the mortality rates associated with ovarian cancer in Aboriginal women (Laurvick et al. 2003). Therefore, it is essential that gynaecological cancer screening is delivered in a manner that is deemed acceptable to Aboriginal women (Mak & Straton 1997). Interviews with medical and nursing staff in remote areas indicated difficulties in communicating to Aboriginal women the seriousness of screening and follow up care as the following quote attests:

You’d do the initial assessment; you’d say ‘you need treatment but we can’t do it this week’, send them home and there’ll be another 12 months before they came back for their treatment and then they’d be lost to follow up so you’d never get the follow up done that you need to get done. The women don’t like coming in. It’s often really hard to get them to come in because they don’t know X (RDH doctor).

The literature on Aboriginal women and gynaecological cancers reveals that while many women select traditional treatments over those offered by the westernised medical system, others seek the latter, or a combination of the two. However, as acknowledged by Prior (2005), Aboriginal women often feel that by opting for a westernised approach, they are forced to sacrifice their cultural beliefs and values.

The importance of holistic health care approaches is echoed throughout the literature, supporting the provision of care in a manner that does not compromise the cultural
values of patients. This is particularly critical as the experience of cancer has been associated with patients placing an increased importance on cultural values and needs (Prior 2005). It is especially important that cultural beliefs and practices are provided for in palliative care situations due to the cultural significance of the manner and place of death (Prior 2006). The association of hospitals and cancer with death is picked up in the following quote and provides one explanation for low compliance:

We could save so many of them if they would come to their appointment … and the high mortality means that most people die in hospital but people are reluctant to come into hospital. So if you can’t meet people who are in the community - and that’s why I’d like to have more consistent follow up done for people who should be seen by Dr X but won’t come back (RDH doctor)

Several studies have examined gynaecological screening programs targeted specifically at Aboriginal women, and revealed factors that were associated with an increase in screening rates. Hunt and Geia (2002) state that these increased rates demonstrate what can be achieved. A comfortable and welcoming environment, the provision of child care, and policies of having only female staff in the consulting rooms and reception areas were identified as beneficial (Hunt et al. 1998). The display of Aboriginal art featuring women’s health promotion stories (Reath 1999) and separating the main clinic from the area providing women’s health services were also supported. Gynaecological screening health promotion measures were also evaluated, showing that personal, informal approaches were better received than letters reminding patients that they were due for a screening procedure (Hunt et al. 1998). We also note that screening programs conducted in home communities have more chance of being successful than those where women have to travel long distances for the service.

Two of the Aboriginal women we interviewed advised that appropriate health education and screening could be done as part of social events. The female Aboriginal health worker had organised cervical screening for all the Aboriginal women in the town for the week following interviews:

Well, we’ll work that one out with the Women’s Shine Clinic next Tuesday…We’ll go together. We’ve got a big day next Tuesday, that women’s play. Duck Bill and the Pussycats says it all, it’s all about pap smears and cervical cancer (R11).

Later in the interview in response to a question about appropriate language and educational material for Aboriginal people one of the women noted:

Yes, they’ve got to know that what it is, is what it is. Just be straight out. Like, I’ve actually written a song about how the hormones run around the body when you get a period and I’ve done one on menopause. But what we’ve done is – and how I educate is I’ve actually done it culturally, that I’ve divided the body up into lands. I’ve made the hormones into the cousins and I’ve made all the organs the aunties and the uncles of the body – or the aunties, but uncles when you’ve got males. (R12).

One of the doctors interviewed also commented on the value of localised education materials using Indigenous illustrations, terminology and context. This is supported by the literature (Mak & Straton 1997; Newman et al. 1999).
The literature questioned whether Aboriginal women’s participation in gynaecological cancer screenings is based upon informed decisions. A rural Aboriginal community featured in one study had high levels of cervical screening, however, many participants had little knowledge of the procedure or the reason for which it is recommended (Hunt & Geia 2002). This raises the suggestion of not only evaluating cervical screening programs in terms of participation rates, but also on the information provided to women to enable the making of informed decisions (Hunt & Geia 2002). The provision of culturally appropriate care requires respecting the factors that may influence a patient’s decision making in terms of treatment (Prior 2006). The interview segment below provides some insights into the need to pace information according to an individual woman’s capacity to absorb the flow of information:

They explained that very well to me. That’s something I never knew about. but after they explained what was going on I – I thought I got very good information and, as far as the hysterectomy goes, I’ve heard of hysterectomies all my life, you know, all the old dolls walking around holding their ...But I used to think you wouldn’t be a woman no more and all that sort of shit [laughing] ... But they did explain that, about the hormones, that they were at low levels but you could have HRT, hormone replacement therapy. They had me on Premarin (R12).

In regard to Aboriginal health, kinship is an important issue to take into consideration. It is common for decisions to be made communally, or with a particular family member having a culturally determined role (Olver et al. 2005). The literature advises that health professionals provide Aboriginal patients with sufficient information. This may be difficult because of language and cultural differences, along with a lack of time on the part of the health professional. It is also important to respect that decision making may be a slow process that is influenced largely by social roles (Olver et al. 2005; Prior 2005). It may also be that like many non-Indigenous women, Aboriginal women assume a Pap smear covers all gynaecological cancers, although no studies reported on this.

The development of trust was identified as an essential aspect of providing care to Aboriginal women in regard to gynaecological cancers. Gaining the trust of clients was associated with increases in screening participation, and clients often returned with female family and friends to encourage them to also be screened. However, high levels of staff turnover in rural and remote regions was identified as having a negative impact on obtaining the trust of Aboriginal clients (McGrath et al. 2007). In some studies, the attitude or approach of a particular health care provider encouraged Aboriginal women to seek advice as they felt comfortable to do so. Conversely, negative or racist attitudes deter women from seeking care. As one of the Aboriginal participants in this study commented, some health workers can make remarks that show a lack of empathy and border on racism:

Couple of little narky nurses when they came to do the stuff you’ve got to do in the treatment rooms and stuff and I actually noticed that my doctor sort of like made sure that the empathy of the nurses were coming out too. He was actually really good you know? ‘You’re not the one on that bed’ I heard him say one time because she was a real bitch. I thought ‘you’re a good doctor. I like you’ (R11).

The availability of female health care providers is crucial, as from a cultural perspective, gender specific health problems should only be addressed by medical staff of that gender.
(Toussaint et al. 1998; Morgan & Slade 1997). This also extends to assistance with tasks such as toileting and showering (Maher 1999). Many women in remote regions would not consider seeking medical advice or treatment for gynaecological problems from a male health professional due to the associated aspect of shame. However, for Aboriginal women in urban areas the need for care to be provided by female health professionals may not be as acute. All three Aboriginal women interviewed for this study said they did not mind what gender their doctor or nurse was, so long as they were caring and respectful.

Not the doctors, because we – I don’t know, I don’t sort of look at doctors in a gender perspective, I don’t think (R11).

For Aboriginal women in remote regions the issue of gender is more complex, but the policy outcome is clear. All the health professionals we interviewed who cared for Aboriginal women noted that doctors and nurses needed to be female. They indicated that where male health professionals are employed in community settings women do not present at the clinic for treatment. The following quote sums this up:

Outreach up here is very much women’s business so for the males – so for Dr X and Dr Y – it is quite difficult for them. If they went to one of the communities and the women found out it was a male they just wouldn’t turn up. They would just not come into the clinic (RDH health worker).

One way in which health services can ensure they provide culturally appropriate services is via community consultation in regard to program development. A failure to do so was identified by health professionals and Aboriginal women as one of the barriers associated with the high incidence and mortality rate of cervical cancer (Kirk 1998). Consulting directly with Aboriginal women was found to provide insight into existing problems from the consumer perspective. Additionally, Reath and Usherwood (1998) found a combination of community and staff consultation to be effective as this provided input from both perspectives and was a strong base on which to develop strategies to address existing problems in service provision to Aboriginal women.

Many successful approaches are being utilised to improve the experiences of Aboriginal women in regard to gynaecological cancer. These serve as examples of what can potentially be achieved elsewhere. All three women interviewed for this study felt that the quality of service provided to Aboriginal people had improved over the last twenty years as the following comments suggest;

Twenty years ago you’d be in the room waiting for your treatment and you’d actually hear the nurse say to another nurse ‘they’re all the same aren’t they, just look at it’. That sort of thing…. I think it’s changed quite a bit. Like, working in the health field years ago, as an advocate I used to get so wild. There was a couple of nurses I felt like taking outside and, you know? You couldn’t do it. These ‘thems’ and ‘those’ and ‘they’re all the same’. The comments you used to hear were shocking. But I think it’s improved (R11).

### 3.4.3 The Challenges Facing Women in Rural Areas

This section follows up on a number of issues that arose during the interviews with the women as they related their stories of care. We begin the discussion by reporting on the
views of women from rural and remote regions. Much of what they report is a direct result of workforce issues.

We interviewed a total of 13 women we have categorised as ‘rural’, including those from Darwin, and the 5 carers were all associated with rural women. The women in regional centres lived in town apart from three who lived an hour away. Nine women had their surgery at a distant capital city hospital, and were generally there for a week, although four experienced longer hospitalisations due to complications (the longest involved admission for more than six weeks to a second hospital in the distant capital city). One woman was living in a capital city at the time she was diagnosed, had her surgery there and then moved to a rural area in another state. Two women had surgery in one capital city, and follow-up radiotherapy in another.

The experiences of the gynaecological workforce by country women was both the same as and different from those of metropolitan women. Non-metropolitan women have to travel to an urban centre for gynaecological cancer surgery, so the surgical and immediate post-operative care was essentially the same for rural as for metropolitan women. However, the experience of rural women in accessing clinical care was strongly influenced by geography.

Non-metropolitan women had complex pathways to diagnosis, intervention and post-intervention care. Some of these pathways were well defined, and women went from diagnosis to treatment and returned in a well-oiled system that took care of them each step of the way. Other pathways were more rugged and required the women to negotiate to obtain what they needed, and sometimes they were not successful. The defining difference was variations in outcomes of interventions, particularly women with post-operative complications. For women whose diagnosis was not clear cut, or whose care outcomes differed from the norm, there were gaps in the system which resulted in harm and difficulty.

3.4.3.1 Diagnosis to Intervention

The time to diagnosis for rural women varied from two days to six years. Two women were diagnosed within days, two within two weeks, three within several months, one within two years, and one woman could trace her symptoms back for six years. Once an actual or provisional diagnosis was made the women had surgical removal of their cancer within two weeks or less. Only one said she had to wait for a bed. Similar to urban women, some women found the speed of referral to be disorienting. Treatment was mostly radical hysterectomy with lymph node removal.

3.4.3.2 Geography Affects Care Adversely

The Clinical Oncological Society of Australia (COSA) surveyed all regional hospitals providing cancer care, with a close to 100 per cent response rate. There are 157 regional hospitals that administer chemotherapy out of 761 public hospitals and 543 private hospitals in Australia. The 2006 study, Mapping Rural and Regional Oncology Services in Australia identified that rural people are more likely to die of cancer within five years of diagnosis than urban people. The report states that ‘People with cancer in rural and remote areas are diagnosed at a later stage than their urban counterparts and are more likely to die from cancers such as lung, cervical and uterine cancer the further they are
located from large cities.’ This is consistent with the particularly poor outcomes for Indigenous people with cancer.

Two examples are detailed to give a flavour of adverse experiences that resulted from rural location. One woman from a regional town was sent for investigation to a capital city without a diagnosis. She returned home and when the diagnosis was made she was re-admitted to the capital city hospital within 3 days for surgery. Her post-operative course was traumatic. She lives on her own so stayed with a family member in the capital city for a couple of days post-operatively. During this time, her stitches broke and she had to wait for 12 hours on a trolley at a nearby hospital to be readmitted to theatre to repair the wound. She developed further complications, and spent six weeks in hospital, including a week in a coma in intensive care, and a week in rehabilitation to learn to walk again. She then caught the train home on her own with her wound still open. There was no care provided for her when she came home. She had some dressings from the hospital and a retired nurse she met playing cards advised her to expose the wound to the sun to dry it up, which she did. Her neighbour brought over some food. There was no medical care arranged to review her recovery. She had rung the local hospital for help and was told they did not provide care for people on the other side of the border. No-one suggested she contact her GP and she did not do so.

So you didn’t ring your GP?---No, I didn’t. I just rang where I was told to ring, which was the base hospital, and I rang, then, aged care to see if they – and they said ‘no, we don’t deal with patients from the other side of the border’, which I thought was absolutely unbelievable (R1).

Another rural woman took six years to get a diagnosis of gynaecological cancer, with a secondary cancer. It took two weeks to get her into surgery in a capital city once a provisional diagnosis was made. She had surgery for both cancers, was discharged on a Saturday by an intern who told her to call her GP if she needed follow-up when she returned home. Her GP knew nothing about her care, had received no discharge notes and would not do a house call. Her bowel was not functioning, her husband called the chemists who did the best they could. He became desperate when he came home from work to find his wife writhing on the floor in agony. They had no idea how to manage and had no help. Eleven days later she had an appointment for chemotherapy at the cancer clinic in her town, and she got the help she needed after that.

Were you in pain?---Extreme. Extreme. I had been so well in hospital and I just felt like you were just dumped once you got home. There was just no help at all (R2).

She had no contact with her GP until after the cancer management was concluded and he is still not involved in her cancer care. If she has any problems she sees the visiting surgeon or the local cancer service. She believes now that they have a nurse who follows up patients with home visits. She and her husband had the added worry that although they relied on his wages they had private health insurance and when he went to claim for the costs of treatment he was told that the local hospital was not covered. He thought he would have to sell their house to pay the medical bills, although finally the health insurance fund did pay. This was an added stress that this traumatised family did not need.
3.4.3.3 Good Care in the Bush

The report by the COSA suggests that poor access to services is a crucial component in adverse outcomes for rural people, and that improved primary care and access to specialist multi-disciplinary services is the key to improving this outcome. This includes the expansion of regional oncology centres of excellence.

One model of such a centre is that provided by the Albury/Wodonga cancer service. In their editorial in the MJA, Drs Craig Underhill, David Goldstein and Paul Grogan (2006) describe this multidisciplinary service which provides chemotherapy and radiotherapy, involvement in clinical trials, and the ability to attract a sustainable workforce of oncologists.

The patient journeys of women from rural areas in this study highlight the need for similar services, and the strength of regional services with strong links to metropolitan gynaecological cancer services.

Another rural woman was clear that her rural community provided the best care. She had travelled to her state’s capital city for surgery then returned to her home town. There she was cared for by the local medical and nursing staff:

> We’ve got a beautiful community nurse and GP; it’s marvellous... They’re outstanding here, their care. That’s all the allied health professionals; we’ve got the best GPs.... I believe I got more care because I was in the country. I had nurses popping in saying ‘are you okay?’ If I’d had a bad morning they’d ring up or something ‘are you all right?’ (R11).

3.4.3.4 Rural Women Managing the City

Rural people want their care delivered locally. They find the journey to metropolitan areas stressful and difficult. Many rural people rely on personal knowledge of their health professionals to assess their trustworthiness and find the metropolitan systems rely on signifiers (such as prestigious hospital appointments) that are outside their experience. They also experience the pace of activity in metropolitan environments as hectic and unsettling. Finding their way, managing traffic and parking, negotiating hotels and taxis, can be very difficult. However, the experiences outlined below indicate some of their needs are already being met:

> The [accommodation], where we stayed at the [city hospital], that was very well done too. The chap that was in charge of that, he was very nice, and the fact that you had your rooms and you looked after yourself. But they had a bus that went every half an hour to the [hospital] and came back. And it took you shopping so you didn’t have to want for anything really (R6).

The accommodation referred to by this patient is for cancer patients from country areas to stay at when they are having treatment at the major hospital. Similar services are provided in other states and women and their carers reported favourably on them.
3.4.3.5 Improving Rural Services

The hub and spoke model of cancer care, where rural cancer services are linked with metropolitan hospitals that provide gynaecological oncology surgery, appears to be effective in meeting the needs of rural women. The relationship between Border Medical Oncology and the Royal Women’s Hospital in Melbourne, and between the Royal Darwin and Royal Adelaide hospitals are examples of this model. In this model diagnosis is usually made locally, the woman is referred to the city for surgery, returns to her rural location for chemotherapy and radiotherapy if needed, and is followed up with a visiting service by the city-based surgeon.

The smoothest path involved provisional diagnosis by a rural GP, referral to a regional gynaecologist for diagnosis, from there to a metropolitan gynaecological surgeon for surgery, discharge into the care of their GP, and back to the regional centre for chemotherapy or radiotherapy and then to local general practice for follow-up care. Almost all women had regular check-ups with their operating surgeon who visited their region for the purpose.

3.4.4 Managing Adverse Events

it takes such a long time to recover from cancer of the uterus (R1).

Half (12 out of 24) of the women had adverse outcomes that required further management that was not predicted as part of the normal course of recovery. All but one of the women we interviewed were in remission or their cancer had been cured following extensive surgery. They, and the husbands who were interviewed, were very conscious of the gift of extra life they had been given and many dismissed the difficulty, pain and distress of the intervention as unimportant compared with the outcome of prolonged life. The implied alternative was foreseeable death.

it was cut it out or it’ll kill you in the end (U7).

One of the abiding themes in the interviews was the impact of what is referred to in the literature as the cascade effect (Woolf et al 2004). This is a situation where once a patient has one mishap, it sets off a train of further mishaps.

Pathways into and out of care were not always smooth and multi-disciplinary care for women with gynaecological cancer must actively plan for management of women when things go wrong. And things do go wrong. In this study three women had post-operative outcomes that left them with life-long disabilities, four had post-operative infections including one who was critically ill, two had debilitating depression, one had persistent inter-menstrual bleeding, and two had other complications. One woman had morphine apnoea and stopped breathing, with possible cardiac arrest during surgery and was admitted to hospital when she returned to her local community, because of chest pain and concern about another complication.

Even women who did not have adverse outcomes found the experience of diagnosis and treatment to be traumatic. As one woman put it:
And it’s a very scary experience because you go from finding something and then it’s all blood tests and scans and ultrasound and then you go through major surgery and then the chemo and you’re just bewildered. You’re not well (U5).

Another described her feelings when told she had stage 3 cervical cancer:

It’s hard because it’s almost like you’re in a wind tunnel when you first get told; it’s a bit of a shock, obviously (R8).

One young woman underwent hysterectomy and was told the good news was that she did not have cancer. She had wanted another child, and is suffering from other post-operative factors that have led to hospitalisation for pain. She is struggling with the impact on her marriage and her joy of life.

Only one of the women mentioned depression as a consequence of their cancer.

I went to my doctor and he said I was severely depressed and I had anxiety and I had nobody to turn to o help me (U5).

In another case it took a husband to tell of his wife’s struggle:

She had depression when she came back and had a lot of trouble coping and getting her life together again after surgery and what she’d been through and she had to – she was taking [an anti-depressant] for a while and that took a period of time for her even to recognise that she had this problem (CR5).

These examples are given to illustrate that there must be sufficient depth and coordination within the health services to manage the variety of post-operative experiences women have, especially when things go wrong. And that this must include assessment of their pain management and psychological well-being, which will require bringing her general practitioner into the team.

It is likely that depression is under-diagnosed. Several women hinted at mood changes but did not say that depression had been diagnosed and this was not pursued in the interview. One woman withdrew permission to use her interview, was subsequently diagnosed with depression and her GP treated it and five weeks later she agreed to be interviewed again. Even successful surgical interventions took their toll. One woman commented:

You now realise and understand that bad things happen (R7).

Another woman summed up the radical change that the cancer journey makes:

you go in feeling extremely well and with me not really knowing there was anything wrong... and from then on your life becomes a bit of a misery because this doesn’t work and the bowels won’t work properly and all that stuff. So, yes, it has been a long haul. When we did the operation the surgeon was really excited - ‘I’ve got it all’, he said ‘and that’s it’ - but, of course it isn’t. That’s not the full story and nobody knows what the full story is (U3).
Adverse events occurred during cancer interventions. Some women commented that the experience of cancer and its treatment was very ‘traumatic’, ‘angry’, and ‘horrific’. Incidents involved all members of the health workforce.

3.4.5 Gender and Care

3.4.5.1 Gender of Health Professionals

The majority of women (18 out of 20 who responded) and their carers were not concerned about the gender of their doctor or nurse. They indicated a preference for a female, but gender was not the defining factor in satisfaction with their care. Other qualities such as excellence in skills, gentleness in performing procedures, lack of embarrassment during examinations, a positive approach to treatment options, and an unhurried demeanour that allowed the woman to ask questions and allay her fears were more important.

While the women were also more concerned about competence than gender when asked about nurses, one in four expressed a preference for female nurses. Some women noted the excellent care they received from male nurses.

What about if the nurse is a male or female?---No. Actually the male nurses were great, absolutely fantastic (U4).

If they’re hugely competent I’m very happy whatever sex they are (U3).

3.4.5.2 Challenges to Sexuality

Gynaecological cancer focuses on a woman’s sexual functioning and those parts of her body, other than breasts, that define her as female. A range of concerns emerged that suggest that gynaecological cancer treatment can challenge some woman’s sense of being female. These responses ranged from those outcomes shared by other people with cancer and undergoing chemotherapy, such as hair loss, to issues specific to gynaecological cancer. A small number of women touched on their sexual relationship with their partner and the difficulties experienced regaining normal sexual functioning. Interestingly, only one participant reported receiving any education or advice from either their doctor or nurse on how to maintain or resume their sexual relationship with their partner, how to maintain hygiene in the care of their colostomies or in self catheterisation or in adjusting to an altered body image. No woman reported receiving information on the impact of chemotherapy or radiotherapy on sexual functioning or her relationship with her partner, although one woman reported her husband received counselling because of a pre-existing mental illness. Research also indicates that teaching women about the physical difficulties of gynaecological cancer makes a significant difference to quality of life.

Several women reflected on the impact gynaecological cancer has on their reproductive capacity. Some hospitals appear to place women with gynaecological cancer in wards with obstetric patients. Similarly, women attending out-patient clinics for their three monthly check-up post cancer found themselves sitting next to pregnant women. Some were confronted with the fact that their own reproductive organs ‘had let them down’. These feelings are captured in the following two quotes:

The two things which happened to me which I found particularly difficult in that sense was (a) they put me in the maternity ward...on the ultrasound unit I need to
be logged in as a male, not as a female, because I don’t have sexual reproductive organs … They put me into the maternity ward. ..And I could not deal with that (R7).

One younger woman felt having a gynaecological cancer stigmatised her as sexually permissive:

It’s not like I’m a slapper, I’ve just been very unlucky, you know. I remember writing very, very angrily, you know. …. I was feeling quite embarrassed at times and I thought ‘oh, this doesn’t look too good’ (R10).

We were fortunate to interview one woman in a lesbian relationship who provided a window into the quality of care and advice she received on when and how to resume her sexual relationships. The comment below from this lesbian woman highlights the role health professionals can play in educating couples on the road to recovery:

The best experience was one of the nurse educators who really told [my partner] and I what to do and what we could do when I returned home. It was the way that she explained everything and her validation, just about the way she did it, validating our relationship. It was a beautiful experience. She is so gifted. That was a wonderful experience (R13).

This woman received her care in a private hospital in a ward that specialised in the care of women with cancer. While it may not always be efficient to provide care in a specialised unit it would appear that where this is the case there is more chance of nursing staff being able to provide patients with appropriate emotional support and education to assist them in dealing with the challenges to their sexuality and self worth.

It would be helpful for oncology nurses working with women with a gynaecological cancer to be supported to provide adequate education in sexual health following surgery, and during chemotherapy and radiotherapy.

3.4.6 Bed Management

The other gender question we explored was how women felt about receiving their hospital care in mixed sex wards. Two thirds of the women were clear that they wanted to be in single sex wards. They were concerned about privacy and dignity and not sharing a bathroom with men, whom they experience as less concerned about cleanliness and hygiene. Some were more concerned about it because they were having gynaecological surgery and did not want to have to deal with that in front of men, others just objected to the whole idea of mixed sex wards.

One woman put her views of the possibility of finding herself in a hospital ward with males this way:

I would prefer only women. I don’t think it’s appropriate that you open the toilet door and see a man’s bottom looking at you (U6).

This woman was aware of the pressure by hospital management to optimise bed occupancy yet she strongly opposes mixed wards as a solution.
Rural women were equally divided about whether they cared about single sex wards, the private hospital patients were more likely to favour single sex wards, and the Aboriginal women all wanted single sex wards, and felt very strongly about this.

Women also wanted to be in a ward with women who were having similar types of care, either cancer care or surgical care. They were distressed if put in with women who were having babies, especially if their cancer ended their reproductive life prematurely. Where they are nursed is important to their overall psychological and emotional health and their experience of their health care:

I was actually asked to give up my room. I was in one room then I was in intensive care then I went back into a really nice room and then on the fifth day they asked would I give up my room because they had a woman with a baby coming in so they moved me to this little tiny room next to the kitchen and it was so awful (U5).

It is an important finding of this study that beds in single sex, cancer or gynaecology wards should be provided for women undergoing gynaecological cancer surgery. Where possible, care providers should ask the question about gender preference, and take into account the views of the minority of women in this study who preferred female staff.

3.4.7 Impact of Financial Issues

Responses from the women and their carers on the financial implications of having a gynaecological cancer were mixed. Those women who received all their care in the public system appeared to experience no burden of cost, while those who had private heath insurance were left with out-of-pocket expenses linked to their level of health insurance. Costs ranged from a few hundred dollars to more than $5000 out of pocket expenses within the financial year.

3.4.7.1 Awareness of the Medicare Safety Nets

In a number of cases it was clear that the women were not aware of the two safety net provisions built into Medicare. These are the family safety net covering the difference between the scheduled fee and the 85 per cent paid by Medicare, and the safety net paid to families to cover gap payments charged by those doctors who do not bulk bill or who charge above the scheduled fee. The women reported that the time of surgery and on-going treatment was such an emotionally charged period in their lives that they found it difficult to focus on the costs.

Has your treatment been a financial burden to you?---Yes, that fiscal year of treatment - we have private health insurance, we just don’t have the absolute top one - … and I can tell you that we were $5000 out of pocket for that fiscal year. You have CAT scans, you have bloods – the blood test didn’t cost anything, but visiting different doctors and all that kind of stuff [U1).

Clear and unambiguous information should be provided for all patients on their entitlements under Medicare.
3.4.7.2 Gaps in the PAT Scheme

The PAT scheme provides financial support to women and their families to travel to capital cities for treatment, especially surgery and chemotherapy, however there appear to be anomalies in costs linked to cover for partners, taxi fares, and weekend meals that leave families with additional costs. In the case of women who need to stay in a capital city for an extended period for chemotherapy the cost is a burden both on the family and woman. The interviews revealed a mixed response to the PATS scheme with some women reporting out of pocket expenses, and others suggesting it covered all their expenses. This difference appears to be related to expenses for carers.

3.4.7.3 Hidden Gap Fees for Doctor’s Visits, Tests, and Hospital Cover

Those women receiving private care appeared to have a range of hidden costs linked to blood tests, anaesthetist fees, chemotherapy treatment or hospital demands for up-front fees to cover the woman’s accommodation. This is well expressed in the following quote:

*In the end did it cost you very much?*---It did cost us a bit… Professor X wasn’t too bad but the one that really got to us was the anaesthetist because we ended up out of pocket …and they started to send us letters like ‘you’re in trouble because this hasn’t been paid’ and …that’s added pressure that you shouldn’t have to have (R2).

There were also costs associated with time off work for the younger women, and for their partners.

Two findings arise from this issue. Firstly, some research could be done on what mortgage relief provisions the major banks offer to families during periods of chronic illness and this information made available to women. Secondly, time should be taken to explore in some detail with the women and their partner, prior to their surgery, the care they will need following a hysterectomy and during chemotherapy treatment cycles. This would allow partners/carers to consider applying for holidays or long service leave or order to care for their partner without the stress of trying to manage work.

3.5 Contributions of Carers

A total of six carers who were involved in the women’s cancer care were interviewed. Of the 6 carers who were interviewed, five were between 61 and 70 and one carer was in the forties (mean age = 62.2 years). The carers who participated in the interview were all male. All of them were taking care of their wife.

Education levels were spread. Two had university qualifications, four carers had less than high school education. Five carers were retired with one carer working as a professional. All but one did not have any children. All of the carers interviewed were living with their wives. All carer’s wives had surgery at least 4 years ago but one indicated his wife was also operated on in 2007.

3.5.1 Role of Carers

Caregivers are responsible for providing physical and emotional care over longer periods. More care tasks are falling to informal caregivers as the detection and treatment
of cancer leads to increased treatment as outpatients, and the length of stay in hospital is reduced. Rural patients encounter numerous domestic and work related problems if they have to travel to the city for surgery and/or treatment. The roles of caregivers discussed in the interviews were:

1. Emotional support
2. Communication with the doctors
3. Experience with cancer
4. Transport and travel
5. Managing information
6. Personal care

3.5.1.1 Emotional Support

The role of family and carer is particularly important when the women are first diagnosed. Because of the emotionally distressing nature of the diagnosis the women need physical and psychological support and encouragement. In many ways the carer’s support mirrors that of a personal trainer. As one carer noted:

The people undergoing cancer, they’re looking death in the eye and they’re going to feel psychologically down so just a few words of encouragement here, there and everywhere. That’s just as important as the physical care too (RC2).

The role of emotional support is particularly important when gathering information in order to make decisions. One carer noted that the women are too emotionally involved and this prevents the information provided by health professionals from being fully taken in. This carer went to the doctor’s appointment with his wife to take notes.

Talking with friends, carers and families were also perceived as beneficial to the women and constituted an important safety valve for the women.

Then you’re an emotional carer when you go through the whole – you know, you’ve got to fill the gaps in between the operations. You’re waiting for results of blood tests and then when she got the leukaemia and she went through radiotherapy at one stage and getting the result of that, which was negative – the emotional side of it, certainly, I suppose, from her point of view, having me there certainly helps (RC1).

One husband reported difficulties managing his own emotional responses while providing support to others:

there’s a burden that I feel guilt about what’s happened and there’s nothing in place for people like me and the guilt and anxiety that I am feeling at the moment. So with this recurrence I’ve gone to the doctor to get something to help me sleep because I haven’t had any sleep for three days. ... Someone could have said ‘how are you going?’ ‘Do you need something?’ But that’s not done (RC5).
3.5.1.2 Communication with Doctors

Five carers were satisfied with their involvement in treatment discussions they felt that the doctors communicated with them well and they were included in the system. However it was mentioned by one carer that he did not have an opportunity to participate in discussions.

it seemed to be that this ‘doctor knows best’ is still reasonably current and the patient, or the client, is not meant to be involved. It can be difficult involving the patient and they can make not very well informed decisions (RC5).

I’ve been there in an emotional capacity right through but actual caring physically, she had an operation in ’99, she had one in 2000 and then she had another one in 2005 and another one at the beginning of this year and this one. So, you know, for 10 or 12 weeks after each of the operations I’ve been a physical carer (RC1)

3.5.1.3 Experience with Cancer

One carer indicated that his prior experience with cancer made him and his wife more prepared. His mother had a bowel cancer and he has had three life threatening events and had come through.

We sort of view cancer just as a normal part of life, it’s just another sickness. We’ve been blessed, of course, by the fact that we’ve recovered so many times (RC4).

This contrasts with the carers who have no previous experience with cancer care, where they indicated that the whole experience was very stressful. ‘Not knowing what to do’ was considered the worst experience for carers who had not been involved in the cancer care before:

If I knew then what I know now I could have done things differently (RC5).

3.5.1.4 Transport and Travel

One of the major challenges for carers from rural areas was negotiating their way around the major cities, although as the patient interviews indicate a number of services offered by state run cancer agencies provide valuable transport and other services that alleviate travel related anxieties. Some patients from rural areas also encounter numerous domestic and work related responsibilities if they had to travel to the city for surgery or ongoing care. This meant their partner had to take up these tasks and not accompany them to the city.

3.5.1.5 Managing Information

It was mentioned by one rural carer that the discussion about the procedures and the options should have commenced where they live, prior to travelling to the capital city so his wife and he could have started putting their minds to the decisions to be made:
it was only when [wife] got off the plane in [capital city] and had a meeting with the surgeon that the options - the actual specifics of her surgical options were discussed with her, whether she could keep her ovaries or not, what the scope of the surgery was likely to be, what they were actually going to do (RC5).

Two carers noted that information needs to be prepared and given to patients separate from managing the details of surgery and treatment. It was also highlighted that some women suffer from post-operative depression and that there is a need of additional visits and counselling to be provided by the health professionals for the women and for the carers especially after the women are being discharged from the hospital.

there was a lack of information. I’ve a number of times said ‘what about some ultrasounds?’ and ‘what about some other tests?’ I mean ‘you’re doing these general physical inspections but if there are secondaries and if there is going to be a recurrence are you sure you can pick it up doing this? (RC5).

Two carers experienced anxiety and stress associated with the need for information and communication with the health professionals. Information is of exceptional importance for both patient and their families.

### 3.5.1.6 Personal Care

Cancer caregivers provided physical care, did the housework, took care of children and animals, cooked, shopped, cleaned and generally took over the household management tasks of their wives as well as providing physical care to her:

there’s been no one else looking after her. There’s a void so you fall into that role. You’re not skilled to do it. I’m not qualified to do it. I’ve got no experience. By default you’re then taking on this additional burden of responsibility as the carer (RC5).

One carer had a full time job at the time when his wife was diagnosed with cancer. He commented that there was no support for his wife and him after his wife was discharged from the hospital. There was virtually no one in the house because he had to work from 5am and the son had to work so there was no one to look after his wife. He was frightened of losing his job so he kept working.

### 3.5.2 What Carers Say They Need

The needs identified by carers included:

1. Personal risk management plan
2. Protocol for the emergency situation when they are out of the hospital
3. Case manager
4. Assist in knowledge of operation and treatment – help with the medical terminology
5. Knowledge to be shared with others
6. Patient priority at the general practice
3.5.2.1 Personal Risk Management Plan

One carer suggested that a risk management plan which included the patient’s medication, details of the cancer and what to expect next as well as how to access support should be provided to all carers.

This is my view: do a risk management for a patient. … There’s not much information available. What is available is clichéd. You’ve got cancer things on the internet, which are really completely useless, or there’s some technical information, but most people can’t understand and interpret that … this is a complex thing to put together but that could be provided to patients like pharmacists do with product information on drugs, medication slips, and ‘this is cancer information for you’ and it’s explained (RC5).

3.5.2.2 Protocol for Emergency Situations

Three carers mentioned that support is needed from health professionals to deal with the post-operative period. Provision of information on how to support their partner while they are providing care for them at home and a protocol for the emergency situation once they are out of the hospital were suggested:

One thing has always worried me. Because we know this thing keeps reappearing I’ve felt a bit of stress or anxiety. If it’s getting towards when they’re ready to come back – and it’s only happened the once – I just wonder what do I do? (RC1).

3.5.2.3 Case Manager

Carers suggested that a case manager be provided who could provide flexible and customised care and response:

They’d need to be intimately involved in each case and the detail of each case, because you can’t project manage flipping bits of paper around – they need to be – and they need to build a relationship with a patient. This is where it takes time. I think it would be great (RC5).

3.5.2.4 Assistance with the Medical Terminology

One carer said that he needed help with the medical terminology to understand what the doctors were telling him:

Sometimes it’s an alien language if somebody doesn’t do that and goes into the doctor’s surgery; there’s no communication. The doctor talks in clear and concise language but the person doesn’t understand what he’s saying (UC1).

3.5.2.5 Knowledge Sharing

It was highlighted that ‘not knowing what to do’ was considered the worst experience for those who had never involved in the cancer care before. One carer suggested this may be overcome by sharing information and knowledge with others so that everyone does not feel like they are doing this role for the very first time:
I’m thinking about some way that this knowledge can be shared so that everyone doesn’t feel like they’re doing this thing for the very first time and you’re finding your way in the dark and it’s very scary and it’s really, really serious and there’s nothing for someone like me, that I can really hang my hat on here. So then, in that absence of knowledge, we hand ourselves over to the health system and we’re not empowered in any other way than to do that. Possibly there is a lack of knowledge because it’s all kept together and controlled and marshalled by the health care providers in the health system (RC5).

3.5.2.6 Patient Priority at the General Practice

One carer suggested that the patients with cancer should be on a priority list when they make appointments with GP.

Maybe some way at the GP level, that they be given a bit more priority when they make appointments, number 1. And that’s not from the GP, that’s from his staff, that they be instructed that this particular patient, when they ring in, that they’ve got cancer and if it’s a two week waiting list, forget about that, instead of having to cajole and ask and try. I get the impression that some of these girls – that everybody wants to get in straight away, obviously, because that’s human nature, but maybe if they get tagged so that they get a bit of special treatment (RC1).

3.6 Suggestions for Improvement

Carers play a vital role in providing continuing support and medical, physical, emotional and social care for women. They accept much of the burden of care that is effectively now outsourced from hospitals. Particular attention needs to be paid to the follow up care needs of women who do not have partners doing this critical work.

3.6.1 On Discharge

• Project manager for each woman
• Organised visit from community nurse on discharge
• Awareness of the psychological, sexual and emotional impact of cancer and its treatment
• Identified support when discharged home
• Recognition of depression
• Priority when trying to access general practice care
• An easy system to access
• Information and support for carers
• More awareness of Cancer help line
• The onus is on people to contact the women and offer support rather than rely on the women and their carers asking for help
• Local support groups

3.6.2 In Hospital
• Continuity of care
• Inform the patient so they can be involved in decisions
• More frequent bed making and attention from nurses while in hospital
• Anticipation of need for pain relief by nurses
• Written information about what to expect
• Written information about drugs and different sorts of cancers, including survival rates
• Kindness

3.6.3 General
• More public awareness of the symptoms
• Be aware of the particular needs of rural and regional women
• Culturally appropriate care for Indigenous women
• Culturally appropriate resources for Indigenous women, using pictures rather than words

3.7 Conclusion
Positive experiences of the models of care (and the teamwork that supports them) were common, as this comment succinctly puts it:

I was very, very well looked after after once I got into the system (R2).

Women appreciated the teamwork, the efficiency and the caring they received during inpatient and acute phases of their care. There were three main problems – the lack of coordination with GPs, system breakdown when things went wrong, and the problem of ‘dropping out’ of a care system on return home from hospital. The problem of communication between specialists and hospitals on the one hand and GPs on the other has been the subject of concern for many years, and progress has been made. However, for the women in this study, failure to make this relationship work is a major factor that requires attention.

Women were also asked about who helped them, and they nominated family, friends, volunteer services and other home-based carers (and in one or two cases, their GPs). It seems that the women expected that when they needed skilled help at home, or just the safety net of knowing someone was looking out for them, they should have been able to rely on their GPs directly, or for their GPs to be able to provide access to other support services. This is particularly important when the patients live remotely from the hospitals, but it also affects urban women.
4. **Views of the Workforce**

4.1 **Introduction**

Women with gynaecological cancers come into contact with members of a workforce with a range of skills and backgrounds, a range of capacities. Other staff, who patients may never meet, also contribute to developing their treatment plans and to their care. This chapter presents the results of interviews with a sample of these staff. It describes the relevant workforce, considers their career pathways, their skills and how they acquire them, how they work together, and special issues arising for those providing care to patients in rural locations. The aim is to describe the current situation in relation to these issues, where possible to make some comparisons across the five sites in which the research took place, and draw some conclusions about current and future issues in the gynaecological cancer workforce.

Trying to draw precise boundaries around the ‘designated’ gynaecological cancer workforce is not a very useful exercise. Amongst the many healthcare professionals who care for women with gynaecological cancers, only a small number have specialist skills that are focused specifically on treating these diseases, only a small number spend all of their work effort in caring for women with these diseases, and only a small number will focus on these diseases for most of their careers. Thus, the ‘gynaecological cancers workforce’ consists of a small core of professionals with career defining specialised skills in treating gynaecological cancers, and a much larger number of staff, often highly skilled and trained, whose role in treating gynaecological cancer is defined by the particular jobs they hold. For some of these latter staff, caring for women with gynaecological cancers will become the central focus of their healthcare careers. But for many others, this group of patients will be only one of a number of groups that benefit from their skills and commitment through their careers in healthcare. So the challenge of developing policy for the workforce that treats women with gynaecological cancers has different dimensions. It certainly involves ensuring that there is adequate supply of staff with specialised skills focused on treating these diseases, and that these skills are used as effectively as possible. But it is also a matter of taking account of the staff whose careers are not defined by their specialisation in these diseases, but who have central roles in treating patients who have them. These staff must have the disease-specific skills they need to perform their tasks; and care needs to be organised so that the skills they have are used effectively, and they are not assumed to have expertise they cannot be expected to have.

These issues are complex at any time, but are especially challenging when new models of care are being developed. The gynaecological cancers area is therefore of special interest because of the emphasis that has been placed on the use of multidisciplinary teams (MDTs) in this field. In this chapter, special attention is given to how these teams work in practice. As is shown below, important aspects of how these teams operate in practice have to do with the roles of healthcare staff with different levels of focus on gynaecological cancer, especially in the context of their other healthcare roles and responsibilities.

4.2 **Occupations and Roles**

People in many occupations and roles contribute to the care of women with gynaecological cancer. Outlining the main occupational groups involved in this care, and
the work each does, is a useful beginning point. The focus is on those occupations most centrally and specifically involved in providing care, touching only briefly on other relevant groups.

4.2.1 Gynaecological Oncologists

Gynaecological oncologists are the specialist medical practitioners who direct and take responsibility for the overall course of treatment of women with gynaecological cancers. For certification as gynaecological oncologists, they are required to have completed a basic medical degree, specialist obstetrics and gynaecology training, and specialist gynaecological oncology training. They are registered as sub-specialists by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. To maintain their registration, they must renew it every three years, and must spend at least two thirds of their time on gynaecological oncology work. Much of their work is surgical, and they are widely regarded as amongst the most skilled gynaecological surgeons. They are sometimes asked to perform or assist in complex gynaecological surgery that is not cancer related because of their special surgical skills. There are currently 36 certified gynaecological oncologists practicing in Australia; 31 of these are men. All work primarily in metropolitan areas, though several visit rural and remote locations periodically to consult and undertake surgery. The result is that many patients from regional, rural and remote areas travel to metropolitan areas for consultation and treatment by gynaecological oncologists. In addition, there are a number of gynaecological trainees who undertake gynaecological oncology work under the overall guidance of certified gynaecological oncologists. These trainees are generally at various stages of the three year sub-specialty training program. There are probably 5-12 of these at any given time.

Senior gynaecological oncologists are in charge of all gynaecological oncology services at major public hospitals. They direct and coordinate these services, and those who work in them. Gynaecological oncologists convene the tumour boards and multidisciplinary teams focused on gynaecological cancers. All gynaecological oncologists operate private practices as well as having public hospital appointments. They are assisted in their day to day care of inpatients in public hospitals by trainees (referred to as fellows or academic consultants) who conduct ward rounds and often act as the primary contact with public patients.

4.2.2 Other Medical Specialists

In addition to gynaecological oncologists, three other medical specialties are heavily involved in the care of women with gynaecological cancers. Pathologists assess tissue samples to aid in diagnosis. Medical oncologists provide expertise in deciding the utility and course of any chemotherapy treatment, and direct or administer that treatment. Radiation oncologists provide expertise in deciding the utility and course of any radiotherapy treatment, and direct or administer that treatment. Members of each of these groups are certified through their membership of the appropriate specialist college (Royal College of Pathologists of Australasia, Royal Australasian College of Physicians, or Royal Australian and New Zealand College of Radiologists). Medical oncologists and radiation oncologists are certified as sub-specialists by their respective Colleges, following special training courses.
Pathologists almost never consult directly with patients, instead passing their findings on to other relevant professionals, most commonly through tumour board meetings. Radiation and medical oncologists may see patients more frequently than gynaecological oncologists because the courses of treatment they direct typically require repeated administration (of drugs or radiation). Medical oncologists are located in regional, rural and remote areas as well as metropolitan ones, so that patients may receive chemotherapy in these areas. Radiation oncologists are located where radiation facilities are available. Some radiation facilities are available in regional cities, as well as in metropolitan areas. No pathologists, radiation oncologists or medical oncologists who participated in this research devote all of their practice to gynaecological cancers. These specialists develop expertise in gynaecological cancer both through their training and through practice. Few seem to devote more than half of their practice to diagnosing or treating gynaecological disease. Members of all three specialty groups involved in the treatment of gynaecological cancer patients typically attend MDT meetings.

4.2.3 Other Medical Practitioners

Women being treated for gynaecological cancers encounter a range of other medical practitioners. General practitioners (GPs) are often involved in the initial diagnosis and referral to either gynaecologists or directly to gynaecological oncologists. GPs also have roles in ongoing care and monitoring of women following initial treatment of their disease. General gynaecologists usually refer patients to gynaecological oncologists if they suspect gynaecological malignancies, though they sometimes unsuspectingly encounter them when operating and a few may operate knowingly on gynaecological cancer patients. Hospital medical staff, notably interns and registrars, often monitor the progress of gynaecological cancer patients post-operatively, making decisions about some forms of care and about when to consult more senior practitioners. These junior medical staff may have very brief experiences of working on wards with gynaecological cancer patients as part of rotations through a variety of areas of medical practice. They have no ongoing role in relation to the treatment of the gynaecological cancer patients who happen to be in wards for which they have some responsibility. These practitioners are not usually involved in MDT meetings.

4.2.4 Gynaecological Oncology Nurse Coordinators

Gynaecological oncology nurse coordinators are nurses who have responsibility for monitoring and coordinating the various aspects of a gynaecological cancer patient’s treatment and care. They are generally located in public hospitals and are closely linked to a gynaecological cancer clinic. The exact nature of their duties varies from site to site, depending on how the gynaecological cancer services are organised and on how the coordinator’s role has been developed. Typically, they will monitor patients’ ‘journey’ through treatment and care, keeping in contact with patients and their families, and with those caring for them. They assess the adequacy of services or support for patients, initiating additional care when they believe it is necessary and sometimes attempting to smooth the organisation of patients’ care programs. They also act as a point of contact and information for patients, and sometimes for health carers too. They usually attend relevant MDT meetings. They have limited specialised training in gynaecological cancer (see below for further details).
4.2.5 Ward Nurses

Initial treatment for many gynaecological cancer patients involves surgery, and surgery is also often important in diagnosis of these patients. Surgery may also be used for treatment some time after diagnosis and for palliative purposes. Ward nurses play an important role in caring for women post-operatively and during any in-patient procedures they require. Any specialisation of ward nurses depends on the dominant conditions for which patients in the ward are being treated. In some hospitals, gynaecological cancer patients are a minority in the wards in which they are placed, while in others they are the major patient group. In wards where they are the major patient group, ward nurses are likely to have developed expertise in their care through experience, possibly augmented with training in oncology or surgical nursing. In wards where gynaecological cancer patients are in a minority, the ward nurses may have little or no expertise in the area.

4.2.6 Other Nurses

Gynaecological oncology patients come into contact with a range of other nurses. These include those who manage and are involved in gynaecology and gynaecological oncology clinics, ‘research nurses’ who may be involved in treatments that are part of trials, and many others. Typically, these nurses have little or no specialised training in gynaecological oncology. They are not part of a ‘designated’ gynaecological oncology workforce in the sense that their gynaecological oncology roles are part of more generic roles and are not viewed as requiring specialised gynaecological oncology skills.

4.2.7 Social Workers

In the case study organisations, social workers are the primary occupational group providing ‘psychosocial’ support and services to gynaecological cancer patients. They also provide some assistance with patients’ access to other community services. No social workers in the case study organisations worked solely with gynaecological cancer patients, though this work tended to be given to one or a few social workers so that they developed experience in working with these patients over time. Relevant social workers are generally members of the appropriate multidisciplinary teams, and often attend team meetings. These social workers are based in hospitals (which are usually their employers), and it is through patients’ contact with hospitals that social workers have patients referred to them. In other words, referral of patients to social workers usually occurs when patients are inpatients, or visiting hospital clinics. In some sites, there are well established patterns through which social workers access patients, as, for example, when they routinely contact all gynaecological cancer patients who have surgery in a hospital. These patterns are associated with clear (though apparently informal) protocols for the support and assistance social workers provide to patients. In other sites, patients are referred to social workers through more informal processes (e.g., through informal discussions with specialists or the gynaecological oncology nurse coordinator), and the support and assistance offered is less standardised and more adapted to assessments of patient need. To some extent these variations in how social workers receive referrals and work with patients may be due to differences in the social work resources made available to gynaecological oncology units.
4.3 Career Pathways

The pathways through which people come to their jobs are crucial to understanding the dynamics of a workforce, as are their future career options. If pathways are highly institutionalised and inflexible, the supply of new workers will be determined largely by the entry of potential workers into the starting point of the career pathway. This is substantially the case for gynaecological oncologists. On the other hand, if pathways are flexible and multiple, then there may be no single entry port that usefully predicts which people will eventually enter a group of jobs. For example, while gynaecological oncology nurse coordinators usually have nursing qualifications, there are no well established pathways for nurses to enter these positions. Hence it is not possible to sensibly predict the future supply of gynaecological oncology nurse coordinators beyond the supply of nurses in general. Focusing on career pathways also involves examining how people enter the pathways into the gynaecological cancer workforce, whether or not these pathways are strongly institutionalised and defined. It also entails considering factors influencing retention of workers, particularly the aspects of the work they like and dislike.

4.3.1 Training

Training pathways for medical practitioners involved in treating women with gynaecological cancers are well established. As was noted above, gynaecological oncology is a certified sub-specialty in the Obstetrics and Gynaecology specialty, with an appropriate training program. This program involves an additional three years of hospital based training following certification as a specialist obstetrician / gynaecologist. It appears that all practicing, certified gynaecological oncologists in Australia have undertaken this specialist training in Australia, if they began practice after it was instituted. Certainly, it is reasonable to assume that virtually all future supply of gynaecological oncologists in Australia in the foreseeable future will be through graduates of this training program.

For medical oncologists and radiation oncologists, the other main medical specialists involved in treating women with gynaecological cancer, training pathways are not so specialised. There is no specialist training in the treatment of gynaecological cancer for these groups, though each of the specialists interviewed had come to specialise in gynaecological cancers to some extent. Radiation oncologists who use brachytherapy (the placement of a radioactive source inside or next to the tumour being treated) require specialist training for this work, though it is not used solely in treating gynaecological cancers. All medical oncologists and radiation oncologists worked in radiation or oncology services with other colleagues who specialised in the treatment of other tumour types. Two of the three medical oncologists interviewed for this study had a focus on gynaecological cancer during their oncology training, and viewed their subsequent practice in the area as a logical outcome of their training experience in the area. However, the fact that they specialised in this area in their current work was also partly a pragmatic consequence of the need for someone to focus on this area, rather than being purely a matter of choice. This was, broadly, the pattern for the radiation oncologist interviewed too. The third medical oncologist interviewed appeared to have become the primary medical oncologist treating gynaecological cancers at his hospital primarily because this was an area in which no other specialist was focused when he arrived, though he had had some prior experience in this area in his previous position. In short, for these medical
specialists, there was no required specialist training in the treatment of gynaecological
cancer, though they had often developed some expertise in the area through the
particular areas in which they received their advanced training. Nevertheless their
general training allowed them to treat these cancers and their specialist practice in the
area was usually largely a pragmatic response to training experience in the area and need
in the hospitals that employed them.

Basic training pathways for nurses and social workers are well established. Formal
registration is required to work as a nurse and, although this is not legally required for
social workers, completion of training approved by the Australian Association of Social
Workers is necessary for eligibility for most social work positions. Completion of basic
training provides nurses and social workers with access to most jobs in their profession,
including those in providing services and treatment to women with gynaecological
cancer. Specialist training in areas such as cancer nursing is available, though this is not
focused on gynaecological cancer nursing. Interviews indicated that most nurses and
social workers entered gynaecological cancer work following a largely contingent event
in their training or career. Thus, for example, a nurse might have been placed in a ward
where gynaecological cancer patients were located as part of her rotations during
training. Or a social worker might have found an initial position following training in a
hospital that was focused on some other form of cancer.

Overall, training pathways lead directly to gynaecological cancer work only for
gynaecological oncologists. Although there is some specialist training in gynaecological
cancer care available for some other occupations (see section 4.4), these are designed as
in-service skilling programs (usually of limited scope and duration) rather than as
training that leads to work in the area. Training may influence these workers’ routes into
gynaecological cancer work through the experience they give workers in this area, but it
does not confer certified expertise in the area, and many workers spend some time in the
area during training without going on to work in it. In general, medical specialists’
training pathways lead them towards gynaecological cancer work more predictably than
do those of nurses or social workers.

4.3.2 ‘Choosing’ Gynaecological Cancer Work

Like many forms of specialised work, providing care and treatment to women with
gynaecological cancer is virtually never something that workers consciously choose to do
at the beginning of their careers. Instead, they gain experience in the area, often through
largely serendipitous circumstances, and then become committed to it, though to varying
extents. Indeed, there were no examples in our interviews of people who had embarked
on their professional training with the intention of working in the gynaecological cancer
area. The incremental choices through which workers tend to come to the area play out
somewhat differently for specialist medical staff than for nurses and social workers.

Gynaecological oncologists often described becoming interested in the subspecialty as a
result of their experiences with gynaecological surgery as trainee obstetrician
gynaecologists. They described gynaecological oncology surgery as very complex,
interesting and challenging. For example:

I always had a surgical interest. All through medicine and junior residency,
surgery was what I was really interested in ... As part of the gynaecology I was

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exposed to gynaecological oncology, which is really good, challenging complex type of surgery, and decided that was the field I enjoyed. (Gynaecological Oncologist)

This respondent also illustrated the contingent pathways specialists often followed – his surgical interest had initially led him to beginning training as a general surgeon. He had shifted to obstetrics and gynaecology when he gained the impression that the generally surgery work that would likely be the mainstay of his future surgical practice would be routine and boring. Another gynaecological oncologist ‘chose’ the field because there was a significant shortage of skilled practitioners in the field at the time. In general, gynaecological oncologists make a series of active career choices, usually linked to their own interest in fields of practice or to their perceptions of need, that incrementally lead them to the subspecialty.

As suggested in the previous section (4.3.1), medical and radiation oncologists appear to focus on gynaecological cancer, as opposed to other cancers, in a largely contingent way. Although active choice played some role, need and opportunity usually played a significant role in their focus on treating gynaecological cancer. On the other hand, their paths into medical or radiation oncology were usually presented as far more driven by choice – usually by the inherent interest of the field. A medical oncologist’s path into his current work mix, with about 5-10 per cent of his work being in gynaecological oncology, illustrates this combination of choice, need and opportunity:

I decided I really wanted to be a physician. Then there’s a physician training course of three years of basic training, exams … then I started advanced training where I did a couple of years [in Australia] and then a couple of years at Guys Hospital in London … I can tell you that in the two years that I did my first medical oncology experience [in Australia], I had very limited exposure to gynaecological oncology. … When I went to London and I did a research fellowship I was also working in three main clinics each week, one of which was a gynaecology oncology clinic. … At the end of the two years I felt very confident in managing most gynaecological oncology tumours, but I learned all that in London, not here. Then, when I came back to Australia, I was expecting a lot of that would just get wasted because it would be back to “They only use gynae oncologists” … But …[I] came along here as a consultant and discovered that it was very different here (Medical Oncologist)

For nurses and social workers, the role of choice in their pathway to gynaecological cancer work was primarily in the initial decision to enter one or other profession, and then in a decision to pursue continuing work in gynaecological cancer once they had experience in the field. Their pathways between completing their basic training and gaining their first experience in working with gynaecological cancer patients were usually a matter of chance, or of choice driven by the convenience of a job (such as the hours or shifts). This latter point is unsurprising since most nurses and social workers interviewed for this project were women who often worked part-time while children were young and sought jobs with hours that fitted with their domestic care responsibilities. One gynaecological oncology nurse coordinator’s story illustrated this path:
How did you end up in the gynaecological oncology area?—When you graduate from nursing school, where there’s a job you go and it just happened to be in that area. I was really happy with the ward, the role models on that ward, the philosophy of the nursing staff on that ward towards gynaecology and the consultants who motivated the nursing staff in gynaecology ... [I] did some formal study into prostate cancer nursing, so a support role in prostate nursing. There was no funding for that position so I continued to work on the ward area and then had an injury which required me to work out of the wards for a little while, which opened up a lot of opportunities. Went back to the ward. This job was advertised and vacant so I applied and was successful (Gynaecological Oncology Nurse Coordinator)

This interviewee then went on to explain that staying in the gynaecological oncology area was something she chose to do because of the particular satisfactions it offered. In fact, she clearly had become increasingly committed to her work in the area.

A ward nurse told a similar story of working in the area more by chance than choice, and discovering its satisfactions:

I actually originally wanted to do midwifery so I thought I’d come here for some women’s health experience but I ended up enjoying it so much, working with the gynaec cancer patients, and I really got involved and really interested and was doing my own self-directed reading at home. I really enjoyed it and I just ended up staying and never went on to do midwifery, I loved it too much. I got more satisfaction out of looking after patients that were really unwell and I thought they needed a bit more. (Registered Nurse)

A social worker illustrated a more pragmatic approach: her job was attractive, mostly because the hours fitted her life well:

I kind of more fell into this job than had clinical training around it...I fell into it, absolutely...I saw a locum advertised just after the kids had started school...So I fell into it because I wanted to work in a hospital close to home part-time. (Gynaecological Oncology Social Worker)

4.3.3 The Role of Experience

For most categories of workers other than gynaecological oncologists, experience working with gynaecological cancer patients is important in their career paths not only because it leads them to a choice to work in the field. Experience, often gained through an initial chance entry into the field, is also the basis on which they develop expertise that then leads to further work in the field.

A gynaecological oncology nurse in a private hospital described this pattern:

Did you always specialise in gynaecology?—No. My gynaecology started when I went overseas to England and I worked in a private hospital over there in gynaecology, then gynaec oncology started 5 years ago. I wanted to stay with gynaecology ... I went from [public hospital] to [private hospital] because I wanted to do gynaecology. They would not let me work in gynaecology there
because they only employ midwives. I was lucky that [private hospital] took me as an RN working in gynaecology obstetrics ward.

They employed you there because of your experience overseas?—Yes, as a gynaecology nurse. (Gynaecological Oncology Nurse)

This nurse was planning to apply for a new position as gynaecological oncology nurse coordinator, thus further using her experience-based expertise to become more centrally located in the care of women with gynaecological cancer.

A cancer care nurse coordinator described her accumulation of experience-based expertise in the following terms:

What’s your background?—I’m a registered nurse and I have had 10 years experience in palliative care and I worked eight years in an oncology ward at [hospital] and I’ve been in this position since November last year. I’ve been 18 years in cancer services ...

Just a potted version of your career? ... Because I trained at [hospital] I then went to Sydney when I was first married and worked in a couple of nursing homes, but when I came back to [regional city] I actually started back at the [hospital] and worked in the palliative care unit up there, which at that stage was only a four bed unit and it had a medical ward attached to it. Then they opened up a 10 bed ward up there, so I used to work on the unit up there. When the [hospital] opened I actually decided that I wanted to have a change. Even though I wanted to stay in cancer nursing I wanted to have a bit more clinical knowledge so I worked at [hospital] for eight years on the inpatient unit. I also used to do some shifts in the day chemotherapy unit when they required me to do that. Then this job came up and I thought ‘well, this is done in a different way. It’s still oncology nursing but you have the time to actually spend with patients which you don’t get on the ward’, and looking at their social issues and their emotional issues. (Cancer Care Nurse Coordinator)

Clearly, this nurse’s sequence of jobs involved gaining expertise through experience; there can be little question that this expertise played an important role in her success in getting the series of positions she describes.

4.3.4 What Workers Like About Working in Gynaecological Cancer

The features of work that people find rewarding are important for understanding what affects their attraction and retention in jobs. Treating and caring for patients with gynaecological cancers involves many challenging aspects: patients confront life threatening illnesses, some die, others are in considerable discomfort, their families are distressed, etc. So what aspects of their work do professionals in the area find rewarding?

Medical professionals – gynaecological, medical and radiation oncologists and pathologists – all talked about the intrinsic interest of their work, and the technical challenges it involved. At least half of these medical professionals mentioned this aspect of their work when simply asked what they like about the area. As was noted above, gynaecological oncologists often mentioned the challenging nature of the surgery in the field as one of the features of the work they like most.
On the other hand, nurse coordinators, nurses and social workers did not refer to this aspect of the work. They were much more likely to talk of the caring and assistance they could provide to women. One cancer care nurse coordinator touched on many of the themes mentioned by most nurses when she said:

So that’s been the best part of the job, being able to actually go and spend time with patients and just listen to their story, because that’s what most people want you to do, listen … I like to be involved with families and the interaction with families and I think it’s a special gift if you’re able to help people. I think people that work in oncology should feel privileged to actually be let into peoples’ lives. (Cancer Care Nurse Coordinator)

Coordinators were particularly likely to mention the fact that they had sustained contact with patients:

It’s following the ladies’ journeys and being – not only the ladies but the partners as well, and that’s interesting, following that journey. On a ward when you nurse you just see them for a little block whereas in this role you get to follow up all the way through. That’s the nice thing about it. You don’t just see your patient then forget about them and move on to the next one, you keep on going with them. And the personal reward you get when you know that you’ve helped someone along their journey. (Gynaecological Oncology Nurse Coordinator)

This last point, the satisfaction arising from feeling that one ‘made a difference’ in patients’ lives, was commonly mentioned (at least nine interviewees, from a range of occupations, talked in these terms). Another nurse said:

I suppose I went into this profession because I am a caring type of person and I like a challenge and I like to know that at the end of the day I’ve actually made a difference to someone’s life or someone’s experience. (Gynaecological Oncology Nurse)

Sentiments like these were not confined to nurses. A radiation oncologist described some of the satisfactions of the job in this way:

After you’ve had 6, 7, 8 weeks of seeing them every week and talking about the radiotherapy you get to know them quite well. That’s one of the nice things about the job, the relationship with the patients.

*Is that one of the big satisfactions?---Yes, it’s one of the joys. That’ why I like radiotherapy. I don’t mind the physics and the bits and pieces, I liked maths and science at school and stuff, but I do think it’s the patients really.*

Similarly, a gynaecological oncologist described the satisfaction he felt from taking the responsibility of treating a patient’s cancer, and fulfilling that responsibility:

You have been there for them, you are there to co-ordinate things for them, they’re not abandoned and the fact that they look up to you. That’s an essential part of gynae oncology, to not do the surgery and then say ‘goodbye’ and gone, that’s why you need the team. (Gynaecological Oncologist)
As was already noted, some members of the gynaecological cancers workforce focused on employment conditions - particularly the hours and shifts of work - when asked what they liked about their jobs. Those who mentioned this aspect of the work were all nurses, nurse coordinators or social workers. Medical specialists did not mention it, hardly a surprising result given their long hours of work. Amongst those who did mention hours and/or shifts, this was never the only aspect of the work they like. It was often mentioned along side satisfactions to do with the caring nature of the work, and the feeling that workers had made a real impact on patients’ lives and wellbeing.

4.3.5 Stresses and How They are Dealt With

Most jobs have stresses of some kind associated with them. Treating and caring for patients with gynaecological cancers might be expected to produce particular stresses, ones that would have effects on workers’ inclinations to stay in their jobs or to continue working in the area. In fact, there are certainly some stresses that are distinctive for work of this kind, while others are likely to be more widespread in the healthcare system.

A total of at least 20 of the 37 members of the gynaecological cancers workforce interviewed for this study mentioned dealing with very ill or dying women as a stressor in their jobs. Those mentioning this issue were spread fairly evenly across all the occupational groups in the study. In a small number of cases (three in all), these stresses arose from identifying with the patients themselves or with their families. In most cases, the issue was more to do with managing the emotions of patients and families confronted with serious, possibly fatal, disease. While the level of pressure this put workers under varied, the description of one nurse coordinator is illustrative:

> It’s a highly stressful time and once again it’s the unpredictability of how patients are going to cope. They can be aggressive and they are human so it’s not necessarily that they’re angry with you personally but it’s just their way of venting. So if you’re a person who can’t cope with someone screaming at you and abusing you because something’s not going their way, being able to identify that they’re not necessarily mad at you personally it’s more how they aren’t coping with their diagnosis. So dealing with difficult patients. And families. It’s not only the patients that you’re dealing with, it’s the families, the husbands, the partners, the kids, the grandparents. (Gynaecological Oncology Nurse Coordinator)

Medical specialists often described the issue in much milder terms, if they mentioned it at all:

> I’m wondering about whether there are aspects, or which aspects of the work that you do that you might find particularly difficult or stressful?...I suppose meeting the patients for the first time and trying to convey the diagnosis to them and having - and the patient has not been exposed to - in a clinic setting...

> Do you think that’s the most stressful …? Yes, probably stressful. Certainly it’s not too much of a stressful thing because I suppose once again I’ve been trained to do that and once you get into surgery you just do it. (Gynaecological Oncologist)

Statements of this kind were quite common. Practitioners recognised that working with very ill and dying patients might be seen to be stressful, but then went on to say that they actually did not find this particularly problematic.
One senior social worker noted that stresses arising from the confronting nature of constantly dealing with very ill women could produce tensions amongst staff. Thought she regarded this as routine, it was still significant and required energy to deal with:

*Do you find it a stressful area to work?*—It can be sad. The stresses are mainly maintaining the relationship with the staff as much as anything because the work I’m very used to because I’m very comfortable with it. It is sad when people die that you get to know. When young people are diagnosed there are obvious stresses with staff about what patients are told and what parents are told and the patient’s told and the families and all the communication difficulties. They’re probably the most stressful times, that everyone’s communicating openly and giving the patient what they want to hear.

*What are the stresses with staff?*—Mainly about communication. Mainly getting the communication direct and getting them to speak to the patients and keep them fully informed and not avoid them when they get angry. Patients get stressed and angry when they aren’t getting enough support and communication. Keeping everybody involved and keep talking about things. (Social Worker)

Overall, it appeared that the stresses of treating and caring for women with serious, sometimes fatal, diseases were shouldered much more by nursing and social work staff than by medical specialists. This was partly because the latter came into much more frequent contact with patients than the former. Indeed, the division of tasks and responsibilities between specialist medical practitioners and other staff sometimes virtually guaranteed that this would be the case. This is not to say that specialists were protected from this issue, but the extent to which they experienced it did vary substantially, at least partly depending on how frequently they saw each patient. A radiation oncologist, for example, who saw patients at least once per week while they were in treatment, seemed to find this aspect of the work more stressful than gynaecological oncologists who did not always see patients so regularly.

A second widely cited source of stress was shortages of resources, ranging from equipment or access to other specialty services to lack of crucial or skilled staff. In general, this issue appeared to cause at least as much stress as the fact of treating and caring for very ill and dying patients. It was mentioned by at least 20 interviewees, including five of seven gynaecological oncologists. Their concerns included waiting times and patient anxiety, under-resourcing in psychosocial services, ward management where cost savings were being made by putting gynaecological oncology patients in mixed surgical wards, lack of support from hospital administration, and lack of funding for research. The level of frustration here was sometimes quite high, as illustrated by this comment:

*Are there particular aspects of the work that you do that you find particularly difficult or stressful?*—Yes, the ward. The ward management of patients I find stressful because of the mentioned reasons. I do not have nursing staff you can address. You go on the ward and you have a patient with a problem, who are you going to talk to? You have to talk to the nurse who you don’t know because she’s just randomly rostered and you haven’t necessarily met her before because she’s usually not working in the gynaec cancer area and you don’t know how much she
Concern with lack of resources sometimes shaded into stress caused by managing the complex competing priorities in large hospitals, as the above interviewee went on to indicate:

It can be difficult to work in a very big hospital … you run under certain specialties and then they have to prioritise and your cancer patient might not have the highest priority because you have to compete against a vascular surgical case or you have to compete with trauma patients, which can be hard, obviously. Sometimes then you have to take some patient back to theatre, then obviously you’re ranked somewhere between the rest of them. … today we had a problem of how do you get an urgent CAT scan for a cancer patient? How urgent is a cancer patient? Then you have to, obviously, justify why you think this patient is particularly urgent when there are …

Not as if it’s someone coming in from a road accident?---…car accidents, road accidents line up. A classic example, to illustrate what the problem is: a young patient, 42. Recurrent peritoneal cancer; end stage, more or less. Fluid in the lung. Got a drain inserted. Wants to marry in 10 days. Is she going to be able to leave hospital? Is she going to die or not? She needs an urgent CAT scan but if you can discharge her at least there’s a last couple of days with her family. How do you explain this to a radiology department, the urgency? So these are the issues. (Clinical Academic Consultant/Trainee Gynaecological Oncologist)

A few nurses, particularly those with organisational responsibilities, referred to the stress that arose through long established patterns where doctors tend to devalue the knowledge of nurses. For nurses with considerable experience in gynaecological cancer care, it was not only galling to be treated as unknowledgeable subordinates by junior doctors, but also threatened the quality of patient care. It was this latter issue that seemed to cause most stress:

Medical staff not listening and taking notes. It seems to be a strange thing that medical staff don’t want to take notes when you’re talking. Maybe it’s because they don’t like taking direction from nursing staff … But, yes, I find working with the medical staff particularly frustrating … With my junior medical staff it’s a love-hate relationship. I have high expectations of them and … they can be quite lacking in their motivation. Some of them see that it’s just a job that they’re doing and gynae oncology is such a subspecialty that they’re not really interested … they have to do this rotation. Then others are really exciting to work with. They use and abuse me quite a bit. (Gynaecological Oncology Nurse Coordinator)

Some workers described the workload as a stressor. This was rarely mentioned by those who worked the longest hours – medical specialists. Instead, it was primarily an issue for those whose hours of work were limited, particularly those working part-time. These workers, nurses and social workers amongst those interviewed for this study, sometimes described working unpaid hours in order to ensure their commitment to their patients was fulfilled. For example, one nurse who worked two days a week with responsibility for gynaecological cancer patients in a private hospital, said:
I even ring from home a lot. I do a lot of stuff out of hours which is starting to drive me nuts, but I do a lot at home, ringing up and just making sure what’s been ordered and what’s been done. So many times you can come in on a shift and what the doctors have ordered quite often has been missed or someone doesn’t know what to do. Yesterday I rang up from home because a patient had a [problem] … She’s in renal failure so I got the medical doctor to review that. I wasn’t going to be at work the following day to follow up - there was going to be different nursing staff - so I rang the next day to make sure the 2 units of blood were ordered, that they had rung the doctor and let her know that the blood has been ordered and not to give the blood until she had come and chatted to the patient. A lot of that does go missed. (Gynaecological Oncology Nurse)

About 12 of the interviewees talked about formal mechanisms for providing workers with support to cope with the stresses of their work, especially those associated with the strain of caring for very ill and dying patients. These mechanisms focused around the availability of counselling, whether it was from psychiatrists, psychologists, social workers, other trained counsellors, or clergy. In most cases interviewees described the lack of such services, or the fact that they had been withdrawn. No interviewees talked about having used them themselves, though many thought they would be (or were) valuable. Medical specialists seemed a little less likely than nurses to see these services as relevant, though one senior gynaecological oncologist commented:

I think we probably need that, to be honest. I think when you’re dealing with patients with severe illnesses all the time, doing it on your own is tough. (Gynaecological Oncologist)

Most interviewees used informal mechanisms of some kind to deal with the stresses of their jobs. Most commonly, they debriefed with co-workers – this was mentioned by 20 interviewees. However, a range of other sources of support and strategies were mentioned. Quite a number used their families or friends for debriefing and support or described their commitment to family life as an essential balance to the stress of their work, some relied on outside interests or holidays, some described simply learning to take short breaks (‘time out’) during their working day, a few mentioned the value of a ‘glass of wine’, and several used exercise to dispel stress.

4.4 Skills

The most fundamental determinant of the outcomes of women diagnosed with gynaecological cancers is the skill that those treating them bring to their care. The future capacity of the workforce to provide high quality care and treatment is therefore intimately tied to their skills and their capacity to use them effectively. This section of the report examines the pathways through which workers acquire skills, whether the current workforce sees skill gaps or new skill needs, and how issues of workers’ work-life balance impact on skill supply. It concludes by considering the overall skill dynamics of this small, specialised workforce.

4.4.1 Skill Acquisition Pathways

There are two primary ways in which skills are acquired: through formal education and through experience. Formal education sometimes involves experiential components, but
these are usually consciously constructed as part of a formal education process and often assessed for that reason too. This pattern is obviously particularly common in the area of medical education. Here, the focus is on the role of formal education and experience that is not part of a formal education program in instilling skills in the gynaecological cancer workforce.

4.4.1.1 Formal Education

As outlined above, the formal training program for gynaecological oncologists consists of a three year hospital based program following certification as a specialist obstetrician gynaecologist. In effect, this means that gynaecological oncologists complete at least 15 years of formal post-school training before being certified in their sub-specialty. This training is undoubtedly demanding, and appears to be viewed as producing highly skilled practitioners – one trainee gynaecological oncologist who had come to Australia from Europe to undertake the program told us that Australia’s system for training these sub-specialists was widely recognised as amongst the best in the world. Several younger gynaecological oncologists did note that the program is costly to trainees, both financially and personally. In financial terms, the long training period results in considerable foregone earnings, especially compared to their colleagues who moved into specialist practice more quickly. The program’s requirement that trainees work in a number of different hospitals (normally three), usually in different cities, is especially expensive and often disruptive for trainees with young families. Indeed, it may be one element in explaining the substantial under-representation of women in the sub-specialty. While a couple of interviewees did suggest that, overall, these demands of the program may be excessive, the much more common view, even the consensual one, was that they were necessary and formed the basis for the very high level of skill of Australian gynaecological oncologists.

Medical and radiation oncologists and pathologists undertake the standard 6 year specialist training following their first medical degree. Many of those interviewed had undertaken some gynaecological cancer work during this period, so had gained important skills in the area through their training. However, work in this area was not a necessary part of their programs, and so there was something of a chance element in their acquisition of relevant skills during their training. Having said this, none seemed to feel that greater focus on gynaecological cancer during their training, or more specialised training in treating these cancers, would have been necessary, or even particularly valuable. When they needed additional knowledge or skill in an area, they either developed through their own research and investigation, or used their professional networks to assist them.

As was noted above, nurses working in various gynaecological cancer care roles rarely have formal education that specialises them in this area. Basic nursing training has minimal content that is specific to gynaecological cancer. Some nurses had, or were undertaking, qualifications in cancer nursing. However, there are no formal qualifications available for nursing in gynaecological cancer. A number of nurses referred to short courses, usually of a day or two, or meetings focused on gynaecological cancer. For example, both the Adelaide based gynaecological cancer nurse coordinators interviewed had links to Sydney based gynaecology oncology nurses who organised some specialist study days and meetings. The nurses found these to be very valuable.
Social workers were in a very similar position to nurses. Their basic training provided no special knowledge or experience in assisting and supporting cancer patients, let alone specialist training in the gynaecological cancer area. Some talked of attempting to develop some specialist skills in the area, though it appears that no Australian social work school has been offering specialist oncology social work courses until very recently. In one site, there was some professional development in oncology social work. While social workers did express interest in having some additional specialist training in this area, it wasn’t altogether clear that this would be of value:

We had an oncology social workers conference and we had a couple of speakers and I didn’t actually gain anything extra. (Social Worker)

4.4.1.2 Experience

Experience in working with women with gynaecological cancers is the main route through which staff other than medical specialists gain specialised skills in the field. Experience in nursing these patients was widely seen as the basis for the specialist skills many interviewees saw as necessary for ward nurses and nurse coordinators. Indeed, the lack of such experience-based skill in some situations was commented on by a number of interviewees. Most frequently this was in relation to ward nurses. If, for example, gynaecological oncology patients were located in wards dominated by other patients, ward nurses were said often to lack the experience and knowledge that was needed to provide these patients with the best care. This happened, for example, when a ward focused on obstetrics and staffed by midwives was also the primary ward for gynaecological cancer patients; or when a ward primarily oriented to reconstructive surgical cases was also the first choice for locating gynaecological cancer patients. At least one gynaecological oncologist commented that he was frequently frustrated with the lack of experience of some theatre nurses with whom he worked. He said that, for whatever reasons, those he trained were quite frequently moved elsewhere forcing him to spend time training new ones.

In some respects skills of this kind are undoubtedly transferable technical skills. Because the workforce is small, and depending on how quickly they are learned, they may be best learned in these more informal, experience based ways. However, some of the ‘skills’ learned by workers other than medical specialists in the gynaecological cancer workforce are more about knowing and understanding intimately the work processes and practices set up by the specialists who direct the services. These skills may be very valuable to the service, but may not be very transferable because they relate to the working relationships and styles of the particular individuals in a unit, or the particular administrative arrangements and configurations in a hospital. Nurses take much of the responsibility for day to day management of patients in relation to larger hospital systems, and their understanding of these is very important to their work. But this kind of skill is most sharply evident amongst workers who have little relevant formal education, such as administrative staff, because it is the main skill they use. For example, the secretary to a gynaecological oncology unit described her job, and was then asked about her skills:

What are your main responsibilities?---I like to think that my main job is making things smoother for the patients and the doctors. I’m a kind of liaison between the two because obviously they’re busy and they’re in theatre and they’re doing
Clinics and all the rest of it so I’m kind of the point of contact, I guess. People can come to me if they need something …

Could you tell me a little bit about what clinical training and education you have?—I haven’t got any clinical training. I’d say just experience. When I first started this job 10 years ago I knew nothing about gynaecology but now I consider that I know quite a bit about it – obviously not in a clinical sense.

Did you have any training or short courses?—No. In my day you just got it on the job. You started work when you were a kid and you just picked up experience on the way. I’ve had short courses in office management and things like that, through the hospital. They send you off every now and again on some course, dealing with difficult customers and stuff, but nothing in a formal manner.

(Gynaecological Oncology Unit Secretary)

The experienced knowledge and skill this secretary has is likely to be very valuable to the unit. Yet it is not formally credentialed or recognised. Nurses and social workers undoubtedly also have components of their skills that are of this kind too. How units are organised, and how they relate to larger institutions such as hospitals within which they are embedded, is likely to have considerable impact on the development and retention of these kinds of skills. For example, in one of our case study sites, although there was a dedicated gynaecological oncology service, there was no hospital ward in which gynaecological cancer patients dominated. In fact, gynaecological cancer patients were quite often simply placed in whatever ward had vacant beds. The result was that there seemed to be little accumulation of specialist experience in the care of these patients by ward nurses, and they were not integrated into the gynaecological oncology team. Even if a ward nurse did develop some expertise in caring for these patients, there were no institutional mechanisms for ensuring that she was recognised for her special skills or even that they were used effectively.

4.4.2 Skill Needs and Gaps

The perceptions of the current workforce about skill needs and skill gaps are an important basis for thinking about the future skill needs of this workforce. While our interviewees did identify some skill needs and gaps, it is important to be clear that they also generally felt well skilled for their work.

In particular, medical specialists universally felt very well skilled for their work, and saw no significant gaps in their knowledge or expertise. Most saw value in communication and counselling skills that could be taught, but they also felt they already had what they needed. However, one did express some interest in undertaking some additional training in this area. In terms of clinical skills, the only specialist to express any desire for further training was a public hospital obstetrician gynaecologist in a remote location. He was interested in some further gynaecological oncology training, but also believed it was probably not very useful in his practice because the work is done by a visiting gynaecological oncologist.

As noted above, a number of nurses expressed interest in undertaking further training in oncology or specifically in gynaecological oncology. They believed that understanding the disease process and the specific types of care issues that arose in treating patients
post-operatively were important to provide the best care. In addition, a number of nurses expressed interest in gaining more skill in counselling. It is clear that gynaecological cancer nurses, especially those in coordinator roles, often find themselves attempting to counsel patients or communicate with them and/or their families in situations that are highly charged emotionally. A common view is that counselling training would assist them. As one put it:

[A] bit more understanding of how to talk to some patients, because we have no understanding of what they’re going through. They’ve just been diagnosed with cancer and we’ve got no understanding of - it would be nice to have a bit more of - I don’t know whether it would be counselling skills. Sometimes they’re talking to you and they’re upset and you don’t know what to say back to them. (Associate Unit Manager, Gynaecology Oncology Ward)

As noted above, a number of interviewees (both medical specialists and nurses) expressed concern about the skills of ward nurses on wards where gynaecological cancer patients were not the dominant patient group. Given the significance of experience in nurses’ development of specialised gynaecological cancer expertise, it is not surprising that nurses in wards where only a few patients have been treated for gynaecological cancer may not develop expertise in the area. Some interviewees thought some quite short professional development training in gynaecological oncology, and the care of gynaecological cancer patients would be useful for these nurses.

Senior medical specialists and some nurse coordinators also expressed some concerns about the skills and commitment of junior medical staff. Residents were said often to lack skills and interest in treating gynaecological cancer patients, since these patients were seen as simply part of a rotation. Similarly, even some registrars were said to have limited skill or interest in these patients. These issues are unlikely to be specific to gynaecological cancer patients, but are more general and a product of the organisation of hospital staffing.

Many interviewees indicated that they believed more psychosocial support was needed for gynaecological cancer patients. While most nurses and doctors believed that they provided some counselling support for patients, they also saw this as something they were not expert in, and that they did not have time to undertake to the best effect. They pointed out that many patients confronted with a potentially fatal disease will benefit from such support, and that gynaecological cancer has special challenges for patients’ sense of self and identity. One gynaecological oncologist put it this way:

*Are there things about the patient’s journey and the experience of the patient which could be improved?*---I’m sure there are. I think we need more psychological support. We need a lot more cognisance of the fact that the patients have not just physical disabilities but are going to have emotional and spiritual problems to deal with and I don’t think that we have enough resources to be able to deal with those properly.

One important possible source of future skill gaps is turnover of staff. If large numbers of skilled staff leave a workforce, new skill shortages can appear. There were no indications in our interviews of likely future dramatic change in turnover patterns. With one exception, all medical specialists expected to continue to work in their field until
retirement. The only exception was an oncologist who thought that he may enter a primarily administrative role in the future. Unless there is a demographic structure amongst gynaecological oncologists that means a large number will retire during a short period (a possibility that is not assessed here), this suggests no future wave of retirements and consequent sudden skill shortage.

Unlike medical specialists, nurses were unlikely to imagine that their whole careers would be spent in gynaecological cancer care. Some thought that they would ‘burn out’ and need to change to a different area at some point. And the work histories of nurses suggested that they may change to work in a different area for various possible reasons, such as family moves or changing domestic care demands. At the same time, a number expressed deep personal commitment to gynaecological cancer care as an area of practice, as was noted above. In short, while nurse turnover is likely to be higher than that of medical specialists, this is a well established pattern and seems unlikely to cause particular skill shortages in the foreseeable future.

4.4.3 Hours of Work, Work/Life Balance and Skill Supply

The availability of the skills held in the gynaecological cancers workforce to treat women with these diseases depends not only what skills workers have, but also on how much time they spend working. Skill supply may be affected by changes in working hours, or threatened by unsustainable hours.

Medical specialists indicate that they work long hours. Aside from one ‘part-time’ specialist (who worked at least 45 hours per week), none worked less than 55 hours per week, and three of the gynaecological oncologists interviewed said that they worked 70 hour weeks. While these hours are long, they are quite common amongst medical specialists. Most of those interviewed indicated that the hours were a major issue for them. They were committed to devoting this time to their work. Nevertheless the younger specialists with young children did indicate varying degrees of concern to limit their hours of work so that they could spend time with their families. It is also worth noting that, in all cases where interviewees supplied this information, medical specialists had partners who did not work for pay, or who worked part-time with much shorter hours. Thus, although these specialists work very long hours, they have been doing this for many years, sometimes for decades, and there is no reason to expect that their ability to work these hours will change suddenly. At the same time, some younger specialists suggested that they were consciously limiting their hours of work for family (or work/life balance) reasons.

Nurses’ patterns of work hours are quite different to those of medical specialists. Nurses generally work on a shift basis. Many work part-time, defined as a certain number of shifts per week or fortnight. The nurses interviewed were all women, and their hours of work were closely related to their family responsibilities. These nurses generally had partners who worked full-time, or were single parents. Part-time nurses had children, and they used part-time work so that they could spend the time they wished with their children. Full-time nurses had no children or adult children. As a result of these patterns, nurses’ weekly hours are highly variable. However, many reported working unpaid hours beyond their rostered shifts. This was sometimes simply to complete work that had not been done during the shift; it also happened when emergencies towards the end of a shift.
Clearly, the ways nurses combine their paid work with their domestic lives and responsibilities has a major influence on the amount of time they make their skills available for caring for patients. Hospitals and other organisations that employ them are undoubtedly well aware of these patterns, and can be expected to increase the flexibility of hours and shifts when it is necessary to secure the staff they need. Nevertheless, this issue is undoubtedly one of ongoing negotiation between employers and nurses.

Social workers showed similar patterns to nurses, in many respects. They quite often felt that some additional training in oncology social work would be beneficial, but did not find this easy to access. Most were women and often worked part-time, in much the same way as nurses. They often had significant domestic responsibilities, and used part-time work to give themselves sufficient time to do spend on their domestic lives.

4.4.4 Highly Specialised Skills

The gynaecological cancers workforce is a small one, irrespective of where its boundaries are drawn. At its centre are gynaecological oncologists, highly trained and highly specialised, amounting to a total of 36 people in Australia. They work with other specialists with similar levels of training - medical and radiation oncologists and pathologists, primarily - for whom the treatment of gynaecological cancer is only a part of their work. Their specialised skills in treating gynaecological cancers come from both formal training and the experience of practice. These medical practitioners are assisted by other professionals (primarily nurses and social workers) who accumulate specialised skills through their work experience, but whose formal training does not produce specialist gynaecological cancer expertise. In some cases these skills relate quite generally to the treatment of women with gynaecological cancer, while in others they are specific to the operation of particular clinics and services.

How care and treatment of patients is organised will have significant effects on the development of skills amongst workers whose formal education and training is quite general. These workers, particularly nurses, are probably too small a group to warrant explicit formal training programs, although some formal short course training is likely to be valuable. Because the organisation of care services is so central to how they develop expertise in gynaecological cancer, it is probably important to view the training functions of these services alongside their patient treatment roles when designing them. Some of the staff who gain gynaecological cancer expertise largely through experience will remain in the gynaecological cancer workforce for a limited time, while for others their experience will lead to a much deeper commitment and identification with the area. The latter’s expertise will become more like the ‘career defining’ expertise of specialists. There are likely to be payoffs in terms of workforce capacity to designing care services to take account of the learning needs of these staff, to most effectively use the skills they develop, and to adequately value and reward them as their skills deepen. It is worth noting that nurses and some other workers (e.g., social workers) who come to define their expertise and identify themselves in the gynaecological cancer area will invest considerable time and effort in developing their skills, but will receive no formal certification for them. Their skills may be very specialised, without a particularly large range of opportunities for being rewarded for them. Hence, it is likely to be important to have adequate arrangements to recognise, value and reward these skills within the services where they are developed and most valuable.
4.5 Working Together: Multidisciplinary Teams

Gynaecological cancer treatment models have used some form of ‘multidisciplinary team’ (MDT) for a considerable time. Indeed, many practitioners believe that gynaecological cancer treatment has been at the leading edge of treatment models in its use of MDTs. In this section the focus is on how interviewees described working together, both using MDT models and in other respects. The demands these models place on workers are examined, as is how the ways they are organised can affect workers.

All the gynaecological cancer services in our study used some form of MDT. In fact, contemporary diagnosis and treatment of gynaecological cancer is unavoidably ‘multidisciplinary’. It may involve any or all of pathology, surgery, chemotherapy and radiotherapy. Services vary not in whether they use all of these ‘disciplines’, but in how they are coordinated with each other and integrated with the input of other support workers such as psychologists, social workers, nutritionists, and physiotherapists. While there were some differences in coordination patterns across sites in this study, all involved some variation of a ‘tumour board’ model in which patient cases were brought to a group of practitioners. At a minimum, these groups discussed the diagnosis and treatment of new cases. These MDTs were focused around large public hospital clinics. Virtually all gynaecological cancer cases were brought to a MDT of this kind, whether they were being treated in the public or private system. Indeed, referral of new cases to an MDT was a very strong norm, if not a requirement of practice, for all the gynaecological oncologists interviewed. The rural services in this research also routinely bring new cases to an MDT in the public hospital where the treating gynaecological oncologist is located.

The MDTs in the case study sites for this research appeared to be designed and organised by the senior consultants who directed the services around which they operated. Differences between the operation of MDTs, and their place in regimes of patient treatment and care, appeared to be largely consequences of variations in how these senior consultants had set up the teams. These variations in turn seemed to reflect the working styles and practices of consultants.

4.5.1 Role in Patient Care

Multidisciplinary meetings are at the centre of how MDTs operate. They occur weekly, and generally consider new patients and existing patients with new problems. A unit manager in a large public hospital described the meeting this way:

Those meetings start either at 7.30 or 8 o’clock every Wednesday morning and go until 9.30 ... we go through all the new cases or all women with problem situations, post-ops and what we find. So they present pathology, they talk about their issues and what’s happening with them, any other radiology imaging. All of that gets presented at that meeting. It’s a cast of thousands; there could be at least 40 people in the room and they’ll be oncologists, radiotherapists, radiologists, the gynae oncs, general gynae, all the support people, data managers and trials. (Gynaecological Oncology Unit Manager)

Meetings revolve around reaching a diagnosis and developing a treatment plan for patients. In some cases agreement on these matters is easily reached, but in others there
may be considerable discussion. Several medical specialists indicated that they felt they needed to be ‘on their toes’ at these meetings since discussion could be robust at times. Unanimous agreement on treatment is not always reached, but practitioners generally follow the majority view even if they are not personally certain it is the best course. However, at least one interviewee indicated that there were occasions when the majority course was not followed if a specialist felt there were strong reasons to follow a different course – it appeared that this was a rare occurrence.

Through the treatment programs for patients agreed at MDT meetings, each professional involved in the treatment plan understands his/her role in the treatment, and what other professionals will do. In this sense, the MDT meetings function to facilitate a more holistic understanding of patient treatment than if a single specialist decided on the treatment plan and then coordinated the treatment himself/herself.

Those attending MDT meetings do appear to vary somewhat from service to service. Specialists involved in the diagnosis and treatment of patients always attend: gynaecological oncologists, medical oncologists, radiation oncologist, and pathologists. If there is a gynaecological oncology nurses coordinator, or a key gynaecological oncology nurse, that person usually attends. However, the extent to which other staff attend seems to vary. In larger public hospitals it seems to be common for psychosocial support staff to attend these meetings, though this is not always a matter of routine. In fact, interviewees clearly indicated that the extent of involvement of staff who were not medical specialists tended to depend on the extent to which the staff were prepared to put their views forward. Some found the meetings intimidating and either did not attend or did not participate. A social worker who had some management responsibility for a social work team, as well as doing most social work in relation to gynaecological cancer patients, indicated that social workers in other cancer areas were reluctant to attend MDT meetings, but that she did go:

It’s [the gynaecological oncology MDT meeting] very medically oriented, so it came in before any of the discussions of multidisciplinary care of cancer, but it’s better than a lot of the others in the hospital, the other tumour screening groups. Social workers don’t go and I can’t get them to go, they say it’s too difficult and they feel uncomfortable.

*What’s different about gynaecological cancer [MDTs]?*—Probably nothing. It’s just that I don’t mind going. It felt uncomfortable at first, sort of talking, but then I just got used to it.

MDT meetings are also used in more informal ways by some nurse coordinators and professionals with psychosocial support roles (notably social workers). These meetings provide easy access to medical specialists to discuss patient issues that may have arisen during the previous week, whether the issues are to do with patients formally listed for consideration or not. Other regular events in the care of in-patients provide similar opportunities. So, for example, the social worker quoted above goes on ward rounds and attends outpatient clinics as a way of finding out about patient needs.

This last pattern of informal interaction also illustrates the variable nature of the involvement of staff other than medical specialists in multidisciplinary teams. For example, in one public hospital, a social worker works almost entirely in the
gynaecological oncology ward, and routinely sees all inpatients, as well as following up with patients when ward nurses suggest this is appropriate. She does not attend MDT meetings. However, in another public hospital, the social worker sees only patients who were perceived to be in particular need of her services. She attends MDT meetings and gets referrals through wards, outpatient clinics, and informal contact with all staff involved in patients’ care.

Existing MDTs operate almost entirely in public hospital environments. They involve the key medical practitioners who provide care through hospitals, either on an inpatient or outpatient basis. They are quite effective, and probably comprehensive, in treating and caring for patients through hospitals. However, as other parts of this report emphasise, they rarely or never involve non-specialist medical staff, such as GPs, general gynaecologists, nurses or psychosocial support workers, when patients are not under hospital-based treatment. These staff undoubtedly do play a role in patient treatment, especially as gynaecological cancer becomes more of a chronic condition. Some coordination with them as part of MDT activities might well assist in the coordination of patient care. As is emphasised below, it might also help in instilling the skills in these non-specialist workers that specialists often note is lacking.

### 4.5.2 Workforce Views about Value / Effectiveness of MDTs

All members of the gynaecological cancers workforce are involved in multidisciplinary care models since, as noted above, treatment models are inherently multidisciplinary. For these workers it is virtually impossible, and also irrelevant, to imagine care models that were not fundamentally multidisciplinary in the sense of involving expertise from different specialties. The main issue considered here, therefore, is workforce views of the effectiveness and value of the mechanisms through which multidisciplinary care is achieved, generally the MDT.

In general, specialists and other staff held positive views about the operation of MDTs. They saw MDTs meetings as the centrepiece of their multidisciplinary practice, and as working effectively. As already implied, the primary value of MDT meetings was seen to lie in their role in ensuring that the treatment courses developed for patients were optimal, and that each key member of the MDT understood his/her role in the patient’s treatment in the context of the whole treatment plan.

With regard to the role of MDT meetings in optimising patient care, specialists often commented on the fact that discussion amongst peers ensured that a better treatment plan was developed than would have been possible if they had done it alone. MDT meetings necessarily produced ideas from the different perspectives of those involved, and this was where their value in developing treatment plans originated. There clearly are robust discussions at some of these meetings about difficult cases, and some specialists suggested that the possibility of being challenged in these discussions ensured that they performed at their best in bringing cases to the meetings and developing care plans. Some specialists also suggested that having colleagues discuss difficult cases gave them greater confidence in treating them, even if the treatment course was rarely different than that they would have developed independently of the MDT meeting.

The second important function of MDT meetings, to coordinate the role of different specialists in patient care, was widely recognised and felt to be important. Non-specialist
staff, such as nurse coordinators and social workers, also said that their role in MDT meetings helped them to play their part, since they understood the overall treatment plans for patients.

Several interviewees also referred to more informal benefits of MDT meetings. The opportunities for informal discussion of patient problems, especially for psychosocial staff to talk to specialists, have already been noted. One gynaecological oncologist also referred to the value of these meetings in providing a forum for some informal ‘venting’ with colleagues about various aspects of the work.

4.5.3 Problems and Difficulties in MDT Operation

Despite the general view that MDTs were operating effectively in the study sites, there were some common themes suggesting some areas of difficulty.

The first was with respect to the physical location of members of the teams and patients in hospitals. In one hospital the outpatient clinics and key administration offices were located separately from hospital wards, with the gynaecological oncology nurse coordinator and social worker each having offices in other parts of the hospital. Radiation oncology and medical oncology specialists were located in other places as well. This diffusion of staff made communication less than optimal on occasions. It required conscious organisation of consultations and meetings, reducing the possibilities of some informal contacts. This was exacerbated by the placing of gynaecological cancer inpatients in a ward where other non-cancer, non-gynaecology conditions prevailed. Another public hospital provided a sharp contrast – it had outpatient services located next to a dedicated gynaecological oncology ward, and also appeared to have the main support staff located in or near the ward. However, a new building was about to change this. The gynaecological oncologist who had set up the previous arrangement was concerned about the effect the new arrangement would have on the team, partly because it would dilute the specialist focus on gynaecological cancer in the ward, and partly because it would remove the experience nurses had of following patients through. He described the advantages of the existing arrangements:

You know, when graduate nurses get a sense of belonging to a team and they come to somewhere where they are valued - these are young kids, most of them, you know they’re 21, 22, 23 they’ve been through university, they don’t have a huge experience at the coal face and suddenly they become a part of a team and they’re looked after and they get educated and the patient care is the priority for the team, then that’s very attractive to young women who often go into nursing with that vocational remit and I think that’s why we’ve always attracted good graduate nurses. ... And that was just fantastic because they were not just seeing women when they were sick, they were seeing women when they were getting better and getting back into the community. That great continuity of care. And our nurses love that. (Gynaecological Oncologist)

Interviews provided a number of other examples of how the physical arrangements through which services were organised had quite significant effects on how smoothly the service operated. The effects range across a number of issues, as the above quote suggests. They certainly include ease and smoothness of communication. However, they also appeared to affect the efficiency and effectiveness of the specialised experience-based
skill development of nursing and psychosocial support staff. Most medical specialists saw this form of skill development as important to quality care. And there were also indications that they affected the morale and sense of collective responsibility and commitment that can have significant effects on team performance.

MDTs generally operate within the environment of large public hospitals, and there did appear to be occasions when the two systems did not operate together very smoothly. One area in which this was notable was in the attendance at MDT meetings and in the sense of membership of MDTs that this tended to produce. For example, there were no cases of ward nurses or junior medical staff (residents and registrars) routinely attending MDT meetings. As noted above, specialists and other dedicated gynaecological oncology staff sometimes criticised the commitment, knowledge and skills of ward nurses and junior medical staff. The roles of these latter staff in the care of patients are largely determined by larger hospital structures and arrangements, rather than any dedicated assignment or commitment to treating gynaecological cancer patients. While it is understandable that they do not attend MDT meetings, it is also possible that their attendance could boost their knowledge, skills and commitment to the patients. They are, in the end, part of the team that treats these patients.

New communication technologies such as videoconferencing do also offer opportunities for some wider constitution of MDTs and MDT meetings. This is already being developed to include specialists in outer urban areas in meetings centred around large public hospitals. There may also be value in developing these models to include rural and remote specialists in MDT meetings.

4.5.4 Workforce Implications of MDTs

The multidisciplinary character of established gynaecological cancer treatment means that most people working in the field today have considerable experience of working in MDTs. For new entrants to the field, MDT work will be context in which they gain their experience-based skill. In these senses, the MDT nature of gynaecological cancer treatment does not appear to require any special training. But it does emphasise that how MDTs are organised plays a key role in their effectiveness as training arrangements. Thinking of them only as modes for delivering treatment, while neglecting their role in developing expertise, is clearly inappropriate.

Certainly, how MDTs operate in gynaecological cancer treatment needs to be seen as having workforce policy implications. Experience is an important source of expertise for staff who do not receive specialised gynaecological cancer training, and the ways that gynaecological cancer MDTs are integrated into wider hospital and health system functioning may have significant effects on the development and use of this expertise. This integration includes both the involvement of categories of staff in MDTs and MDT meetings and the physical arrangement of services.

Involving ward nurses and junior doctors in MDT meetings may help to integrate them into teams more effectively, and thereby to improve the opportunities for them to develop experience-based skills. Certainly the training aspects of MDT arrangements were rarely, if ever, mentioned in the interviews undertaken for this study. This suggests that they could receive more attention in decisions about how MDTs and MDT meetings operate.
The need to locate gynaecological cancer patients in appropriate wards is a theme that runs through this report. It has many implications, and one is in relation to how MDTs function to develop and deploy expertise. In several of the sites studied here, it was clear that the development of nursing expertise was impeded by the inappropriate location of gynaecological cancer patients in wards where patients with other, quite different, conditions were dominant. In these cases, it did appear that ward nursing staff were not really thought of as an integral part of the MDT that delivered care to gynaecological cancer patients. If these nurses were regarded as a more integral part of the MDTs, then there may be greater recognition of the role of their ward work in developing their expertise, and more appropriate arrangements may be viewed as important.

Beyond this, the physical location of staff and components of services also appears to be important in maximising the smooth functioning of all aspects of MDTs. Physically locating services near each other integrates the operation of teams, and is likely to facilitate the development of commitment in the teams and also greater expertise amongst staff whose formal training is more general.

4.6 Rural and Remote Service Provision

The provision of gynaecological oncology services to rural and remote areas raises problems that are undoubtedly common to other areas of specialist health care. However, they are in particularly stark relief in the area of gynaecological cancer because the specialist workforce is very small. As noted above, all practicing gynaecological oncologists in Australia are currently based in metropolitan areas. This seems very unlikely to change in the near future. At the same time, virtually all gynaecological cancer treatment is coordinated by these specialists, with the strong professional view being that this specialisation provides the best outcomes for women. Under these circumstances, rural and remote patients must either travel to metropolitan areas for treatment, or gynaecological oncologists must travel to rural and/or remote areas.

In the two non-metropolitan sites studied for this report both solutions were used: patients travelled to see specialists, and specialists travelled to treat patients. The two sites did differ significantly in their location. One was within 3 or 4 hours drive of a major metropolitan centre, while the other was about 3,000 km from the metropolitan centre that provided specialist gynaecological oncology service. In this section of the review, these services are referred to as being ‘rural’ and ‘remote’ respectively. In both cases, on-site medical oncologists provided chemotherapy once an initial diagnosis had been made and any surgery undertaken. The rural service also offered radiotherapy, but the remote one did not. Cases from both services were usually considered at MDT meetings in the metropolitan centre where the gynaecological oncologist was located.

These service arrangements, with a gynaecological oncologist located in a metropolitan centre taking the lead in developing a treatment plan for patients, necessarily requires considerable coordination between the gynaecological oncologist and the rural or remote treatment centre. This may involve the movement of patients, coordinating short visits by the gynaecological oncologist, communications between local specialists (ranging from gynaecologists to medical and radiation oncologists) and the gynaecological oncologist, and so on. How smoothly this coordination functions has a large effect on the efficiency and harmony of patient treatment. It may also have some impact on clinical outcomes, although this issue is beyond the scope of this report. The two non-metropolitan sites
examined for this report did appear to function differently on these dimensions. Interviews in the rural site suggested that coordination between the visiting gynaecological oncologist and local specialists, and the arrangement of ongoing treatment in the rural location, functioned fairly smoothly. On the other hand, various tensions arose in the provision of gynaecological cancer treatment in the remote site. There are various possible explanations for these differences, and there is no definitive explanation for them in this report. However, it is clear that several factors contribute to them.

First, sheer distance appears to matter. The remote site is 3,000 km from the metropolitan home of the gynaecological oncologist who services it, while the rural site is about 300 km from the relevant metropolitan area. This means that travel for patients, specialists and patients’ families is much simpler in the latter case than in the former. Specialists in the rural area routinely visit the nearby metropolitan area, and their immediate professional community is located there. By contrast, specialists in the remote centre do not find it easier to get to the metropolitan centre where the gynaecological oncologist is located than to other major metropolitan centres, and are therefore not particularly oriented to it. For the gynaecological oncologist visiting the remote location, travelling takes at least half a day each way, meaning that visits are infrequent, intense and last a week or so. Travelling is not nearly so problematic for the specialist who visits the rural location.

The second difference between the rural and remote services is that the remote service is run through the local large public hospital, while the rural one is private. For the remote service, this means that a large public hospital, with its own systems, clinic arrangements, and specialist gynaecology staff and other staff, must coordinate with a visiting specialist whose primary orientation is towards a metropolitan public hospital and clinic and metropolitan private patients. Local hospital staff felt that they have little influence over the practice or timing of the gynaecological oncologist’s visits. This specialist, using best practice from the metropolitan centre, brings patients to the metropolitan MDT meetings. However, the local specialists from the remote location have no involvement in these meetings, and communication appears to be somewhat problematic as a result.

In contrast, in the rural location, coordination of treatment is achieved through standard private professional relationships and arrangements. In this sense, the coordination of care between rural and metropolitan specialists functions as simply an extension of the private practice professional relationships that are normally used in specialists’ local private practices. These relationships are essentially managed through one to one direct contact between specialists. To repeat, these relationships appear to function almost as effectively at a distance as they do when specialists are located in the same city. Further evidence for this effect lies in the fact that the treatment of private patients in the remote location, which was generally undertaken by the same visiting gynaecological oncologist who provided services in the public hospital, seemed to have none of the tensions that existed in the public provision. Again, treatment coordination of private patients was based on a standard model of professional relationships between private practitioners.

Solutions to these issues are unlikely to be simple. Moreover, if the explanations for the difficulties evident in the interviews for this study are correct, the problems are unlikely to be confined to the provision of gynaecological cancer services. They will arise with the provision of any service to a rural or remote location by visiting specialists when the size
of the location does not warrant a permanent specialist. Simply advocating greater use of
direct collegial contact between rural or remote specialists to coordinate care in the public
as well as the private system is unlikely to be effective. Public specialists are necessarily
bound by the systems and modes of management of the public hospital in which they
work, and cannot simply circumvent these. In fact, the difficulties described above
undoubtedly reflect wider tensions in the health care system between the public and the
private provision and coordination of care. Any solutions will need to find ways of
integrating a visiting specialist more effectively into the remote public hospital service.
One possibility could be an arrangement that operates between remote and metropolitan
hospitals, especially if the integration was two-way, so that there was some involvement
of remote specialists in metropolitan activities such as MDT meetings. New
communication technologies may play an important role here.

In some ways, the workforce implications of these patterns may be similar to the ones
already outlined with respect to MDTs. It was suggested above that it may be useful to
regard MDTs as vehicles for enhancing the expertise of staff who are necessarily involved
in gynaecological cancer treatment and care, but for whom this area is not career
defining. Extending this view to include staff involved in gynaecological cancer
diagnosis, treatment and care in rural and remote areas may have benefits. On the one
hand, this involvement may enhance the skills of rural and remote staff for whom
gynaecological cancer care is a small part of their work. On the other hand, it may help
develop the more informal linkages that are important for professional respect and
coordination of patient care and treatment. Thus, it could both develop workforce
capacity in the area, and improve the efficiency and harmony of services to patients.

4.7 Conclusion

The core specialist gynaecological cancer workforce in Australia is a small one, no matter
how its boundaries are defined. It is also highly skilled, with the very small group of
gynaecological oncologists providing specialist treatment that they believe is world class.
Others with whom they work concur in this view of the quality of treatment. MDTs,
operating primarily through meetings at which all relevant medical specialists are
present, are central to the practice of gynaecological cancer treatment. In general,
members of the specialist gynaecological cancer workforce, both those with career
defining expertise and those with expertise that is unlikely to be career defining, believe
they have the skills they need for their work. There is no evidence that there is likely to be
any particular crisis in workforce capacity or skill in this area in the near future.
Although the number of gynaecological oncologists is small, a well respected and
structured training system is in place and produces new practitioners. This report has not
systematically assessed the process through which new trainees enter this system, but
this appears to be little different from other specialties and subspecialties, and therefore
has the advantages and problems associated with that system more generally. Beyond
these highly specialised practitioners, the gynaecological cancer workforce will be
affected by wider patterns of staff availability. For example, while nursing staff with
expertise in this area can quite quickly be recruited from the more general nursing
population and trained to replace existing staff, any significant changes in the availability
of nursing staff will impact on the supply of nurses with special gynaecological cancer
expertise.
Aside from medical specialists, staff who work in gynaecological cancer treatment rarely have specialised training in the area. In fact, no substantial specialist training is available for nurses, let alone for other staff such as social workers, psychologists, dieters or physiotherapists. For these staff, the special expertise they develop in relation to gynaecological cancer care arises through their experience in working in the field. This is also true for some medical specialist staff in rural and remote areas. For many, their expertise will not be career defining, in the sense that they will not necessarily continue to work in the field throughout their careers once they have developed expertise in it. In this respect they are unlike medical specialists, and their expertise may be more easily lost to the system requiring the training of new staff. The research reported here suggests that there may be benefits in more careful consideration of how these staff gain their skills, how the skills are deployed and what affects their retention in the workforce.

In particular, it may be valuable to more explicitly regard MDTs as arrangements for staff training and retention, rather than solely viewing them as mechanisms for providing high quality care to patients. This would imply that certain kinds of arrangements of services, and inclusion of staff in MDT meetings, may be especially important. Thus, for example, locating patients in appropriate wards with sufficient gynaecological cancer cases and focus on developing ward nurse expertise in the area would be considered part of the operation of the MDT. Similarly, inclusion of ward nurses, junior doctors and/or remote specialists in MDT meetings or other MDT activities might be considered. It is beyond the scope of this report to judge whether there might be other difficulties associated with these kinds of arrangements, but it is highly likely that they would serve both to enhance the skills of staff whose careers are not defined by gynaecological cancer care but who are nevertheless integral to it, and to promote retention of these staff.

However, the research reported in this chapter also highlights some of the barriers that might be faced in developing MDTs in the directions just suggested. The gynaecological cancer MDTs studied here operate largely in public hospitals, and in the environment of a well established system of private practice that revolves around collegial relationships between medical practitioners. It appears that the optimal functioning of MDTs is sometimes compromised by the fact that they are laid over other established arrangements and processes in the health care system. For example, some decisions about the physical location of MDT members and the ward location of gynaecological cancer patients appear to be made with limited reference to the operation of the relevant MDT, but in accordance with public hospital management processes. If MDTs are to be developed as models of best practice, and as routes for skill development amongst some staff, it seems likely that it will be necessary to integrate them more effectively with some of these other arrangements in the healthcare system.

The research reported here indicated that existing gynaecological oncology staff see some shortcomings in the availability of training and skilled staff. In particular, nursing staff whose work is primarily concerned with gynaecological cancer were often hungry for some systematic training in cancer disease processes and care, especially if it was oriented primarily to gynaecological cancer. In addition, a number of well-placed interviewees expressed the view that more psychosocial services were needed in gynaecological cancer care. In part, this is a matter of finding the necessary additional resources. But it also involves the problem of locating staff with the necessary skills or, more likely, ensuring that the experience-based accumulation of skill amongst relevant staff occurs as efficiently as possible to supply any rising demand.
A final dimension to the workforce picture is the medical staff who provide treatment and care to gynaecological cancer patients when they leave hospital or end treatment by specialists such as medical and radiation oncologists. The MDTs studied in this report had extremely limited coordination with these staff. It seems likely that some form of integration of them into overall care and treatment plans through MDTs would be valuable, both in terms of enhancing the gynaecological cancer skills and knowledge of these staff, and improving patient experiences.
NILS conducted a review of the state / territory cancer control plans to ascertain the level of action taken towards implementing the plans and to identify any implications for workforce planning. This involved identifying the key components of each plan, and then conducting interviews to explore the action taken to date. An ethics application for this section was approved by the Flinders University Social and Behavioural Sciences Ethics Committee.

Five states – NSW, Victoria, Queensland, SA and WA – had cancer control plans. Tasmania and the ACT had draft plans while the NT had not developed a plan to date. Only those states with plans were assessed for the action taken. However, all plans were reviewed for implications regarding:

- Workforce capacity and workforce planning
- Changes to the preferred models of care (especially the workforce implications)
- Services for women with gynaecological cancer

NILS conducted interviews with at least two key stakeholders in each state that had a plan (plus Tasmania), one of which was a senior clinician in the field of gynaecological oncology, the other a senior health policy bureaucrat or administrator with responsibility for implementing the plans. Throughout this report comments made by these participants are referred to by their state and role, for example WA clinician or WA policy. Details of their organisational affiliation can be found in Appendix B. In addition, NILS invited 30 organisations to participate in consultations for the Review. This resulted in consultations with 13 stakeholders who had an interest in the above aspects of the cancer control plans. These included members / representatives of professional and advocacy organisations and covered a spectrum of disciplines including gynaecological oncologists, gynaecological oncology nurse coordinators, nurses, allied health care providers, GPs and consumers. These participants are referred to by an acronym of the organisation through which they were contacted, or by their initials. Details of these participants are also in Appendix B. As all but one person involved in these broader consultations had little detailed knowledge of the cancer control plans, the interviews canvassed issues relating to workforce planning more generally including the shift in models of care.

This part of the Review is in five sections. Section 5.1 provides a brief overview of the context within which the cancer control plans were developed. Key policy documents are identified and the implications for the development of the plans discussed. It was anticipated that this would provide the basis for NILS to map the cancer control plans against the guiding principles of the Health Workforce Impact Checklist and Guidelines, however this level of detail could not be determined from the cancer control plans or the consultations. In Section 5.3, an outline of the state / territory cancer control plans is provided and the key areas in which action has been
taken are identified. In section 5.4, the enablers and obstacles to the implementation of the plan are identified and discussed.

The analysis of the workforce implications of the state cancer control plans is in Section 5.5. In contrast to the state by state analysis in Section 5.3, the issues affecting workforce planning are addressed thematically across the three selected areas: workforce capacity, changes to the models of care and specific services for women with gynaecological cancer. It is from this section that the preliminary assessment of the differences between the current workforce and the workforce required for full implementation of the plans is developed.

5.1 Development of the Cancer Control Plans

Over the past five years several reports have been released that have influenced the direction of cancer control in Australia. At the federal level, the Australian Health Ministers’ Advisory Committee (AHMAC) was pivotal in developing the strategic frameworks that shaped the priorities and actions of the state cancer control plans. Two of these frameworks are particularly relevant to this review of the gynaecological cancers workforce: the National Health Workforce Strategic Framework & Health Workforce Action Plan (2004) and the National Service Improvement Framework for Cancer (2005) (which was developed in conjunction with the National Chronic Disease strategic Framework, 2005). Not long after the release of these reports the Senate Community Affairs Committee commissioned a report on gynaecological cancers, Breaking the Silence: A National Voice for Gynaecological Cancers, out of which emerged the National Centre for Gynaecological Cancers. Figure 5.1 depicts a flow chart of the development of the state and territory cancer control plans and key elements of the reports released by AHMAC are summarised later in this section. This provides the background material for the analysis of the action taken on the state and territory cancer control plans in section 5.3.
5.1.2 National Service Improvement Framework for Cancer, 2005

The cancer framework is the first of the national service improvement frameworks to be developed. It aims to provide a general overview of what cancer services in Australia should look like, based on optimal pathways of care, but it states that plans
must be developed at the national, state/territory, and local level for practical implementation of the framework. The framework emphasises coordinated, multidisciplinary, and evidence based care spanning the patient journey from prevention and early detection to palliative care. The patient, their carer and their journey through the health care system are emphasised.

Each of the states and territories are required to develop their own cancer service frameworks in line with the national strategy. To date, the five mainland states each have a cancer control plan. Tasmania and the ACT cancer control plans are in draft stage while the NT does not have one. Victoria developed their plan prior to the release of the Framework and has just released their second plan, while NSW is currently implementing its second plan.

Table 5.1: Overview of the State / Territory Cancer Control Plans

<table>
<thead>
<tr>
<th>Details of State/Territory Plan</th>
<th>Date</th>
<th>Action Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW The NSW Cancer Plan (second plan)</td>
<td>2007-2010</td>
<td>Yes</td>
</tr>
<tr>
<td>QLD The Queensland Cancer Control Strategic Directions</td>
<td>2005-2010</td>
<td>Yes</td>
</tr>
<tr>
<td>SA The Statewide Cancer Control Plan</td>
<td>2006-2009</td>
<td>Yes</td>
</tr>
<tr>
<td>WA The WA Health Cancer Services Framework</td>
<td>2005</td>
<td>Yes</td>
</tr>
<tr>
<td>TAS Draft Strategic Framework for Statewide Cancer Services</td>
<td>n/a</td>
<td>Partial</td>
</tr>
<tr>
<td>ACT Draft Cancer Services Plan</td>
<td>2008-2012</td>
<td>n/a</td>
</tr>
<tr>
<td>NT No plan</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

The National Service Improvement Framework has eight priority areas which states are expected to work within:

- Establish integrated and networked cancer services
- Accreditation of cancer services and credentialing of practitioners
- Support Multidisciplinary Care in hospitals and the community
- Monitor all aspects of cancer control
- Develop evidence-based consumer information
- Assist primary health care providers (especially GPs) in cancer care
- Implement culturally appropriate programs (especially for Aboriginal and Torres Strait Islander people)
• Conduct regular reviews, at least every 3 years

The extent to which states have addressed these priorities in their plans is outlined in Table 5.2. The priority areas are highlighted in bold text to differentiate them from the priorities of the National Health Workforce Strategic Framework.

5.1.3 National Health Workforce Strategic Framework, 2004

The National Health Workforce Strategic Framework was published by AHMAC in 2004. The action plan is based on the vision that:

Australia will have a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. It will provide safe, quality, preventative, curative and supportive care, that is population and health consumer focused and capable of meeting the health needs of the Australian community. (Australian Health Minister’s Conference, 2004)

The principles outlined in the National Health Workforce Action Plan are:

• Ensuring and sustaining supply
• Workforce distribution
• Optimal use of skills and workforce adaptability
• Best practice workforce policy and planning
• Health environments being places in which people want to work
• Ensuring the health workforce is always skilled and competent
• Involving stakeholders and working collaboratively

While these principles have had some bearing on the development of the plans (see table 5.2), they have not been implemented as consistently as other elements of the plans. Initially it was anticipated that this Review would incorporate a mapping of the action taken on the plans against the Health Workforce Checklist which was developed as a result of the National Health Workforce Action Plan. This was not possible given the lack of action on workforce issues. Nevertheless, workforce issues relating to the plans are discussed in section 5.5.
### Table 5.2: Mapping Cancer Control Plans Against the Priority Areas of the National Service Improvement Framework for Cancer

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>NSW</th>
<th>QLD</th>
<th>SA</th>
<th>VIC</th>
<th>WA</th>
<th>ACT</th>
<th>TAS</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish integrated and networked cancer services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Involving stakeholders and working collaboratively</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Accreditation for cancer services and credentialing of practitioners</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ensuring the health workforce is always skilled and competent</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Develop funding structures which support multidisciplinary care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Support multidisciplinary care in hospitals and community</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Monitoring all aspects of cancer control</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimal use of skills and workforce adaptability</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best practice workforce policy and planning</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensuring and sustaining supply</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Workforce distribution</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Health environments being places in which people want to work</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Evidence based consumer information</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assist primary health care providers (especially GP’s) to participate in cancer care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Implement culturally appropriate programs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review within a specific timeframe, at least every 3 years</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.2 Summary of the State/Territory Cancer Control Plans

NILS conducted an analysis of the National Chronic Disease Strategy, the National Service Improvement Framework for Cancer, and each of the state/territory cancer frameworks to see how national policy had influenced the cancer control plans. Table 5.2 provides a summary of the principles from the National Service Improvement Framework for Cancer and the National Health Workforce Action Plan covered by the each of the state/territory cancer frameworks. While there was a focus on the health workforce in most of the plans, it was evident from the interviews that action on the plans had been more focused on the service framework, models of care and patient referral pathways.

To summarise the action taken to date, NSW, WA and Victoria are on target to achieve the goals of their plans. Queensland is on target in all areas except their service planning, which includes a building program. The implementation of the SA plan was delayed for 18 months and only began in mid 2007. The Tasmanian and ACT plans are in development and the NT does not have a plan. Common elements across the plans where action has been taken include:

- Developing a service framework for integrated cancer services
- Promoting and supporting a model of care based on multidisciplinary teams
- Establishing tumour collaboratives (or streams) that focus on developing appropriate referral pathways and treatment guidelines
- Finding ways of providing outreach services in rural and regional areas
- Increasing the role of primary health care providers – this has focused primarily on the role of nurse coordinators and GPs

Elements across the plans that have not had action taken, or are not as advanced as interviewees would have liked include:

- Accreditation for cancer services and credentialing of practitioners
- Development of data management systems
- Development of culturally appropriate programs
- Provision of evidence-based consumer information
- Workforce planning

As would be expected, given they have both finished the implementation of their first plans, NSW and Victoria are the most advanced in the action taken to achieve their proposed outcomes. An overview of the state / territory plans and the action taken is provided in Section 5.3.
Interviewees were asked whether there were any specific enablers or obstacles to the implementation of the plans. A summary is provided below, with a more detailed discussion available in Section 5.4.

Factors *enabling* the implementation process include:

- Support from government
- Commitment from clinicians – key people in leadership roles
- Support of powerful organisations
- Clearly structured process

Factors *constraining* the implementation process include:

- Systemic tensions
- Clinician resistance
- Lack of reliable data on patients
- Workforce issues
- Rural extension

In order to more fully understand the workforce implications of implementing the plans, especially in the field of gynaecological cancers, specific questions were asked of the clinicians, senior bureaucrats and representatives from professional and advocacy organisations relating to workforce planning, including:

- Workforce capacity in relation to implementing the cancer control plans
- Changes in the models of care toward multidisciplinary teams
- Services for women with gynaecological cancers

Each of these areas is discussed in Section 5.5.

### 5.3 Overview of Each Cancer Control Plan and Action Taken

#### 5.3.1 New South Wales

The NSW Cancer Plan, published in 2006, covers the period from 2007 to 2010. This is the second cancer plan to be enacted in NSW. The first NSW Cancer Plan covered the period from 2004 to 2006 and focused on reducing smoking rates, improved screening services, providing new staff and technology, and increasing cancer research. The second plan continues the principles of the first plan and concentrates on working collaboratively with the private sector, enhancing multidisciplinary care, and a cancer services accreditation framework. Its priorities are preventing cancer, detecting cancer early, improving cancer services and professional education,
accelerating improvement through research, and recording relevant cancer data and information.

This cancer plan highlights the role of the Cancer Institute of NSW in establishing the workforce enhancement program and the professional development program in response to the 2005 Professional Workforce Review, and acknowledges the need for ongoing monitoring of the cancer workforce. The primary goals for the NSW cancer workforce are the coordination of care, the provision of comprehensive patient support, and the development of specialist cancer practitioners. These goals will be used to develop the Clinical Cancer Workforce Plan (which includes the cancer support services network) with the aim of providing skilled staff to meet current and expected demand through the retention and development of key cancer specialties.

Gynaecological cancer is acknowledged as one of the 12 cancer specific groups under the NSW Oncology Group, the state-wide expert advisory panel. This group is linked with the Greater Metropolitan Clinical Taskforce. The main task of the group is to provide treatment guidelines, patient management frameworks and data for the Clinical Cancer Registry.

**ACTION:**

- Met the milestones in each of the five areas; have an evaluation framework
- Funded 50 cancer nurse coordinators and 28 clinical trials nurses
- CI-SCaT (Cancer Institute: Standard Cancer Treatment ) has over 400 treatment guidelines on the website
- Funding for multidisciplinary team development projects provides administrative and information technology support. There are 158 MDTs.
- Directory of cancer services funding developed
- Funding and recruitment for lead clinicians in each area health service. Lead clinicians take responsibility for implementing area wide projects, some of these are tumour specific although in some area health services funding has been made available for tumour group leaders
- Established tumour specific groups in each of the tumour groups and then specific groups in discipline areas such as radiotherapy, palliative care, pathology.
- Gynaecological Cancers: Plan being implemented well – made improvements in MDTs, improved access to operating time and to medical and radiation oncology; taken initiatives in providing psychosocial care; appointed a lead clinician

### 5.3.2 Queensland

Published in 2006, the Queensland Cancer Control Strategic Directions 2005-2010 has three strategic priorities: the workforce, health promotion, and providing
collaborative, multidisciplinary care. It highlights the need to provide evidence based prevention, screening, early detection and treatment, to meet future demands, and patient and carer support needs. Primary considerations of this framework are the aging and increasing population of the state, new technology and drugs, and the shortage of skilled professionals. This framework is informed by the Smart State: Health 2020 Directions Statement published in 2002 and the Queensland Health Strategic Plan 2004-10, as well as the National Service Improvement Framework for Cancer.

The Queensland cancer services framework has a strong emphasis on workforce issues, with a series of priorities aiming to align the cancer workforce with projected service and patient needs. These priorities are strengthening relationships with national and other state governments, teaching institutes and professional associations to address workforce development and management issues, developing a training plan, developing administration models to support networked and innovative service delivery, and configuring the workforce to support clinical practice standards and methods and to support the research, development and teaching roles of the workforce.

No priority for gynaecological cancer services is evident within the Queensland cancer services framework, however this plan was developed prior to the establishment of the National Centre for Gynaecological Cancer and the coinciding push for services aimed at controlling this group of tumours.

**ACTION**

- Service planning finalised early 2008, currently part way through approval process. Have decentralised and there are three area health services. Issue is now the funding of statewide services (eg gynaecological cancer)

- Thirty-two Clinical Networks have been established across a range of disciplines (not all cancer) to improve the quality of patient pathways. Each area health service has a clinical network in cancer – this drives the statewide program of care coordination

- Multidisciplinary care being promoted. Some investment at area health level and through the clinical networks at major tertiary hospitals. The gynaecological oncology multidisciplinary team at Mater and Royal employ an admin assistant to help with the functioning of the team.

- Projections on some areas of workforce supply and demand have been undertaken. Currently vacancies in clinical haematology, radiation oncology, medical oncology. No vacancies in gynaecological oncology, although according to AMWAC modelling there should be 10 gynaecological oncologists - there are currently 6 with another trainee to be employed in 2009. Seven is seen as optimal by clinicians in this state.

- Queensland’s gynaecological cancer services are well coordinated and integrated across the public and private sectors, throughout all of the hospitals; they are gradually addressing workforce issues; have an excellent
network with other clinicians and provide outreach services to Townsville and the Gold Coast.

### 5.3.3 South Australia

In South Australia, the Statewide Cancer Control Plan 2006-2009 focuses on cancer prevention, diagnosis, treatment, supportive care, workforce and infrastructure, and research. The aging population within South Australia is one of the key considerations of the cancer plan. This plan is informed by the National Service Improvement Framework for Cancer, a report on Specialist Medical Workforce Planning in Australia: A Guide to the Planning Process Used by the Australian Medical Workforce Advisory Committee published in 2003 by the Australian Medical Workforce Advisory Committee, and the Cancer Prevention Policy 2004 – 2006 produced by the Cancer Council Australia in 2004.

A primary focus in the SA cancer services framework is the workforce. Whilst it is suggested that the cancer services workforce should be addressed in the context of the broader SA health workforce, the following principles were highlighted in regards to the cancer workforce: that the cancer services workforce is adequate across the entire cancer services system; educational, learning and recruitment is matched to the future needs of the workforce; workers participate in accredited and continuing education; and the curriculum of tertiary courses provides optimal cancer education.

The only specific reference to gynaecological cancer in the SA cancer services framework is the suggestion that gynaecological oncology may be one cancer service that should be considered a specialised service. Because of the size of the population in the state, the need for rationalisation of services, and the highly specialised expertise and facilities required for the treatment of this type of tumour, gynaecological oncology is considered a good example of the type of service that should only be provided at a single, central site within the state.

**ACTION:**

- Implementation delayed until the release of the SA Health Care Plan in 2007. This has then been superimposed over the Cancer Control Plan
- Clinical network in Cancer established July 2007 to implement the Cancer Control Plan. Consists of 6 working subcommittees each focussed on a different strategic area (one subcommittee specifically focused on workforce).
- Identified three cancer related pathways (gastrointestinal, lymphomas and adolescent young adult) and looking at progressing the plan around these three areas as a ‘template’ for other cancer pathways. Gynaecological cancer pathways scheduled to be looked at in 2009 (SA Bureaucrat)
- Focus on multidisciplinary teams. Currently inconsistent practice. Have set up a pilot program at Flinders Medical Centre and Mt Gambier.
- Workforce committee has done a survey on the cancer workforce in SA
• Rural issues: not cost effective to provide all services in the country. Radiotherapy has to be done in Adelaide

• Gynaecological Cancer: in the public sector, gynaecological oncology still spread over 3 sites (plan suggests having a specialised service at the RAH); integration between these sites could be better. Concentration of services would result in better access to expertise as well as the allied health and multidisciplinary care (pre-operative and post-operative); also make data collection easier. “patients really well looked after ... matter of fine-tuning and maximum utilisation of resources rather than any glaring deficiencies” (SA Clinician)

5.3.4 Victoria

A Cancer Services Framework for Victoria was developed in 2003, emphasising the need for multidisciplinary care, access to care and, safety and quality of care. The framework proposes the generation of tumour streams which involve the development of tumour specific evidence-based standards of care and role designated services, as well as the progression towards an integrated cancer services system. One of the primary areas of interest for the Victorian cancer services framework is the role of the Peter MacCallum Cancer Institute in providing cancer care for the state. This cancer services framework was published prior to the development of the National Service Improvement Framework for Cancer. It draws on the British cancer services framework, being primarily informed by the NHS Cancer Plan published in 2000. This Framework has now been replaced by the Cancer Control Plan 2009-2012. The new plan has a focus on multidisciplinary care in rural areas, psychosocial support, workforce issues and enhanced data collection.

The main focus of the Victorian cancer services framework in regards to the workforce is the adequacy of the supply of skilled workers across the spectrum of cancer services. The radiotherapy, palliative care, surgical, radiation and medical oncology workforces were reviewed as part of service planning. Deficiencies in supply of radiotherapists and medical oncologists in rural and regional Victoria, and in the palliative care, psychosocial support and rehabilitation workforce were highlighted.

The Victorian cancer services framework has the largest section devoted specifically to gynaecological cancer, with a review of the patterns of care for patients with ovarian cancer that demonstrate that care for gynaecological cancers within Victoria is not always provided by the most appropriate specialist. General gynaecologists and general surgeons rather than gynaecological oncologists provide a substantial portion of the gynaecological oncology surgery within the state. Gynaecological cancers were also discussed in terms of new technology and the need for development of the capacity for specialisation of gynaecological cancers. The following benchmarks were outlined by the Australian Society of Gynaecological Oncologists and the Gynaecological Oncology Committee of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in the Victorian framework: the percentage of women with ovarian cancer managed by, or in conjunction with, comprehensive gynaecological oncology units; the time from treatment decision to commencement of radiotherapy for initial management of
gynaecological cancer; and the number of women with gynaecological cancer who are given the opportunity to participate in clinical trials.

**ACTION**

- The integrated service system has been implemented for both metropolitan and regional areas
- The ten tumour streams have been developed, with gynaecological cancers being one of them
- Patient management frameworks have been developed, including for ovarian cancer
- Consumer support and information centre, BreaCan, initiated in 2003, included gynaecological cancers in 2007
- Role designation, accreditation and credentialing of cancer services were not implemented as per the original plan. Instead they ‘have taken a bottom up approach. Try to bring services closer to the patient insofar as that is possible – have not gone ahead with the designation of specific levels and accreditation as originally suggested in the Cancer Framework’ (VIC Clinician).
- Action on the Peter MacCallum Cancer Institute was not mentioned, except to say that it provides specialised services

**5.3.5 Western Australia**

The WA Health Cancer Services Framework, created in 2005, highlights the need for clinical networks to promote multidisciplinary care, the development of patient pathways and guidelines for evidence-based care. One of the key considerations for the WA cancer Framework is the need for palliative care and haematology services to supplement the cancer clinical networks. This cancer services framework is primarily informed by the National Service Improvement Framework for Cancer.

This cancer services framework highlights the need for workforce planning, concentration of the workforce at fewer sites, guidelines and standards, flexibility, multidisciplinary teams, and accreditation. It identifies the following strategies: identifying gaps in the current workforce and including the workforce plan in the cancer services plan; developing a structure for workforce planning and career pathways (including training); a review of access to support services; accreditation of the workforce; a review of multidisciplinary workforce; and identifying issues that arise when developing the rural workforce plan.

The WA cancer services framework proposes the development of tumour collaboratives, groups of representatives from each party within the multidisciplinary team. Gynaecological cancer is one of the initial twelve tumour collaboratives included in the cancer framework. The purpose of this group will be to define standards of care and treatment guidelines, to improve survival and other defined outcomes, and to become a resource for the care of gynaecological cancer.
from diagnosis, through treatment, to follow-up. Structurally, gynaecological cancer services in WA will also change, according to the current cancer services framework. At the time of the publication of the framework, gynaecological cancer care was located outside of the tertiary cancer centre.

**ACTION:**

- 18 Cancer nurse coordinators have been appointed (not enough to cover need). One nurse coordinator for each major tumour group (located in metro area); and generic nurse coordinators in rural areas. Level 2 clinical nurses provide support to the nurse coordinators.

- Architects appointed for two new comprehensive cancer centres

- CanNET projects at Albany and Bunbury (secondary level services); outreach services at Kalgoorlie

- Multidisciplinary meetings being held via video-conferencing in (some) rural areas. Has worked well for follow up clinics for radiotherapy

- Tumour collaboratives for all site-specific tumours have been established

- Overarching Model of Care developed and approved (18/3/2008), specific models for each tumour collaborative now being developed

- Psycho-oncology service has been established with four psychologists

- Directory of cancer services completed and about to be put on the web

- Funding has been allocated to Health Research and Education, but first lot of bids only just completed; Health Research and Evaluation Unit established between 5 universities

- Unified Hospital Record Data still in development

- Gynaecological Cancer: Clinical network has been established; tumour collaborative officer has been appointed; multidisciplinary tumour board meets weekly (has secretarial support) – reviews all gynaecological cancer patients, initiated through pathology; weekly meetings of gynaecological cancer multidisciplinary teams at which all inpatients and outpatients are reviewed; integration between private and public sector

The ACT, Tasmania and NT did not have Cancer Control Plans from which to ascertain the level of action. Instead we have outlined some of the relevant components of their draft plans (ACT, TAS) or their general health policy (NT). However, for Tasmania, a clinician and policy maker with an interest in the Cancer Control Plan were contacted, and the level of action on the development of the plan was discussed.
5.3.6 Tasmania (Draft)

Tasmania does not yet have a specific cancer services framework however a draft Strategic Framework for State-wide Cancer Services is currently being developed. Tasmania’s Health Plan, published in 2007, focuses on workforce shortages, changing technology, and the rising cost of healthcare. Key considerations are the size and location of the state, and its more rapidly aging population in comparison with the rest of Australia.

One aspect of the Health Plan with specific ramifications for cancer services is the proposed development of twelve clinical networks, one of which will be a cancer network. These networks will enable better information exchange, development of referral protocols and procedures, establishment of clinical guidelines, coordination of scarce resources, evaluation of performance, professional development, support and leadership and service development. However, no specific plans are outlined for particular tumour groups, including gynaecological cancer.

The plans for the workforce outlined in this document focus on attracting and retaining a skilled workforce, the fact that the health workforce in Tasmania is ageing and ill-distributed, and promoting an environment where workers can practice their skills efficiently and effectively to make the Tasmanian health system an attractive place to work. The primary objective for the workforce is to meet the population-based benchmarks for the number of specialists required by the state, as described by the Australian Medical Workforce Advisory Committee.

ACTION:

Although the Tasmanian plan is in development stages we did contact a clinician and the Chief Medical Officer of the Department of Health and Human Services to assess progress on the development of their Plan. A Cancer Clinical Network has been established in the last six months which has responsibility for developing a strategic framework and plan for cancer services in Tasmania. While meetings with clinicians have taken place, there appear to be difficulties in finding common ground: the Network wants to look at the big picture, the clinicians at the ‘nuts and bolts’ end of service delivery (TAS Clinician). For example, in the consultation with the sole gynaecological oncologist in Tasmania, she stated that she was more concerned about ‘fighting to have a gynaecological ward where I can deliver cancer care in a female only setting’ than developing an overall service framework for cancer services.

There are a number of issues that are affecting progress on the Plan’s development:

- Strongly divided community between north and south Tasmania
- Change will be difficult unless workforce shortages, maldistribution and lack of workforce depth and breadth are addressed. Tasmania has particular issues in the recruitment, training and retention of the health workforce.
- The small community of clinicians and health professionals makes the development of multidisciplinary teams difficult, especially as some clinicians would need to be in several MDTs. In addition, there is the problem of
finding time to attend to functions beyond the clinic - eg administration, teaching and broader strategic roles.

5.3.7 Australian Capital Territory (Draft)

At present, the ACT cancer services framework is still in its draft stages. The Draft Cancer Services Plan 2008-2012, which was developed in 2007, proposes a multidisciplinary and integrated model of care that recognises the central role of GP’s in cancer service provision. Other key priorities of this plan are IT and information management, cancer prevention and screening, research and teaching, the development of a comprehensive cancer care centre, and making the ACT health system an attractive workplace for the scarce skilled workforce. The key consideration of this plan is the need to connect with the New South Wales cancer services plan, given that, geographically, the ACT is entirely contained within the borders of NSW. The ACT cancer services framework is informed by the frameworks for other health services in the ACT, the ACT Health Workforce Framework, the NSW cancer services plan, and the National Service Improvement Framework for Cancer. No specific mention is made of the National Health Workforce Strategic Framework. However it is likely that the ACT Health Workforce Framework is informed by this publication, thus indirectly informing the ACT cancer services framework.

The draft cancer services plan acknowledges that cancer services planning will need to consider the ACT Health Workforce plan and its primary principles of workforce redesign and inter-professional learning. The cancer framework emphasises the need to consider both the workforce for cancer support services (i.e. pharmacy, pathology, allied health, psychosocial and general practitioner workforce) and the cancer service workforce. Priority areas are the subspecialisation of oncologists and the development of skills in GP’s through rotation of GP’s through the Capital Region Cancer Service, and the development of information resources and clinical pathways.

In terms of gynaecological cancer, the ACT cancer services framework proposes that a cancer site-specific clinical group should be established for gynaecological cancers, as well as for melanoma/sarcoma and genitourinary cancers. Clinical groups have already been established in the ACT for head and neck cancers, lung cancers and mesothelioma, colorectal cancer and malignant haematology.

5.3.8 Northern Territory (No plan)

The Northern Territory does not currently have a cancer services framework. Building Healthier Communities: A Framework for Health and Community Services 2004-2009 focuses on ensuring that health and community services are accessible and accountable, that the skills of the workforce are used optimally, promoting recruitment and retention of staff, to make the territory a healthier place. Key considerations are the distance and lack of infrastructure for people in regional areas, and the health of Aboriginal people in the territory.

There is no specific focus on gynaecological cancer, nor even a broader focus on cancer within the current NT health plan.
In terms of the workforce, this health plan proposes to increase training, to implement strategies to recruit and retain staff, to develop systematic workforce planning, to encourage a safe working environment, and to encourage employment of people from groups disadvantaged in the workplace with an emphasis on employing Aboriginal staff.

At present clinical specialists from both South Australia and Queensland visit the Northern Territory to provide a range of gynaecological oncology services.

5.4 Implementing the Plans: Enablers and Obstacles

5.4.1 Enablers

Interviewees identified several enablers for the implementation of the cancer control plans. While government funding and support was viewed as critical, plans also needed engagement by key stakeholders at a number of levels to act as agents of change.

5.4.1.1 Support from Government

All states recognised the value of having ongoing government financial commitment to fund the implementation process and provide project based funding to fast-track components of the plan. Project funding was used to appoint ‘lead’ clinicians, fund care coordinators and provide resources for research and evaluation. Funding for these projects also came through CanNET.

The government made a significant commitment ... $150 million over four years ... and that's looking at a range of areas (VIC Policy)

The biggest enabler has been the election commitment - $106 million over 4 years. ... you can’t get a better enabler than the dollars to do it. (WA Policy (b))

Appreciation was also expressed of the ways in which some Ministers of Health had been strong advocates of the plan within the health bureaucracy and within the parliamentary context.

The biggest one single person is our Minister of Health ... his support of cancer, publicly and privately. It makes a huge difference. (WA Policy (b))

In two of the states (SA and QLD) initiatives in the cancer control plan were advanced because they intersected with other government action in health reform.

The new SA health plan ... sets out ... a framework for thinking about how we best progress cancer control initiatives across the state. (SA Policy (a))

5.4.1.2 Commitment from Clinicians

All states highlighted the important role that clinicians played in the implementation process. There were several ways in which clinicians were brought on board. For NSW and Victoria, interviewees said that clinicians had been consulted with
extensively at various stages in the process which resulted in ongoing clinician buy in. Generally, however, clinician involvement was limited to a few very dedicated individuals, leading to some concern that excellence was achieved through individuals, and not being built into the system (WA Clinician).

Mostly, clinician engagement occurred through their involvement in tumour collaboratives or clinical networks (VIC, QLD, NSW, WA) which often had as one of its tasks to ‘bring clinicians on board’ (VIC Policy). Some states also appointed staff such as ‘lead clinicians’ (NSW, SA) or cancer nurse coordinators (WA, NSW) to ‘take on and champion the aims and goals of the cancer plan’ (NSW Clinician (b)). The appointment of clinicians / nurses to these positions required project funding. As one lead clinician in gynaecological oncology in NSW stated, this ‘allowed him to take time away from clinical work to do some of this strategic organisational development’.

5.4.1.3 Support of Powerful Organisations

Four states mentioned having powerful and well resourced organisations as key change agents. The Cancer Council was named by WA and SA as being pivotal in developing the cancer control plans, ‘keeping cancer on the agenda’ (WA Policy (a)) and having a strong advocacy role. The NSW Cancer Institute and Victorian Ministerial Task Force on Cancer took more strategic roles in implementing the plans. The Task Force, for example, ‘had carriage of the Cancer Plan and was able to make it happen’ (VIC Clinician).

5.4.1.4 Clearly Structured Process

Besides the funding commitment to the plans, one of the factors that had set these Cancer Control Plans apart from previous attempts was that the process was strategically structured so that parts of the plans could be simultaneously implemented. The structure differed between states according to their size and their particular approach and priorities.

- NSW has five divisions each responsible for delivering one part (priority area) of the cancer plan.
- Victoria uses its Integrated Cancer Services and its tumour streams to drive improvements in cancer care
- SA implements its plan through the Clinical Network in Cancer which has 6 subcommittees, each focused on a different strategic area within the plan.
- QLD implements its plan through the three area health services, each of which has a clinical network in cancer.
- WA uses its clinical networks and tumour collaboratives to implements relevant aspects of the plan
5.4.2 Obstacles

5.4.2.1 Systemic Tensions

Other than Victoria, states identified systemic issues that had contributed to disruptions in the implementation process. In particular there were tensions between the Cancer Control Plans and other service frameworks:

- NSW: tension in developing an enhancement program on top of existing services and structures
- SA: tension in superimposing the clinical network (part of the health reform plan) over the proposed integrated cancer service in the Cancer Control Plan
- WA: tension in the simultaneous implementation of the Cancer Control Plan with a ‘whole of health’ reform. Particularly problematic for the level of clinician buy-in.

For Queensland the systemic tension was different in that the state had reached the threshold of its physical capacity with existing hospitals having ‘limited scope on their current footprint to expand’ (QLD Policy). Plans for two new hospitals and a rebuild of the QLD Children’s Hospital were underway.

The interviews with organisations reinforced the above findings. In addition they identified the need for Cancer Control Plans to address how the integration of private and public services might be achieved. The Plans currently focus on changes in the public sector, however interviewees discussed the need for an integrated service framework and a review of the funding structure – which was seen as ‘rewarding perpetuation of old practices’ (NSW Policy (b)).

5.4.2.2 Clinician Resistance

While the commitment of clinicians in key roles had been an enabler for the implementation of the plans, it was evident that all states had problems with getting and maintaining broader clinician engagement in the implementation process. Several issues were identified:

- High workloads and long work hours meant that it was difficult for clinicians to make time, even if they had the enthusiasm.
- Clinicians were too comfortable with existing practices and unable to see the benefits that change would have for them.
- Some elements of protecting professional autonomy and territoriality were evident.
- There was a level of scepticism borne out of a history of similar previous plans and reports that had not been implemented or resourced.
- Difficulties for clinicians and health professionals in rural and regional areas to be part of the process.
In SA there was recognition that the 12-18 month time-lag between the release of the Cancer Control Plan and the implementation process had led to a level of disengagement and a sense that the process had been futile.

5.4.2.3 Lack of Data

Two states (VIC and WA) identified the lack of data as a barrier to implementation. While most states were developing a system that could record patient data, the process was not always moving as quickly as needed to provide the information required for planning decisions. From the interviews with organisations, concern was also expressed that the data systems needed to be national so that they could track patients across state boundaries as well as between services within the one state.

5.4.2.4 Workforce Issues

Workforce shortages and the perceived lack of depth in the current workforce profile were identified as key obstacles to the implementation process. All states mentioned problems in workforce planning and sustainability and a full discussion of these issues is in the following section.

5.4.2.5 Rural Extension

Queensland, Victoria and WA identified issues in the provision of rural services which were viewed as being ad-hoc and unsatisfactory. All state Cancer Control Plans addressed the issue of rural services, but in these three states the feeling was that the Plans were not having as much impact in rural/regional areas as they were in the cities. SA was also concerned about their capacity to implement the Plan in rural areas. Concerns were expressed about:

- Lack of capacity to provide outreach services (QLD, and WA)
- Limited engagement in the implementation process by clinicians in rural / regional areas (VIC)

The difficulty of providing services in rural / regional areas was mentioned in several interviews with organisations and their comments covered issues regarding the workforce, working in multidisciplinary teams and in delivering specific services for women with gynaecological cancers. These are discussed throughout the next section of the report.

5.5 Issues Affecting Workforce Planning

From the previous overview of the state cancer control plans and the action taken in implementing these plans, it is evident that getting the workforce ‘right’ is important. In many ways workforce issues have affected the implementation of the plans just as much as the implementation of the plans will affect the workforce. As suggested above, it is difficult for clinicians to engage in a change process if they cannot get the ‘breathing space’ from their heavy workloads and time commitments. There is, however, an element of Catch 22 here. The plans are supposed to bring in greater
efficiencies for the designated cancer workforce, but there needs to be greater efficiencies in order for the plans to be implemented!

Despite this issue, the plans are moving ahead. This section examines the cancer control plans in relation to workforce planning. In addition to the clinicians and senior policy officers interviewed regarding action on the plans, this section also incorporates the views of members and/or representatives of professional and advocacy organisations that agreed to participate. Of the 27 people consulted for this component of the Review, eight were gynaecological oncologists and two were gynaecological oncology nurse coordinators (regional level). This provided a solid basis for canvassing their views on the specific implications of the plans for the gynaecological oncology workforce.

The consultations specifically canvassed views on the workforce across three areas:

- Issues relating to workforce capacity
- Changes in models care toward multidisciplinary teams
- Implications of the plans for services for women with gynaecological cancers

5.5.1 Workforce Capacity

Workforce capacity – the numbers of workers, their qualifications and specialisations, their physical location, and their roles – is an important element in implementing the cancer control plans. It requires a certain amount of capacity for change to occur, new innovations to be developed, and goals to be achieved. Without the required capacity, the implementation of the cancer control plans can lack consistency, depth and breadth. As one interviewee succinctly put it: ‘we do not have the workforce to provide the best care for everybody; we are saying what we should be doing, but we can’t because of the shortages’ (SA Policy (b)). This section reports on issues regarding workforce capacities that were raised during consultations with key stakeholders.

5.5.1.1 Skill Shortages

It was evident from the interviews that there was a general perception of a skills shortage and that the cancer workforce was ‘depleted’. Three states (WA, VIC and SA) had undertaken reviews of their cancer workforce, but these were either outdated (VIC) or only just finished (SA) and they tended to cover only certain sections of the workforce. Mostly, information about workforce shortages primarily came from experience in service provision, although there were a few references to population-based modelling which allocates a certain number of service providers per 100,000 people. Ascertaining reliable numbers regarding shortages from the consultations was therefore not possible. Nevertheless, the issues raised during the consultations provided insight into the complexity of workforce planning.

All states and many of the organisations mentioned difficulties with the recruitment and retention of the cancer workforce. Some states discussed particular problems:

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9 A list of their organisational affiliation and acronyms is in appendix B.
• SA could not attract people from interstate because of lower wages (SA Policy (b))

• WA found it difficult to compete with the salaries and conditions offered in the mining industry: ‘staff can earn more driving trucks’ (WA Policy (b))

• QLD had difficulties recruiting from overseas. The process was lengthy and people often returned home after getting their qualifications here (QLD Clinician)

• Victoria found that even when people did move into the cancer care sector, it was difficult to retain them

The lack of adequate staffing levels had an impact, not only on service delivery, but also on the capacity for current staff to ‘get the breathing space to do things such as training and implementing new models of care’ (WA Policy (b)). It also presented a problem for services in rural areas (discussed further below) such as the provision of outreach programs.

Getting the numbers right was therefore important for the effectiveness of the cancer control plans: without the staff, the plans could not be fully implemented. Too few people and there would be no capacity for skill development or service improvement (eg undertaking research for protocol development); too many people and there would be the risk of encroaching on other clinicians and deskilling (QLD Clinician). However, there was also recognition that workforce capacity was not just about the numbers, it was also about working ‘smarter’.

Several people had ideas about how the workforce could be more efficient. Two of these ideas were mentioned more than once. Firstly, there was a perception that the shift toward new models of care would produce workforce efficiencies: ‘if we look at modified or different models of care then perhaps we don’t need as many more as we think we do’ (NSW Policy (b)). Further discussion on the workforce implications for adopting models of care based on multidisciplinary teams and patient management frameworks are presented later in this chapter. Secondly, the idea of ‘skills escalating’ was discussed in three consultations. Skills escalating relies on knowing what can and cannot be achieved with a health professional’s level of qualification or training and then ensuring that they work at the upper end of their skills, doing the work that only they can do (NSW Policy (b)). For example, nurse practitioners could do follow ups for benign breast cancers; psychiatrists only see people with clinical problems with other mental health issues being referred to psychologists or social workers. Ensuring that skills escalating occurred would require high levels of competency in needs assessment (clinical and psycho-social), as well as rigorous treatment guidelines and patient management frameworks.

5.5.1.2 Rural Services

All states and the majority of organisations felt that general skill shortages in the cancer workforce were exacerbated in rural areas. As mentioned above, shortages in the city meant that outreach services were under-staffed. This was not restricted to the provision of fly-in, fly-out services to remote regions, but also to regional centres such as the Gold Coast (QLD Clinician and Policy). There was awareness that unless
there was a critical mass of staff in regional areas with some regard to the number and mix of staff, then workloads would be high and work conditions less than optimal (QLD Clinician and Policy). Certainly these were issues that the Tasmanian gynaecological oncologist was facing in her battle to provide services as the state’s sole practitioner (TAS Clinician).

Estimating the extent of workforce shortages in rural areas requires some agreement on the kinds and levels of services that can be delivered outside of the metropolitan area. This was still being debated, particularly for the workforce that had designated roles in cancer treatment. While most states agreed that surgical services needed to be relatively centralised, there was less agreement on the extent to which local chemotherapy and radiotherapy services could be made available.

In contrast, there was more agreement on the need to improve the uptake of cancer services as a sub-specialty in rural areas as a means of up-skilling generalists and attracting people to cancer care. Several ideas were put forward, some of which were being implemented, including:

- Rethinking the training model so that training positions incorporate experience in regional centres and allow people to move more easily between different sites, like the radiation therapists
- Training of hospital medical officers (usually more junior) by visiting specialists, so that they can provide consistent care at the local level.
- Providing extensive support for Allied Health workers in rural/regional areas to attend workshops, conferences and training
- Developing training materials (eg DVDs) to provide workers in regional areas with access to information
- Building up the capacity of the workforce to participate in cancer research

5.5.1.3 Private Versus Public Services

Although the cancer control plans primarily address the public sector there was concern that there were inequities between the two sectors that had workforce implications. While interviewees in NSW and WA indicated that there was good integration between private and public sectors in the gynaecological cancers area, it was evident that the differences between private and public sectors were a concern.

Distinct differences in the workforce capacity between private and public sectors were identified whereby the private sector was regarded as being more efficient. For example, in Queensland private pathology services were reported to be excellent while the public services are described as under-resourced and slow (QLD Clinician). Two interviewees suggested that clinicians who practice in both the private and public sectors allocate their time per patient differently. In the private system, clinicians tend to see a large number of patients while in the public system they would spend more time per patient. Either way there are workload implications. The clinicians who mentioned this as an issue suggested that the fee for service model is not the best way to provide optimum care or deal with workforce shortages.
However, we note that there may be differences in the spectrum of disease and levels of patient need in the public and private settings.

5.5.1.4 Impact on Specific Disciplines

Throughout the consultations, people mentioned issues within specific disciplines relating to the gynaecological cancer workforce. The discussion about the workforce capacity of specific disciplines traversed a number of areas:

- Gaps in the workforce
- Recruitment and retention issues, including succession issues
- Education, training and skills development
- Role expansion

**Gynaecological Oncologists**

- There was a need to recruit more gynaecological oncologists in QLD (2 more) and WA (1 more), with Tasmania requiring a strategy to relieve pressure on their existing gynaecological oncologist (sole practitioner). Succession issues were raised by SA and NSW.

- The sector was responding to these needs. There are plans to take on 3-4 trainees next year (instead of usual 1-2) to counteract the impact of retirements over the next 4-5 years. However, in next 2-3 years demand may outstrip supply.

**Other specialist services:**

- Shortages in the medical oncology workforce were identified in SA and Queensland, and also in rural NSW and some regions of Victoria.

- Shortages in radiation oncologists and radiation therapy technicians were identified in all states except for Victoria. While Victoria did have a shortage of radiation oncologists, they are now in the position of having an oversupply (VIC Policy).
  - Suggestion that radiation therapy workers be up-skilled in line with the new technologies being introduced in radiation oncology (NSW Policy (b))
  - Shortage of radiation technicians meant that throughput capacity of radiotherapy equipment was inadequate (WA Clinician)

**Nurses**

- In addition to the general nursing shortages in the area of cancer nursing, specific areas where the recruitment of nurses were identified were:
• Recruitment of (the most experienced and keenest) nurses in the cancer networks and as nurse coordinators means that there are fewer nurses with clinical expertise ‘on the ground’ for service delivery; especially critical in surgical and ward nursing (private and public sectors) (WA Policy (b); VIC Policy)

• There is a need to develop a clearer career pathway for nurses in cancer care, specifically the care of women with gynaecological cancer

• Consultations across the states and organisations indicated that nurses were viewed as having the capacity for role expansion. This was already occurring in some areas, with others being identified as possibilities for the future. For example:
  
  o Increasing opportunities for oncology nurses and nurse practitioners to do some of the work currently provided by doctors

  o Nurse-led clinics, the nurse practitioner model (from UK) provides evidence of how multidisciplinary teams can work without being reliant on one specialist

  o Gynaecological oncology services increasingly have a gynaecological oncology nurse and look for nurses with training in cancer care

  o Role for nurse educators to be available to assist people working in oncology areas

  o Chemotherapy training for nurses could to some extent address workforce shortages in chemotherapy services

• Need more specific education for nurses in cancer and cancer subspecialties. Model already developed in Breast Cancer – could be adapted for use in

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RCNA – Royal College of Nursing Australia; CoN – College of Nursing; CaPCN (WA) – Cancer and Palliative Care Network, Western Australia
gynaecological cancer. Barrier to attending training is clinical relief time (CoN)

- Nurses have an increased role in rural areas however they do not always have a ‘designated’ role in gynaecological cancer or cancer more broadly, and rarely have specialty or subspecialty training. College of Nursing has a focus on skilling up nurses and rural clinicians via education, training, workshops, scholarships etc – often delivered in rural areas.

- Scholarships are available to nurses in rural areas to do a nursing degree or a re-entry program. Currently, these are not targeted toward nurses in cancer care (RCNA)

_GPs and primary health care_

- GP workforce was said to be overstretched and maldistributed.

- The need for a greater role for GPs and nurse practitioners was recognised across the states. The issue is how to more systematically engage GPs in the cancer care process (AGPN).11 Suggestions included:
  
  o Expanding and legitimating GP roles (through the patient management frameworks) in areas such as: early detection, follow up care (administration of treatment and treating the side effects) and palliative care. (AGPN).

  o Improving the efficiency of communication between hospitals and GPs.

- GPs are increasingly recognising the need to have co-located services, and employing practice nurses who can provide some of the non-clinical care to women. (AGPN).

- Need to train more nurse practitioners so that we make better use of doctors (WA Clinician)

_Allied Health_

- Shortages in some areas (e.g. dietetics, clinical psychology, services for lower limb lymphoedema) were identified. The main issue is to attract allied health workers to develop a sub-specialty interest in cancer care. This was discussed in relation to:
  
  o Recruitment and retention being a particular issue in rural areas

  o Recruitment from interstate being difficult unless the protocols for cancer care are consistent across the states

  o The capacity for states to source allied health workers from interstate and overseas

11 AGPN - Australian General Practice Network
Define what kinds of care are required under which circumstances, to ensure that skills development of the existing workforce will result in the levels and types of services required

- Specific workforce needs will be influenced by the development of models of shared care, assessment strategies and patient management frameworks for the different roles in the allied health workforce.

5.5.1.5 Conclusion

Skill shortages were identified across a number of disciplines and were seen as being exacerbated in rural areas. In the face of recruitment and retention issues, alternative suggestions for addressing these shortages have been put forward, including modifying models of care (discussed in the next section), skills escalation and role expansion. While the first two options offer some efficiencies for the designated cancer workforce, the latter option is about expanding the workforce. Expansion seems likely to occur in one of two ways: by expanding the designated cancer workforce, or by expanding the cancer-related roles in the general health workforce. They have different implications for workforce planning.

Expanding the designated cancer workforce is primarily about the recruitment and retention of people in required roles. Identifying exactly where the shortages are requires workforce data that has not been collected in most of the states. Attracting people to the cancer workforce also appears to be problematic – it does not seem to be viewed as a desirable vocation for graduates. Issues such as pay and location were mentioned in the interviews, but the extent to which these influence decisions about career direction is not clear. Recruitment and retention is also about providing appropriate education and training as well as developing clearly defined roles (through patient management frameworks) and a career path. In specialties such as gynaecological oncology, chemotherapy, radiation oncology and medical oncology, these are relatively well-defined. The same can be said of the more traditional nursing roles: ward nursing, theatre nursing, and clinical nursing. However, nursing, and to a lesser extent, radiation therapy, is rapidly evolving with new roles constantly being developed. Cancer nursing is a recognised specialty within which roles such as nurse coordinators, nurse practitioners, and nurse educators are becoming increasingly common. Some nurses specialise even further according to particular tumour groups. This change in the roles in which nurses contribute to cancer care has implications for the nursing workforce – for the numbers employed in cancer care; for education and training requirements; for establishing the appropriate parameters for work conditions (hours, salary, responsibilities) and career paths; and for regenerating the workforce as the more skilled nurses move up into specialised areas.

Expanding the role of the general health workforce into cancer care is more about the provision of appropriate education and training than recruitment. Areas in which this approach has been foreshadowed are allied and psycho-social / sexual health care, primary health care and rural nursing. The issue here is how to deliver education and training in ways that ensure a health professional has the required skills and knowledge to fulfil their role in providing cancer care. While there is more development required in delineating who needs to know what, the consultations
highlighted the need for training to be locally delivered, for there to be general training in cancer care with options for specialisation in particular tumour groups, and for there to be consideration given to the issues of funding and clinical relief time. Although expanding the general health workforce into cancer care will help address some of the issues with shortages in the designated cancer workforce, it is by no means an easy endeavour.

5.5.2 Changes in The Models of Care Toward Multidisciplinary Teams

Shifts in the model of care can have a significant impact on the workforce. Within cancer care the main shift being advocated is from specialist-centred care to multidisciplinary care, coordinated through multidisciplinary teams (MDTs). In many areas of cancer care, and for many specialists and other health professionals, this is a significant departure from existing practice. Participation in MDTs may require new skills, the capacity to secure clinical relief time and another layer of rigidity in schedules (attending regular meetings). However, MDTs are also thought to introduce new efficiencies into cancer care and be more patient-centred than alternative models.

In 2005 a joint information paper on ‘A Models of Care Approach to Health Workforce Planning’ was released by the Australian Health Workforce Advisory Committee, The Australian Medical Workforce Advisory Committee and the Australian Health Workforce Officials’ Committee. The paper identified several issues leading to a ‘models of care’ approach, including ‘workforce shortages and a predicted shrinkage in the available pool of potential new workers’ (p.4). The trend in addressing such pressures is to facilitate more consumer-focused and cost effective ways of using the health workforce. The shift toward multidisciplinary cancer care is being advocated within this context.

Within the cancer control plans, the shift to multidisciplinary care is explicitly advocated by all states. During the interviews, however, it was evident that providing care through MDTs was not straightforward: it is a model of care that is still evolving. To this extent it is difficult to draw conclusions about the extent to which shifting towards a MDT approach to cancer care will impact on the workforce. Several themes emerged from the interviews that will impact on workforce planning and these are discussed below.

5.5.2.1 Defining a Multidisciplinary Team

Although there was broad support for the principles of multidisciplinary care and for working in MDTs, it soon became apparent from the consultations that people were not always speaking about the same thing. In effect it was possible to delineate four levels within which MDTs functioned, all of which had a different role in cancer care:

- Tumour boards. These were the most common form of MDT. They were primarily pathology or specialist driven, and included those specialists involved in the treatment of a tumour. In gynaecological cancer care, the majority of patients seen by a gynaecological oncologist (public or private) would be presented at a tumour board. Some of these boards included a nurse coordinator.
or palliative care nurse; and, more rarely, someone with psycho-social qualifications. Tumour Boards operated mostly in (public) tertiary hospitals and dealt with the progression of cancer (focused particularly on the tumour) from diagnosis to palliative care.

- **Ward team.** Some public hospitals had MDTs for their inpatients that focused on their post-operative care, including the return home. In gynaecological cancers these teams were most likely to be coordinated by the gynaecological cancer nurse coordinator. There was variability in which disciplines were ‘invited’ to participate in formal meetings, although allied health workers and health professionals in the field of psych-social/sexual support were more likely to attend these meetings. In many cases there appeared to be more of a multidisciplinary care than multidisciplinary team approach – that is staff from different disciplines were available for consult, but not all teams got formalised into meetings where ‘patients’ are presented.

- **Post-discharge team.** Once a patient returns home, ongoing care is usually required, especially for gynaecological cancers. Treatment of the tumour will still be coordinated by the oncologist, however care of the patient is more likely to be coordinated by a nurse coordinator and delivered as close to the patient’s home as possible. While a multidisciplinary care approach is often taken by these coordinators, it rarely occurs through a MDT. It is often at this level, however, that GPs and primary health care workers are most likely to be involved in cancer care, and issues were discussed about how this could be made more systematic.

- **Multidisciplinary committees.** Some organisations had explicitly selected members of committees on the basis of a multidisciplinary approach (eg GMCT, NSW). This was viewed as particularly important when decisions were being made about referral pathways and treatment guidelines.

The capacity to use multidisciplinary teams in a ‘model of care’ approach to workforce planning is therefore limited until it is possible to clearly define the levels at which MDTs should or could operate effectively.

### 5.5.2.2 Models of Multidisciplinary Teams for Rural Areas

Most of the models for multidisciplinary teams were based on health services in metropolitan areas where there the likelihood of having concentrations of expertise and integrated services are higher. This makes it easier to attend regular face-to-face meetings, network with the members of the team and keep engaged in the process. This is far more difficult for service providers in rural and regional areas, and alternative models of MDTs are required. In Queensland and WA some services are developing ‘virtual’ teams, using video-conferencing technology. NSW and WA are also conducting research into the development of appropriate models for the inclusion of rural practitioners in MDTs, while in SA a pilot program has been established linking Flinders Medical Centre with Mt Gambier hospital in a rural-metro partnership. It is anticipated that this kind of research will provide a much clearer idea of how rural services can best be integrated into the MDT model of care.

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12 GMCT - Greater Metropolitan Clinical Taskforce
5.5.2.3 Delineation of Roles Within and Between Multidisciplinary Teams

The need for clearly delineated roles within MDTs was identified by several people. This is an issue that has arisen partly because of the expansion of MDTs beyond the traditional tumour board model and into cancer streams that had not previously operated on an MDT basis.

The expansion of MDTs beyond the traditional tumour board has meant that:

a) Health professionals who have no, or little, experience in working in MDTs are invited to participate often without a clear induction process into how the teams operate, nor with skill development in how they might best participate.

b) New discipline areas are being introduced into a team without appropriate guidelines on how their role in patient care intersects with those of other disciplines present.

These issues were identified primarily by general practitioners, and professionals in the allied health and psychosocial disciplines. One solution put forward was to have more leadership from (gynaecological) oncologists to develop the roles and integrate new members into the MDTs (GMCT (NM)). However, as MDTs are increasingly coordinated (if not led) by nurse coordinators or administrators this could be another dimension of their role.

In Victoria where MDTs operate at the level of area health service and tumour collaboratives, the point was made that there is a need to rationalise the number of MDTs to which people belong. This may well be a ‘teething problem’ as the new structure is implemented over the top of existing MDTs. However where the issue persists, some clarity of the competencies required in each MDT, and how MDTs work together, could be helpful.

5.5.2.4 Organisation of Multidisciplinary Teams

It was clear from the consultations that MDTs require a level of formalisation. Increasingly, MDTs are being funded for the administrative support needed to coordinate and maintain records of meetings. Sometimes the administrative tasks were divided up with the coordination going to a Fellow within the team (e.g. of gynaecological oncology) or nurse coordinator, and the record keeping being done by administrative support staff.

Another issue raised with regard the organisation of MDTs was the need for funding for time release which makes a difference to the attendance at MDTs and hence their effectiveness.

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33 GMCT (NM) - Greater Metropolitan Clinical Taskforce, Network Manager (for gynaecological oncology and nuclear medicine)
5.5.2.5 Research into Multidisciplinary Teams

The current model for MDTs, beyond tumour boards, is often based on that developed by the National Breast Cancer Centre. However, additional research is being conducted as the purpose, roles and models of MDTs evolve.

- In NSW, 24 research projects were recently funded to examine innovations in seven priority areas: rural-metro partnership; financial sustainability; data collection; NSW specific patient management frameworks; tumour specific MDT treatment plan; outcome measures; private-public partnerships.

- In SA and WA research is being conducted into extending MDTs to rural areas

- The WA Cancer and Palliative Care Network has been funded by CanNET to research models of MDTs

- NBOCC\textsuperscript{14} has just completed an audit of MDTs across five tumour groups (release pending)

One of the NSW research projects addresses an issue raised in the consultations, which is that MDTs are seen to be a ‘public hospital’ thing (GMCT (NM)). MDTs were not as well developed in private hospitals or amongst doctors in private practice. One reason given for this was that the ‘systems’ were not in place to fund and allocate time to MDT participation (DN;\textsuperscript{15} AGPN).

5.5.2.6 Conclusion

As the SA bureaucrat stated, there is a ‘strong body of evidence around the value of having multidisciplinary teams’ and each of the states have recognised this and incorporated MDTs into their models of care for cancer control.

The consultations indicated that there is quite a high level of goodwill in the shift toward MDTs. However, there are still a lot of issues to be sorted out before the workforce implications can be clearly identified for gynaecological cancers. Currently, gynaecological cancers are ahead of most other tumour streams in the consistency with which cases presented to gynaecological oncologists come before a tumour board. It is clear, though, that the membership of these MDTs is changing. In the future there is likely to be more involvement by gynaecological nurse coordinators, palliative care service providers, psycho-social / sexual service providers (social workers, psychologists, psychiatrists), allied health workers (dieticians, physiotherapists, occupational therapists), and primary health care providers, such as GPs, practice nurses and community nurses. In addition, there is currently a far greater effort being put into including rural practitioners into the MDTs. Of course, not all of these will be involved in every MDT, and one of the tasks is in delineating at which level of MDT they would be most appropriate for their contribution to cancer care. This expansion of MDTs will require funding,

\textsuperscript{14} National Breast and Ovarian Cancer Centre
\textsuperscript{15} DN – Deb Neesham (Gynaecological Oncologist)
coordination and administrative support if they are to be effective. Clearly the ongoing research being conducted in this area will be valuable.

5.5.3 Services for Women with Gynaecological Cancers

In 2006 the Senate Community Affairs Committee published the report *Breaking the silence: a national voice for gynaecological cancer*, which led to the establishment of the National Centre for Gynaecological Cancer under the auspices of Cancer Australia. Although most of the cancer control plans were developed prior to the government’s focus on gynaecological cancers, some states have taken specific action in this area. NSW, Victoria and WA each have gynaecological cancer tumour streams, while SA’s service framework has identified gynaecological cancers as being a specialised service requiring centralised delivery.

Over a third of the people who were consulted for this section of the Review had a designated role in gynaecological cancer services. Discussions with these people revealed a strong sense that gynaecological cancers were ahead of the cancer control plans in certain ways – for example, their use of multidisciplinary teams, the integration of private and public services, and their outreach services to rural areas. Indeed, the clinician interviewed from Queensland stated that gynaecological oncology was the ‘jewel in the crown in Queensland Health’. Nevertheless, areas for improvement were identified in the broader consultations and these are discussed below.

5.5.3.1 Referral Pathways

A simplified overview of a common referral pathway for a woman with gynaecological cancer is to go from a GP to a gynaecologist to a gynaecological oncologist. The gynaecological oncologist refers through a tumour board where treatment options (based on the pathology) are discussed. If surgery is recommended a nurse coordinator (if there is one) may then facilitate the patient journey into hospital and support patients to receive any required care in the disciplines of psycho-social/sexual health and allied health. During the consultations, however, there was some discrepancy as to the strength and appropriateness of these referral pathways.

Preferred referral pathways are formalised in patient management frameworks which are part of the cancer control plans. Whether formalised or not, there does appear to be quite strongly delineated roles established (between GP, gynaecologist and gynaecological oncologist) within gynaecological oncology. However, the advantages and disadvantages of this were discussed by four people – two with designated roles in gynaecological cancers. In particular, there appeared to be a need to further clarify the boundary between gynaecological oncology work and gynaecological work, in some instances they were too strong, in others not strong enough:

- In NSW the numbers of non-cancer cases worked on by gynaecological oncologists has doubled within the last 5 years (NSW Clinician), reflecting an

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16 It is also quite common for women to be referred from a GP to a gynaecological oncologist, without the interim step of seeing a gynaecologist
aversion by some gynaecologists to operate on anything that might remotely be cancer. Improvements in triaging and deflecting non-cancer cases have been implemented to address this problem.

- Strong referral pathways usually mean that women from rural areas have to travel to the city for major surgery. Apart from being a major disruption at a period in which they were vulnerable, it also meant that when they returned home there was often no referral point for them (GMCT (C)).

- In Queensland, a gynaecologist working in a rural area suggested relaxing the protocols so that gynaecologists could perform more procedures and do a better job of primary surgery, particularly in rural areas.

Three people suggested that the pathways were not as strong as suggested above. In these instances, there was concern that women were not being appropriately referred to gynaecological oncologists, particularly in rural areas; and women were getting diagnosed outside of the gynaecological oncology units, which was said to be more of an issue in the private sector. (DN; CoN; GMCT (NC)). One suggestion was that GPs should be given a direct path to gynaecological oncologists.

- Another issue relating to referral pathways was that of having appropriate referral pathways for psycho-social / sexual and allied health services. With these services being less established in the treatment of gynaecological cancers there were concerns that women were not being appropriately referred.

- One concern referred to differences in the treatment of women in the private sector. While this has already been raised above, it seems that in private health services, the reliance on a gynaecological oncologist for referrals means that women are less likely to be referred to allied health and psycho-social support services (DAA). This issue arises partly because the multidisciplinary team approach is less well developed in the private system, and partly because of the lack of integration between public and private systems (DN).

- More generally, health providers in the psycho-social and allied health disciplines recognised a need to develop screening, triaging and management pathways to ensure that women are referred to appropriate services and that clinicians are not re-sorting patients as they come through the process (DAA; NBOCC).

5.5.3.2 Patient-Centred Care

One of the shifts in the treatment of gynaecological cancer as a chronic disease is that there is a greater focus on patient-centred care. Behind this shift is an assumption that patients will need to take more responsibility for their ongoing care, over long periods of time, particularly when they return to their home and community. The cancer control plans routinely discuss patient-centred care in relation to involving

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27 GMCT (C) - Greater Metropolitan Clinical Taskforce, Consumer
28 DAA – Dieticians Association of Australia
the patient in treatment decisions – including in multidisciplinary teams; providing patients with evidence-based literature about treatment options; providing accessible services at a local level; providing culturally appropriate care; and providing a more holistic approach to treatment that includes patients, psycho-social/sexual and allied health care, GPs and other primary health care. Although some movement toward these goals had been made, it was evident from the review of the plans that the states have been selective in the areas they have implemented. Most action had focused on providing access to psycho-social / sexual and allied health care; and in the provision of support once women returned to their homes following treatment.

In speaking with gynaecological oncologists it appears that while gynaecological cancers are routinely assessed within multidisciplinary teams at the tumour board level, patients have little or no direct contact with the team as a group. The focus on patient-centred care has led to an increase in the employment of gynaecological cancer nurse coordinators across the states. Most often these nurses are hospital-based and they work with patients during the pre and post-operative stages of their treatment pathway, sometimes maintaining contact with patients into the outpatient stage. In WA nurse coordinators also work at a regional level and, in addition to working with inpatients, have a greater role in facilitating their care once patients have returned home and provide a service to them for as long as required. Interestingly, there was also some variation in understandings about what being ‘patient-centred’ means.

Although there has been a focus on the provision of, and access to, psycho-social / sexual, allied health and primary health care services, there still appears to be inconsistencies in which disciplines participate in care and the extent to which women can access these types of care. These difficulties appear to be exacerbated in the private sector and in rural areas. Issues relating to the provision of these kinds of care were discussed by four of the states and over half of the organisational contacts during the consultations, indicating that the problems are widespread.

5.5.3.3 Patient-Centred Care In Rural Areas

In addition to the general issues relating to patient-centred care discussed above, there are particular issues for women with gynaecological cancers from rural areas. Service delivery for rural women was widely viewed as being problematic. Some states had specific measures in place to address the needs of rural women, however these were relatively new or still being rolled out. Notable amongst these were innovations in WA and NSW:

- In WA, a Nurse Coordinator Network was in place whereby nurse coordinators had specific responsibilities for either a tumour group or a region. The Nurse Coordinator in gynaecological cancers provided a referral and advisory service for women with gynaecological cancers that continued after they had returned home. If they lived in rural areas, she would liaise with the relevant regional Nurse Coordinator to ensure that the woman had access to appropriate services. (Nurse Coordinator, gynaecological oncology, WA).
• In NSW, the Greater Metropolitan Clinical Taskforce are developing a list of health providers who are willing to act as ‘contact’ people for women returning home after surgery. The aim is to have one person in each rural town to provide information and act as a contact point (rather than do the actual service delivery). According to the Network Manager for gynaecological oncology, they have had a good response and will be looking to implement the program in the near future.

It is clear that service delivery for women living in rural areas is still evolving and there are debates about the extent to which care can be locally delivered. Despite some ideas that best practice for rural women would be to ensure that follow up care was centrally coordinated, but locally delivered, questions were still raised about the level at which this is feasible and what the implications would be for workforce planning, skill maintenance, or funding. There appeared to be some general consensus that there was a need for a variety of models of care to cater for rural, remote and indigenous women, just not on what these models might look like.

Another area discussed during the consultations is in the delivery of services to Indigenous women from rural and remote areas. Cultural factors (including language and kinship networks), distance and unfamiliarity with the workings of health systems and cities more generally mean that Nurse Coordinators (and possibly other health professionals) needed to dedicate a lot of time to supporting women with such complex needs (CaPCN (WA)). This impacts on their workload, not only in providing the required level of support but also in learning how to work effectively within a specific cultural setting.

5.5.3.4 Conclusion

Throughout the consultations, the service provision for women with gynaecological cancers was acknowledged as being already well developed. Comments such as that from a clinician in SA, who stated ‘our patients are well looked after so really it’s a matter of fine-tuning and maximum utilisation of those resources rather than any glaring deficiencies’ were not unusual. However, this fine-tuning still has workforce implications.

Ensuring that the patient management frameworks are implemented effectively will bring efficiencies into the field by removing duplication and matching skills with the relevant need. Certainly working ‘smarter’ by adjusting models of care and patient management frameworks was identified as being one answer to perceived workforce shortages (NSW Policy (b)). Nevertheless, other aspects of the plans, such as increasing the levels of patient-centred care, have increased the designated gynaecological cancer workforce through the appointment of nurse coordinators and lead clinicians (with a larger than usual strategic and administrative function). The workforce that have a designated role in gynaecological cancers (which may or may not be career-defining) also has the potential for expansion: providing more consistent access to allied health and psycho-social / sexual health services, extending services to rural areas, and providing greater support for Indigenous women.
5.6 Conclusion

The Cancer Control Plans were developed to improve the treatment and care of people with cancer by implementing a strategic state-wide approach. Five states are currently implementing their plans. Queensland, WA and SA are implementing their first plans, while NSW and Victoria are now into their second cycle. Tasmania and the ACT plans are in draft stage; there was no plan for the NT. Of those states with a Cancer Control Plan, NSW, Queensland and WA were said to be ‘on track’ or making significant progress. Victoria was said to have achieved most of its goals in restructuring the framework of cancer services as per its first plan. The SA plan was deferred for 18 months until the release of the SA Health Care Plan, so progress has been limited.

The Review of the Cancer Control Plans was conducted by consultation with a senior policy officer and a senior clinician (with knowledge of gynaecological cancers) in each state. In addition, 30 invitations to participate in the Review were sent to professional and advocacy organisations, of which we finally consulted with 13 people. This component of the Review is therefore dependent on the knowledge of those with whom we consulted and the extent to which the interview questions were addressed. This process does not provide the same kind of information that an objective review might, with specific performance measures and quantifiable outcomes. However, while there are limitations of this Review with respect to the measurement of the extent of action taken on each of the plans, it collected valuable information on the impact of the Cancer Control Plans on the workforce and this was discussed in Section 5.5.

Each of the plans contained statements or sections that recognised the importance of workforce planning. Some states had conducted audits of specific workforces to identify gaps and shortages. Most states identified shortages in radiation oncology, radiation therapy, chemotherapy and nursing. Several states also mentioned the difficulties in attracting (and retaining) workers to the field of cancer care. Shortages were identified in two ways: either as the need to fill an existing vacancy or to meet a population based allocation of health professionals (e.g. 1 gynaecological oncologist per 400,000 people). They were rarely discussed as being specifically related to the implementation of the Cancer Control Plans. Nevertheless, it is likely that the plans would have an impact on the workforce as one of the aims of the plans was to create efficiencies, including workforce efficiencies, in the structuring of cancer care services. Alternatively, the restructuring of cancer care was creating new roles and expanding others.

Workforce efficiencies were part of the rationale for changes to the service framework, models of care, and patient management frameworks. Services that required highly specialised skills were centralised or offered in a few key locations (primarily in tertiary hospitals) in metropolitan areas. Services such as radiation therapy and chemotherapy were likely to also be provided in major regional centres, although this also depended on cost efficiency regarding the technology. Palliative care and some allied health and primary health care services were more likely to be offered closer to a patient’s home. The service frameworks aimed at achieving the

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19 At the time of writing, Victoria’s second plan had yet to be released.
best distribution of services across a state, in ways that were sustainable and efficient. Similarly the patient management frameworks (referral pathways) provided guidelines for ensuring that women moved through the cancer trajectory and accessed the relevant health professionals in the most efficient and effective way. The aim was to reduce waiting times and the duplication of service provision, and ensure that women saw only the relevant health professionals. The concept of skills escalation was used to describe this process – where professionals focused on aspects of patient care that only they could provide, delegating responsibility for other aspects to the relevant health professional.

Another area in which workforce efficiencies were anticipated was in the shift toward MDTs. In the field of gynaecological oncology this was already well-developed at the tumour board level; however, questions were raised about the extent to which multi-disciplinary care was systematically continued beyond the acute care phase. While MDTs were thought to be an efficient mechanism for the management of cancer patients, it was evident that implementation would involve expanding the breadth of team membership to include primary health care providers and allied health care providers. In effect, this would expand the numbers of people involved in working in cancer-related roles.

The workforce impact of the cancer control plans has yet to be fully realised. This is particularly so for rural outreach services and the provision of patient-centred care. In both cases this involves an expansion in the roles of health professionals to be more involved in chronic cancer care; in the provision of outreach services by existing workers with a designated cancer role (e.g. medical oncologists); and in the development of new fields of cancer-related health professionals such as nurse co-ordinators and lead clinicians.

The impact of the cancer control plans on the designated gynaecological cancer workforce has been to increase the need for lead clinicians, gynaecological cancer nurse co-ordinators and specialist surgical nurses. Projected supply of gynaecological oncologists is likely to be affected by a spate of retirements over the next few years, which has been addressed by increasing the numbers of trainees being accepted into the specialty. The seconding of gynaecological oncologists into lead clinician roles has also increased the need for trainees. Rural outreach services are provided by gynaecological oncologists on a limited basis, but all major surgery is done in the metropolitan centres. There may well be the capacity to increase the scope of outreach services, either in person or using tele-health facilities. The employment of nurse co-ordinators appears to be rapidly expanding as a means of providing patient-centred care. This is an emerging role and has yet to be properly defined – the same occupational title is used for a variety of responsibilities and the nurses are located in various institutional contexts (affecting the scope of their role).

The impact of the cancer control plans is greater for those members of the gynaecological cancer workforce whose work (and career) is defined more broadly. This relates to most of the health professionals involved in the care of women with gynaecological cancer. Some of these, however, will have a designated role in the treatment of cancer more generally, such as pathologists, medical oncologists and radiation therapists. The issue here is to ensure that their role is recognised in the patient referral pathways and clinical networks. Others – general practitioners,
nurses, social workers, psychologists, psychiatrists, other allied health professionals and psycho-social service providers will be more generalist and may therefore benefit from some information or training on the treatment and care of women with gynaecological cancers. Another issue for this component of the workforce is how to systematically include them in the treatment and care of women with gynaecological cancers and ensure that these women get to see the relevant person at the appropriate stage. As mentioned above there is also scope for involving many of these health professionals in a MDT approach to care. Their capacity to work effectively in these teams is likely to be enhanced if they have a clearly defined role, an ‘induction’ into the team and are able to be recompensed for their services.
6. Literature Review: Multidisciplinary Care

The management of cancer services both in Australia and internationally has moved from a focus on acute treatment to a recognition that cancer is best seen as a chronic condition, placing the patient and their carer at the centre of a treatment journey that spans diagnosis through treatment and remission periods and if necessary, to palliation. Changes in the cancer service environment (increased incidence, increased screening and diagnosis, advances in treatment options, workforce shortages and increased costs) have driven a need to maximise the efficiency of services through the introduction of multidisciplinary, patient centred care rather than the traditional sequential, specialist centred care (AHWAC et al. 2005).

The aim of this literature review is to describe the models of care for gynaecological cancer employed in Australia and in comparable Anglophone countries, how these models of care compare, what are the implications of innovations in models of care for the workforce and workforce planning, and what is the evidence about outcomes of these innovations for women with gynaecological cancer, with a particular focus on multidisciplinary teams.

6.1 Methodology

In order to gain insight into current workforce innovation in the field of gynaecological cancer, a review of the academic, policy, and other ‘grey’ literature from Australia, NZ, UK, Canada, and USA was conducted. This consisted of a broad review of national level websites from the five nominated countries, covering: health (general, cancer, and gynaecological cancer), and the College of Obstetrics and Gynaecology. A systematic review was conducted using 6 databases, selected for their coverage of Australian and International health material. These were Pubmed (US academic literature), the NHS specialist library for Cancer (UK academic and grey literature), CINAHL (Australian academic literature), Cochrane (international academic literature), Pandora (Australian grey literature), and Proquest (US academic and grey literature). A selection of ‘key journals’ was also included in this systematic review, comprising the International Journal of Gynaecological Cancer, the European Journal of Gynaecological Cancer, the Medical Journal of Australia (MJA), the British Medical Journal (BMJ), the Journal of the American Medical Association (JAMA), the Canadian Medical Association Journal (CMAJ), and the New Zealand Medical Association Journal (NZMA). The following terms were searched:

- Gynaecological/ Gynecological
- Gyn(a)ecological cancer/ oncology
- Ovarian cancer
- Cervical cancer
- Vaginal cancer
- Vulval cancer
- Fallopian tube cancer
- Uterine cancer
• Placenta and gestational trophoblastic disease

To narrow the search, the above terms were cross referenced with:

• Multidisciplinary team’
• ‘Referral pathway’
• ‘Health workforce’
• ‘Sustainable workforce’
• ‘Key competency/ competencies’
• ‘Innovative practice’
• ‘Coordinated care’
• ‘Integrated care’

The review of the six nominated databases elicited 230,892 hits, which were shortlisted based on their titles to 148 relevant articles, and the shortlist was reduced to 17 articles based on their abstracts. Material that was either too clinical or epidemiological in nature was eliminated whilst material concerned with ‘models of care’ and the workforce was retained. Given the recency of the focus on gynaecological cancer as a priority stream for development, material relating to breast cancer (a more developed stream and the closest to gynaecological cancer in terms of its workforce requirements) and cancer in general was included if particularly relevant. The review of national level websites elicited a further 23 relevant items, and a book chapter by two of the authors of the current report was included due to its relevance.

6.2 Models of Care

Analysis of the cancer control plans for Australia and each of the comparable anglophone countries selected for this literature review revealed seven primary innovations in the model of care for cancer: multidisciplinary care; patient-centred care; chronic care; supportive care, which incorporates psychosocial and palliative care; evidence based care; clinical guidelines; and referral pathways (NHPAC 2005; Minister of Health 2003; Department of Health 2000; CSCCGC 2006; Hewitt & Simone 1999). Table 6.1 summarises the models of care proposed in each of the cancer control plans in terms of these innovations.
Table 6.1: Summary of Innovations of Care in the National Cancer Control Plans for Australia, New Zealand, The United Kingdom, Canada, and The United States of America.

<table>
<thead>
<tr>
<th>Innovation</th>
<th>AUS</th>
<th>NZ</th>
<th>UK</th>
<th>CAN</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient centred care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chronic care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Supportive care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Evidence based care</td>
<td>✓</td>
<td>✔</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clinical guidelines</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Referral Pathways</td>
<td>✓</td>
<td>✔</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

The newly established Australian National Centre for Gynaecological Cancers is working towards a model of cancer care delivery where stakeholders work together to reduce the impact of gynaecological cancers, there is a strong and sustainable health workforce around gynaecological cancer, evidence-based information is available for both consumers and health professionals, treatment is evidence-based, and outcomes are equitable for all women (Cancer Australia 2008).

The current literature review focussed on evidence about multidisciplinary care, as was requested by Cancer Australia. Further literature reviews might concentrate on evidence about the other six innovations in the cancer care model.

6.3 Multidisciplinary Care

Cancer care, because it is a chronic illness requiring complex decisions (about diagnosis, treatment and efficacy for specific individuals) over an extended period, lends itself to multidisciplinary care, especially given its focus on patient-centred care (Willis, Dwyer & Dunn 2008).

There is no universal definition of multidisciplinary care (MDC): ‘the definition of MDC remains fluid in the literature and among health care professionals, with no one interpretation being a perfect fit for all situations (Marsh et al. 2008, p.385).’ Broadly defined, MDC is ‘integrated care by two or more clinical disciplines (COSA 2003).’ More specifically, in cancer care MDC refers to a collaborative approach (Choy et al. 2007; Evans et al. 2008; Marsh et al. 2008; Australian Cancer Network & National Breast Cancer Centre 2004) by health professionals, including medical, nursing and allied health workers (Chang et al. 2001; Choy et al. 2007; COSA 2004; Evans et al 2008; Zorbas et al. 2003), that spans from diagnosis through treatment and management to palliation (Macaskill et al. 2006; Australian Cancer Network & National Breast Cancer Centre, 2004).

Theoretically, MDC has the potential to reduce mortality, improve quality of life, and reduce healthcare costs because it promotes best quality and continuity of care, which allows more patients to be treated according to current guidelines, more
consistent information delivery to the patient, improved patient understanding of their disease and treatment plan, better compliance with treatment recommendations through informed input from the patient, and greater capacity for informed consent (Choy et al. 2007; Fleissig et al. 2006). It is also thought that MDC has benefits for workers who are involved in multidisciplinary teams. Jenkins, Fallowfield and Poole (2001) proposed that working in a supportive, well functioning team can improve mental health and the effectiveness of the team through increased efficiency, morale and work satisfaction.

6.4 MDC Models

According to Crawford and Price (2003), multidisciplinary care can take shape in three ways: multidisciplinary teams, where every team member has a definite and delineated role in the team and contributes their expertise in ‘relative isolation’ to other team members; interdisciplinary teams, where team members contribute their own expertise but share information and work interdependently; and transdisciplinary teams, where members roles and responsibilities are shared and each member’s expertise is not immediately recognisable to the consumer (this model is not used in health care).

There is no commonly accepted model of multidisciplinary care in the realm of cancer care (Choy et al. 2007; Zorbas et al. 2003). The report ‘Optimising Cancer Care in Australia’ describes the variability of how multidisciplinarity is realised in cancer care:

> It [MDC] can range from a team that considers every patient who comes to an institution, through to a range of lesser models, even including teleconferencing to regional areas, etc. (COSA 2003, p.16).

Models of MDC for cancer in the literature range from clinics providing comprehensive multimodality care in a single visit to a single location (Chang et al. 2001; Gable et al. 1997; Newman et al. 2006), to discussion of case management by a multidisciplinary team (Evans et al. 2008; Delaney et al. 2004; Macaskill et al. 2006; Wheelan et al. 2006), also known as a tumour board (Gable et al. 1997).

Models also differ in relation to how involved the patient is in the MDC team (Fleissig et al. 2006), ranging from a situation in which teams of professionals meet and discuss individual patients and then present the end result of their discussion to the patient (NBCC 2005) to a situation where patients are included in the MDC meeting whilst accompanied by a cancer care nurse (Choy et al. 2007). In an Australian study, Choy et al. (2007) assessed the feasibility of including breast cancer patients in the multidisciplinary team. Analysis of questionnaires completed by thirty patients (of whom 22 had attended their MDT meeting) before and after their MDT meeting and by the MDT members, revealed no significant difference in the anxiety levels of those patients who had and had not attended their meeting, and clinicians indicated that those patients who did attend had a higher understanding of their disease and their treatment plan. Clinicians also noted that they felt the need to modify their language when patients attended the MDT meeting. The small sample size of this study and the non-random nature of those who elected to attend their
multidisciplinary meeting (this group had a higher education level and higher status occupations) should be taken into consideration when interpreting the results.

In order to overcome geographical and time obstacles to MDC meeting attendance, teleconferencing has been incorporated into some models of MDC, and it works well at increasing access to MDC for those professionals who are motivated to attend, however teleconferencing by nature tends to increase the formality of meetings which can, in turn, inhibit the lowering of interdisciplinary barriers that is necessary for good MDC (Delaney et al. 2004).

Willis, Dwyer and Dunn (2008) used a case study and narrative along with a review of MDC literature to develop a set of principles for practitioners to establish or extend multidisciplinary team care (MTC), these are outlined below:

**Structural:** MTC depends on some enduring team structures along with the coming together of shorter term teams to meet the needs of particular patients or situations. Team structures need to be supported with good policy and systems. More innovation and experimentation is needed, as well as a stronger evidence base.

**Financial:** Remuneration in support of clinicians (particularly those funded on fee-for-service) engaging in teamwork is needed. The costs of setting up MTC are real, but so are the benefits (potentially including reduced utilisation of some interventions), and mature teams can develop efficient teamwork practices.

**Systems:** Managers and senior clinicians can enhance MTC through financial and human resource support for the smooth functioning of the team. Information systems can make teamwork easier.

**Process:** Effective MTC requires a commitment to regular meetings, and resources for implementing team decisions. Strong leadership is required for day-to-day management of enduring teams, but flexibility is needed to allow the most appropriate member to take leadership for particular patients or kinds of team tasks.

**Respect:** Teams need to operate from a basis of deep respect and understanding for each other’s roles, and clear shared ideas of each member’s roles and responsibilities. This has implications for formative and continuing education. There also needs to be a recognition that not all professionals are effective team players.

**Individual professionals:** Members of teams need to be confident in their own discipline boundaries, and comfortable to make suggestions in support of the client’s care. This includes the ability to provide patients with treatment options and risks, and facilitate patient decision making, along with a capacity to be flexible in the face of decisions made by patients or other members of the team.

**Patients and their families:** The shared goal of meeting patient needs underlies the methods of MTC. Patients and families benefit from confidence
that the care they receive is provided by a responsible team that they can rely on. They need to be factored into planning and decision making, and time is required to acquaint them of options, benefits and risks, and respect their choices about the extent of their engagement in decision making and caregiving. (Willis, Dwyer & Dunn 2008).

6.5 Research into MDC in Australia

6.5.1 CanNET

In Australia, the Cancer Service Networks National Demonstration Program (CanNET) was developed to coordinate cancer services across Australia in order to ensure equitable and improved outcomes for all people affected by cancer (Cancer Australia, 2007). Cancer service networks in each state and the Northern Territory have been established to link groups of health professionals and cancer care organisations and these networks are coordinated by the national program (Cancer Australia, 2007). At the state/territory level, this program will instigate improvements to ensure that people with cancer:

- receive timely and best practice assessment and treatment, as close to home as possible without compromising outcomes,
- have access to a Directory of Cancer Assessment Teams, to ensure their care is planned by a multidisciplinary team,
- have their psychosocial needs acknowledged and have access to appropriate levels of support,
- receive their care from suitably trained health care providers, and
- are more informed about the treatment choices they make. (Cancer Australia, 2007)

Based on consultation and overseas evidence the networks aim to: involve the consumer in all aspects of service planning and delivery; support GPs in prompt diagnosis and early referral to a multidisciplinary team assessment; implement multidisciplinary care; develop a systematised approach to quality improvement; and generate evidence-based protocols (Cancer Australia, 2007). In order to provide more evidence for these interventions, the CanNET program is conducting research at a national level and via the state networks into consumer participation through interviews with consumers, and a literature review around managed clinical networks has been completed (Cancer Australia, 2007). Other programs conducted by CanNET include the development of a quality assurance framework, collation of a directory of cancer assessment teams, and promotion of the continued professional development project, ‘Cancer Learning’, run through Cancer Australia (Cancer Australia, 2007). Resources for consumers and clinicians are available on the CanNET website, these include: reference lists for material on consumer involvement, managed clinical networks, directory of services, quality improvement, and clinical leadership and change management; a document outlining Medicare items concerned with MDC; and three standard national documents for use in quality

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assurance, the ‘dissemination log’, the ‘network assessment questionnaire’, and the ‘sustainability, capacity building and generalisability tool’ (Cancer Australia 2007).

### 6.5.2 NBOCC

Much of the research into multidisciplinary care in Australia has been conducted by the National Breast and Ovarian Cancer Centre (formerly the National Breast Cancer Centre), which carried out the National Multidisciplinary Care Demonstration Project over a three year period, between the years 2000 and 2002 (NBCC 2003). The project assessed the impact, cost and acceptability of MDC in the context of breast cancer care at three sites across Australia. Using clinician and consumer surveys, activity logs and clinical audits, and a survey of acceptability for clinicians, the project found that 88% of clinicians believed that MDC increases communication between team members. Clinicians also reported increased emotional and intellectual support leading to decreased stress and increased professional satisfaction. However MDC also placed additional demands on already time-poor clinicians. The design and short duration of this project meant that it was not appropriate to measure the clinical outcomes of MDC for women with breast cancer.

A follow-up study was conducted in 2004 to explore the sustainability of the changes made during the demonstration project, and any further developments, through semi-structured telephone interviews with key staff members (NBCC 2005). This study found that MDC strategies were sustainable when dedicated funds and personnel were allocated to support MDC, case conference meetings are held routinely, team members perceive strategies to be beneficial, commitment to participate in meetings is encouraged through demonstrated benefits, a ‘champion’ is enlisted, and contingency plans for changes in personnel and organisation structure are in place.

The National Breast Cancer Centre (2005) conducted a national forum series to identify barriers to implementing multidisciplinary care and outline solutions to overcome these barriers. Five principles of multidisciplinary care in Australia were developed, and these state that multidisciplinary care involves: a team approach involving core disciplines integral to the provision of good care, with input from other specialties as required; communication among team members regarding treatment planning; access to the full therapeutic range for all patients, regardless of geographical remoteness or size of institution; provision of care in accordance with national agreed standards; and involvement of patients in decisions about their care.

The results of the forums provided the basis for a series of tools and information developed by the NBCC to aid practitioners to provide good quality multidisciplinary care. These include guidelines for dealing with the medico-legal implications of multidisciplinary medical care, information about new MBS items for multidisciplinary care, information on managing multidisciplinary team meetings, and proformas for recording information, meeting attendance, treatment plans, and for notifying the consumer’s general practitioner (NBOCC 2008a).

The National Breast and Ovarian Cancer Centre is currently undertaking a multidisciplinary cancer care audit, which covers multidisciplinary care in breast, gynaecological, lung, prostate and colorectal cancers, to assess the impact of the
introduction of new MBS items supporting specialists taking part in multidisciplinary teams. However the results are not yet available (NBOCC 2008a).

6.6 **MDT Composition For Gynaecological Cancer**

Analysis of the four documents identified through this literature review that outlined the composition of multidisciplinary teams (MDT) for gynaecological cancer, showed that there was some consensus on who should be included in the teams (Australian Cancer Network & National Breast Cancer Centre 2004; Hacker 2002; Jeffries & Chan 2004; NHS Executive 1999). Teams should include at least one gynaecological oncologist, medical oncologist, radiation oncologist, gynaecological pathologist and specialist nurse (see Appendix C). In documents from the UK, histopathologists and cytologists were listed separately but Australian authors simply referred to a gynaecological pathologist. The Australian literature agrees that teams should also include palliative care specialists, psychologists or social workers, and GPs. Other specialists that were included in the literature but not universally are dieticians, geneticists and genetic counsellors, anaesthetists, clinical nurse specialists, students, and the multidisciplinary team co-ordinator (if not already included in another role).

6.7 **MDT Competencies For Gynaecological Cancer**

There was very little information about the key competencies of MDT members in the literature located by this review, other than the assumption that members were competent and accredited to practice in their field of expertise. However, working with gynaecological cancer requires that clinicians understand some of the issues for women with the disease such as the impact of treatments (surgical and other) on the women’s self esteem and sexuality and the implication of this on quality of life considerations, as well as the consumers’ need for information (Allen 2003). Working in a MDT demands a higher level of communication and collaboration skills from members, as they need to ensure that they understand each other’s informational roles so that consumers get the care they require (Catt et al. 2005). Smith and Lichtveld (2007) outlined a series of competencies for health care professionals with general knowledge of cancer such as GP’s, and while most of these are not particularly relevant for the gynaecological oncology team, Table 6.2 outlines several that are important for good multidisciplinary team care.
Table 6.2: Competencies Outlined by Smith & Lichtveld (2007) for General Cancer Professionals Relevant to Gynaecological Cancer MDT

<table>
<thead>
<tr>
<th>Competency</th>
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</thead>
<tbody>
<tr>
<td><strong>Participate within an MDT</strong></td>
</tr>
<tr>
<td>Define MDT</td>
</tr>
<tr>
<td>Describe the contribution of each professional perspective in the development of a cancer care plan</td>
</tr>
<tr>
<td>Consider the financial implications for recommended cancer care</td>
</tr>
<tr>
<td>Refer patients to an oncology social worker for financial guidance and resource navigation</td>
</tr>
<tr>
<td>Consider the resource challenges of the agency in implementing a treatment plan</td>
</tr>
<tr>
<td><strong>Incorporate psychosocial communication strategies in conveying cancer information</strong></td>
</tr>
<tr>
<td>Refer patients to mental health, psychosocial, and support services</td>
</tr>
<tr>
<td>Recognise the signs and symptoms of cancer related depression and anxiety</td>
</tr>
<tr>
<td>Explain the management of depression and anxiety in patients with cancer</td>
</tr>
<tr>
<td>Explain the useful coping mechanisms following a cancer diagnosis</td>
</tr>
<tr>
<td><strong>Incorporate cross-cultural communication strategies in conveying cancer information</strong></td>
</tr>
<tr>
<td>Identify cultural subgroups in a given patient population</td>
</tr>
<tr>
<td>Define culture specific beliefs and practices</td>
</tr>
<tr>
<td>Communicate cancer care information that is sensitive to religious and spiritual beliefs and practices</td>
</tr>
<tr>
<td><strong>Describe common ethical and legal issues in cancer care</strong></td>
</tr>
<tr>
<td>Adhere to policies, procedures and regulations</td>
</tr>
<tr>
<td>Access institutional and other ethics resources</td>
</tr>
<tr>
<td>Advocate for the use of advanced directives, including the right to refuse care</td>
</tr>
<tr>
<td>Justify the need for informed consent in cancer research</td>
</tr>
<tr>
<td><strong>Incorporate communication strategies that encourage the process of grieving</strong></td>
</tr>
<tr>
<td>Consider personal death awareness and cumulative loss as it applies to the practice of oncology</td>
</tr>
<tr>
<td>Assist oncology team members with the coping strategies over the death of patients with cancer</td>
</tr>
<tr>
<td>Develop a roster of coping resources for assisting family and other cancer care providers</td>
</tr>
<tr>
<td>Suggest resources that help professionals cope with the death of patients with cancer</td>
</tr>
</tbody>
</table>
6.8 Implications

6.8.1 How Do these Innovations Affect the Workforce?

An opinion paper published by the Royal College of Obstetricians and Gynaecologists (Luesley 2007) identified that the role of the gynaecologist in managing women with cancer has changed with advances in knowledge, technology and culture. In particular, roles have developed such that they now incorporate strategies to reduce the burden of disease, new diagnostic technologies, new treatments and new ways of delivering old treatments, and strategies to reduce the morbidity arising from interventions, and multimodality interventions. It is even suggested that the surgical skills of gynaecological oncologists are so sought after in non-oncology gynaecological surgery, that some gynaecological oncologists might adopt a career path outside of cancer (Luesley 2007).

Transition from a specialist centred model of care to a multidisciplinary model requires some alteration to the existing roles of the workforce, either through shifts in the roles performed by individual members of the team (Luesley 2007) or through the development of new roles within the team. Allen (2003) highlighted the usefulness of incorporating a clinical nurse specialist into the gynaecological oncology team, using two case studies to demonstrate the importance of the multifactorial role played by clinical nurse specialists in providing clinical expertise and facilitating the communication and information that are necessary given the distressing symptoms, and the psychological and psychosexual upheaval experienced by women with gynaecological cancer. However, in implementing changes in the composition of the multidisciplinary team, it is important that other team members and the system as a whole support the changes to ensure success. Willard and Luker (2005) conducted a study of 29 specialist cancer nurses (SCNs), using a combination of observation and interviews to explore how well SCNs were able to execute their role of supportive care within the multidisciplinary teams being applied in the UK. They found that SCNs had difficulties in implementing their role (the provision of supportive interventions for patients) because other clinicians did not support them in carrying out their role, either by not allowing SCN’s sufficient time and resources to meet the non-treatment needs of patients, by not referring patients to the SCN, or not understanding the role of the SCN. The authors attributed these difficulties to the conflict between the policy driving the system, which promotes patient centred supportive care, and the reality, which prioritises treatment over patient’s supportive needs as a result of the traditional dominance of doctors in the health care team and the focus on improving waiting times and treatment outcomes within the healthcare system (Willard & Luker 2005).

Working in a multidisciplinary team can have mental health implications for the members of the team, positive or negative, depending on the individual’s role within the team and their understanding of their roles (Catt et al. 2005). A team that works well together will provide emotional and intellectual support for each other, resulting in decreased stress and increased professional satisfaction (NBCC 2003).

Multidisciplinary team work also has implications for the medico-legal responsibilities of team members. These implications include concerns around patient consent (including financial consent), identification of patients in team
meetings, and professional indemnity (Evans et al. 2008; NBCC 2007; NBOCC 2008b). However, the NBCC (2007) has developed guidelines for minimising medico-legal risk in MDC through clear identification of roles and responsibilities within the team, clear reporting of MDT meetings, and obtaining informed patient consent before involving them in MDC.

6.8.2 How Do these Innovations Affect Workforce Planning?

Changes in health service provision brought about by an increasing focus on chronic disease due to ageing populations among other factors, changes in the linkages between service providers, consumers and carers, changes in the type and complexity of work due to technology advances, increased workforce diversity, workforce shortages and increased costs demand a more cost effective way of using the health workforce (AHWAC et al. 2005).

A 2002 Canadian report reviewed the current workforce planning approaches of Germany, the Netherlands, Australia, New Zealand, United States of America, and the United Kingdom in relation to health service provision (Mable & Marriot 2002). In doing so, it highlighted international changes in how health workforce planning is tackled. The focus of workforce planning, at the time of this report, was in a transition from a primarily physician focussed model to a broader health workforce model (Mable & Marriot 2002). Primary health care reform and the incorporation of inter- and multi-disciplinary teams into their health care systems were key considerations in Australia, New Zealand, the US, the UK, and Canada, with planning approaches moving to encompass the total workforce, both at the level of each professional group and at the level of integrated teams (Mable & Marriot 2002).

In Australia, a more recent (2005) paper on health workforce planning outlines the need to employ a ‘models of care’ approach to health workforce planning instead of the traditional profession- or occupation-based planning (AHWAC et al. 2005). The ‘models of care’ approach allows the development of workforce plans that are consumer-focussed, aligned with service delivery plans, multi-disciplinary and multi-occupational, and holistic (AHWAC et al. 2005). Difficulties in implementing a ‘models of care’ approach involve the complexity of this form of workforce planning, which is exacerbated by the broad variation in the model of care employed (AHWAC et al. 2005). It is for these reasons the paper produced a general guideline for implementing ‘models of care’ workforce planning in Australia rather than detailing how to go about this style of workforce planning (AHWAC et al. 2005). The guideline consists of three stages: ‘planning to plan’, which consists of identifying the health issue or workforce group to be addressed and clarifying the objectives of the planning project; ‘assessment of present models of care,’ which aims to provide evidence to support the workforce strategies that can then be recommended; and ‘changing models of care,’ which consists of recommending changes to the current model of care, should this be supported by the findings of the second stage (AHWAC et al. 2005).

The multidisciplinary model of care also impacts workforce initiatives in practice. It is necessary to promote careers in cancer to ensure that people enter training programs and ensure that there is a trained, skilled health workforce for the future. An initiative by the American ‘C-Change’ alliance of cancer organisations tackled the
promotion of cancer careers to high school and college aged students using a multidisciplinary approach to overcome fragmentation in promotional activities and perceived ‘competitive threats’ in promoting single streams of cancer careers (Smith 2005). They developed a program to promote all careers in cancer across the continuum of care, which they believe will prove to be a sustainable effort to build the cancer care workforce (Smith 2005).

6.8.3 How Do these Innovations Affect Outcomes for Women With Cancer?

Whilst there is much literature about the impact of MDC on outcomes for patients in general, the current review focussed on gynaecological cancer and breast cancer. The inclusion of breast cancer was considered pertinent due to the extent to which NBOCC has supported and developed MDTs, and that it includes ovarian cancers in its remit. However, given the differences in incidence and mortality rates, and the implications of these differences for the structure and practices of the workforce, care needs to be taken in transposing findings from one field to the other. Empirical studies into the impact of multidisciplinary cancer service delivery on the outcomes for patients are difficult to conduct because of the challenges in distinguishing the effects of multidisciplinary care from those of other changes which, according to Fleissig, Jenkins, Catt & Fallowfield (2006) include advances in diagnosis and treatment, increased specialisation, improved facilities, the introduction of evidence-based guidelines and protocols of care, changes in referral policy, and raised public awareness.

6.8.3.1 Gynaecological Cancer

There are a few studies that provide evidence for the use of specialised, multidisciplinary teams in gynaecological cancer care. Junor, Hole and Gillis (1994) conducted a retrospective study of all 533 cases of ovarian cancer in Scotland in 1987, in order to assess the impact of variations in prognostic features and cancer service organisation and delivery on survival outcome. The results, adjusted for age, stage, pathology, degree of differentiation, and the presence of ascites, demonstrated that survival increased when patients received appropriate treatment by a gynaecologist and were referred to a multidisciplinary clinic.

Jeffries and Chan (2004) provided further support for the positive impact of multidisciplinary teams in gynaecological cancer care in their case study of the Cancer Service Collaborative at the Birmingham Women’s Hospital. Multidisciplinary team meetings had been in place at the hospital for 5 years incorporating gynaecology oncologists, clinical oncologists, medical oncologists, histopathologists, cytologists, radiologists, registrars and senior house officers, the lead cancer nurse, the clinical nurse specialist and a representative nurse from the gynaecology oncology ward. This case study detailed the introduction of a second set of multidisciplinary team meetings aimed at incorporating other health care professionals into the management of care through weekly meetings of the Director of Gynaecology Oncology with the clinical nurse specialist, the ward manager or nurse, the physiotherapist, dietician, occupational therapist, and the social worker to discuss all active cases. The authors noted that the entire team of health care
professionals believed that the more holistic multidisciplinary team meetings were beneficial to the patients.

Another British study of cancer service delivery and its impact on the outcomes for women with gynaecological cancer was conducted by Kehoe, Powell, Wilson and Woodman (1994). In this study, the authors retrospectively analysed the 1184 patients with histologically confirmed ovarian cancer registered with the West Midlands Cancer Registry between 1985 and 1987. The aim of the research was to compare survival patterns of patients operated on by gynaecologists and general surgeons. The results demonstrated that the median survival rate was significantly higher when patients were operated on by a surgeon specialising in gynaecology rather than a general surgeon (Kehoe et al. 1994).

6.8.3.2 Breast Cancer

The effectiveness of multidisciplinary breast cancer teams was systematically evaluated by Haward et al. (2003) who gathered information about team constitution, processes, effectiveness, clinical performance, and team members’ mental well being from 72 breast cancer teams in England. Multiple regression was used to analyse the data, demonstrating that important relationships existed between team composition and outcome, higher workload predicted better clinical performance, leadership styles were important to effectiveness, and mental health was better for team members than for people in other health settings in the UK or for the general population.

Chang et al. (2001) compared the treatment recommendations made by external physicians and by a multidisciplinary panel at the University of Pennsylvania Cancer Centre for 75 women presenting with breast lesions in 1998. That there was a lack of agreement between the treatments recommended by the external physician and the multidisciplinary panel for 32 of the women and a major change in diagnosis for 3 patients demonstrated the efficacy of the multidisciplinary team. However there was no follow up of which treatment patients underwent, no cost analysis of the process, and the recommendations made by the team were based on their collective judgement rather than evidence based guidelines.

Similarly, Newman et al. (2006) assessed the impact of multidisciplinary care on the surgical management of breast cancer. Retrospective analysis of patients records for 149 consecutive patients referred to the multidisciplinary board at the University of Michigan Medical Centre in the year from July 2000 to June 2001 were reviewed for changes in radiologist, pathologist, surgical and medical interpretations and the resulting changes in surgical and medical treatment recommendations. This analysis revealed that 77 of the patients had a different treatment recommended by the multidisciplinary tumour board, and in at least 7 per cent previously undetected or residual cancers were identified by the board. These treatment decisions were also based on the judgement of the board rather than treatment guidelines and the effect on patient outcomes and survival is unknown (Newman et al. 2006).

In another US study, Gabel et al. (1997) used a combination of a retrospective analysis of patient charts and patient questionnaires to assess the value of a ‘one stop shop’ multidisciplinary breast cancer clinic from the patients’ perspective. Comparison of
162 patients evaluated at the Henry Ford Hospital in the year prior to the opening of the clinic and 177 patients evaluated in the year after the opening of the clinic revealed that those treated in the clinic had increased levels of patient satisfaction in relation to involving their family and friends, and in helping patients to make decisions, as well as a decrease in the length of time between diagnosis and the initiation of treatment.

These studies demonstrate that multidisciplinary care in various forms through the spectrum from multidisciplinary tumour boards to ‘one stop shop’ clinics can alter outcomes for women diagnosed with either gynaecological or breast cancer.

6.9 Conclusion

A review of the models of care proposed in the Australian and comparable international cancer control plans identified seven innovations in the model of cancer care provision, multidisciplinary care, patient-centred care, chronic care, supportive care, evidence based care, and the introduction of clinical guidelines and referral pathways. However, this literature review focussed solely on multidisciplinary teams.

Changes to the model of cancer service delivery include incorporating new roles and changing the previous roles and interactions of professionals, and this has positive implications for the mental health of professionals as well as medico-legal implications. In Australia, resources to aid the transition for professionals into MDC have been provided by the NBOCC however these are aimed at breast cancer teams and whilst they should be transferable to MDT for all types of cancer, they may need to be altered for use with gynaecological cancer teams, and reviewed as teams become more established. Of particular relevance are the differences in the structure and coordination of the workforce in the treatment of women with breast cancer compared to those with gynaecological cancer based on different incidence and mortality rates of the different forms of cancer. CanNET also provides some tools to aid professionals in MDT including reference lists for recent research around MDC, a directory of cancer assessment teams, materials for quality assurance in MDC, and information about professional development provided by Cancer Australia. These general cancer MDC tools should be useful for applying to gynaecological cancer teams.

Research into multidisciplinary teams in gynaecological cancer demonstrates that this model of care improves outcomes for women, but such studies are more than a decade old, based on international (UK) models of care, and have some weaknesses in terms of confounding factors such as work load of clinician, whether the hospital is a training hospital or not, advances in diagnosis and treatment, increased specialisation, improved facilities, the introduction of evidence-based guidelines and protocols of care, changes in referral policy, and raised public awareness. Recent Australian research into multidisciplinary teams in the cancer context has been focussed on breast cancer, which is probably the most comparable cancer group to gynaecological cancer, given that it is a predominantly female cancer, and the two areas have similar workforce requirements. These studies do not document improved clinical outcomes, but use surveys of clinicians to demonstrate that MDC improves patient care. Several US studies have demonstrated that multidisciplinary
care through a panel of specialists alters the treatment recommendations for women with breast cancer, however they did not examine whether women elected to undertake the recommended treatment or whether this improved their outcomes. Another US study did demonstrate that a ‘one-stop’ multidisciplinary clinic did improve patient satisfaction and the time between diagnosis and initial treatment. No evidence was found demonstrating that multidisciplinary care has a detrimental effect on the outcomes for women.

The core gynaecological cancer MDT is comprised of the gynaecological oncologist, the medical oncologist, the radiation oncologist, the gynaecological pathologist, and the specialist nurse. Australian literature details a more holistic team including palliative care specialists, psychologists or social workers, and GP’s, and other specialists who might be included are dieticians, geneticists and genetic counsellors, anaesthetists, clinical nurse specialists, students, and the multidisciplinary team co-ordinator (if not already included in another role). Who should be included in each team depends on the type and stage of the cancer for the individual with gynaecological cancer.

Some information about what skills members of a MDT might need, such as intra-team communication and communication of information to the consumer that is holistic (including psychosocial, psychosexual and palliative care) and culturally sensitive, has been gleaned from material aimed at general health professionals or focussing only on one member of the MDT. More research needs to be conducted into what competencies multidisciplinary team work requires from gynaecological oncology professionals, and what resources are needed to support the development and assessment of these competencies.

Broad models have been developed to modify workforce planning for health services to take into account changes in the model of care. However at this stage the complexity and flexibility of the system have prohibited the development of a method for putting this model into practice. Further research is required into how workforce planning models based on the models of care approach can be implemented.
7. Conclusion

This review was conducted to inform the development of workforce strategies which would ultimately improve outcomes for women with gynaecological cancers. To do this we took a multi-faceted approach that brought together a range of perspectives on the workforce. We particularly focused on occupations involved in the direct care and treatment of women with gynaecological cancers. Each of the five components of the review had a specific research focus and methodology, and a comprehensive summary of the findings is provided in the conclusions to each section of this report. Throughout the report we have identified areas of strength in workforce capacity and service delivery, gaps in knowledge and service delivery and a number of issues that are likely to impact on workforce planning and development.

In bringing this review to a conclusion, we highlight three key findings. First, the gynaecological cancers workforce has been shaped by the relatively low incidence levels and high mortality rates of the disease. Second, the extent that ‘a gynaecological cancers workforce’ can be identified is limited. Instead there are at least three strands to the workforce, each with different levels of involvement in gynaecological cancers and this has implications for workforce planning. Third, the models of care through which women with gynaecological cancers are treated impact on the structure of the workforce. These models of care are influenced by policy directions as well as institutional factors which affect treatment options. In recent years there has been a shift toward patient-centred care, having standardised referral pathways and working within multidisciplinary teams. The research highlighted a number of issues for consideration in the further development and implementation of appropriate models of care for treating women with gynaecological cancers. The conclusion ends with a summary of the implications of our findings for workforce planning.

7.1 Gynaecological Cancers And The Workforce

Gynaecological cancers have relatively low incidence rates and high mortality rates, and this shapes the workforce. With current incidence rates at about 3,800 cases per year, the improvements in screening and prevention (e.g. vaccination) programs are likely to decrease this even further. Given this projection, the workforce in those occupations that are almost entirely concerned with the treatment of women with gynaecological cancers (i.e. gynaecological oncologists) will continue to be small and unlikely to undergo substantial rates of growth.

The relatively high mortality rates, especially for ovarian cancer, has resulted in a workforce that primarily provides acute care and specialised medical interventions, rather than those aspects of care associated with having a long-term chronic illness (although palliative care has been recognised as important in some health services). The effect of this is that there is a core of highly specialised gynaecological oncologists that have played a central role in shaping the treatment and care of women with gynaecological cancers. From patients’ perspectives the treatment of

20 This meant that the contribution of, for example, researchers and health professionals involved in screening and prevention programs were not part of the analysis.
their gynaecological cancer during this acute stage was good, although the speed of the intervention sometimes made it difficult for them to assess the benefits of suggested therapies.

In improving the outcomes for patients further, there is now an increasing emphasis on treating gynaecological cancer as a chronic disease. Such a shift is likely to highlight women’s need for psycho-social/sexual support, ongoing lower limb lymphodoema treatment, and advice on diet and nutrition that may improve their quality of life. It will also highlight the importance of patients’ personal, cultural and geographical differences in affecting outcomes. Throughout the review it was evident that women in rural areas and Aboriginal women (particularly in remote areas) have specific needs that require more consideration in service delivery and care plans. To date these differences appear to have had less of a systematic focus in treatment plans or health service approaches. Given the current trends in health policy initiatives toward cancer control, the expansion of the gynaecological cancers workforce to include a greater range of health professionals and provide care across the geographical spectrum appears plausible.

7.2 The Three Strands of the Gynaecological Cancer Workforce

While it is possible to identify those occupations that either have, or are likely to have, a designated role in the treatment and care of women with gynaecological cancers, delineating the characteristics of this workforce has been somewhat more difficult. In the absence of existing data that was comprehensive and comparable, our findings are based on consultations with patients, workers and key stakeholders. These cover the five selected health services plus clinicians (usually gynaecological oncologists) in each state, and professional and advocacy organisations with an interest in gynaecological cancers. Our findings suggest that instead of speaking about a gynaecological cancers workforce, it is more appropriate to distinguish between the different strands of the workforce as each of these has different training/skill needs and characteristics.

7.2.1 Designated Gynaecological Cancer Occupations

There is a small group of health professionals who work almost exclusively with women with gynaecological cancers. These include the 36 gynaecological oncologists, all located in metropolitan areas, of whom 86 per cent were male and 50 per cent were aged 45-54 years. They are the only occupational group with a career dedicated to gynaecological oncology. To register as a gynaecological oncologist, they must spend at least 66 per cent of their time in gynaecological oncology practise, have undertaken a three year formal training program and passed their examinations. The supply and training of gynaecological oncologists is overseen by RANZCOG. Gynaecological oncology nurse coordinators also work primarily with women with gynaecological cancers. This is an emerging role that has yet to be clearly defined. Common to this role is working closely with gynaecological oncologists and coordinating the patient journey from diagnosis to intervention. Some nurse coordinators also coordinate care after patients leave hospital. There are differences in the location of gynaecological nurse coordinators, with some working in a gynaecological oncology practice, some working more in the wards where they
help coordinate care while patients are in hospital, others work at a regional level with responsibility for coordinating care across health services. There are also differences with respect to their involvement in multidisciplinary teams (tumour boards). Most nurse coordinators have prior experience in working with women in gynaecological cancer, although they may or may not have undertaken formal training. Often their move into the role is opportunistic rather than career defined, although they may have come from a specialisation (e.g. oncology nurse) which provided these opportunities. Little is known about other characteristics of nurse coordinators as it is a relatively recent role and there are relatively few of them. This makes it difficult to capture their role through existing data sources.

7.2.2 Career-Defined Gynaecological Cancer Occupations

There are several occupational groups which have a role in the treatment and care of women with gynaecological cancer, but who do so as part of their broader medical specialisation. This includes medical oncologists, radiation oncologists, anatomical pathologists and haematologists. Their role in gynaecological cancer care is career-defined in that it is highly specialised and clearly specified, and there are career benefits in developing their skills and knowledge, in creating and maintaining collegial networks (used in referral pathways), and in continuing the practice in the area once they have established networks and expertise in it. This component of the workforce is generally systematically incorporated in treatment plans, with their contribution being coordinated through either involvement in multidisciplinary teams (especially in the public sector) or through collegial networks (in the private sector). Despite this, little useful data exists about the extent of their involvement in gynaecological cancer care, their distribution outside of metropolitan areas or the difference that having a gynaecology sub-specialty might make to outcomes for patients. We do know that women are entering some of these occupations in increasing numbers, and that more women than men work part-time. There were also differences in the proportional distribution of these occupations across the states and territories.

7.2.3 Non-Designated Gynaecological Cancer Occupations

Even less data exists on the roles and characteristics of a much larger group of health professionals for whom having a role in gynaecological cancer care is marginal, or at least less central, to their overall career trajectory. General practitioners, nurses (ward, clinical, surgical), and allied health professionals fall mainly into this category. They may, at certain times in their career have a role that means that caring for women with gynaecological cancer is a major part of their work; or they may, as part of their overall career, come into contact with patients on an infrequent basis. Often the participation of these workers in gynaecological cancer care is opportunistic rather than intended. From a workforce planning perspective this strand of the gynaecological cancers workforce presents unique challenges. One such challenge relates to training and skill development. Currently there appears to be little incentive for workers to undertake relevant training in gynaecological cancer care, even though there was a level of enthusiasm expressed for doing such training by nurses and GPs. At present such training tends to be ad-hoc, reliant on individual commitment with only tangential benefit to their overall career. There also appears to be little formal recognition of the skills that health professionals do acquire in
working in the area of gynaecological cancer care. For example, some surgical and ward nurses have highly developed specialist expertise in gynaecological cancer care. Developing modes of recognition and retention incentives could help to reduce turnover and further build on the body of skills and knowledge.

The second major challenge in workforce planning for this group of health professionals is that of coordination. This is a challenge at different levels. The nature of this workforce is such that there is a constant flow of workers in and out of gynaecological cancer care. This means that medical services need to be organised in ways that accommodate this level of flexibility and turnover. One way of doing this would be to ensure that there is an adequate number of well-skilled, appropriately distributed workers across the various professional groups thereby providing a pool of potential workers to draw upon. Having a workforce dependent on a flow of workers is also a challenge for managing the relationships between specialised, career-defined and non-specialised health professionals. Collegial networks are likely to be weaker between these groups, so mechanisms for systematically engaging the various occupational groups are required. To some extent the ‘models of care’ approach being implemented in the cancer control plans addresses this issue. However, action on this has been uneven.

7.3 Models of Care

Models of care influence how, when, and where health services for women with gynaecological cancers are provided. They are therefore critical to the outcomes for women. Just as importantly they influence the structure, location and coordination of the workforce. As such, health workforce planning is increasingly taking account of models of care. In the field of cancer care (including gynaecological oncology), the various models of care are currently in a transition phase. This review identified numerous shifts in the models of care that will have workforce implications just as it will have implications for the outcomes for women. We have not attempted to identify or propose a model of care for gynaecological oncology: a task that would require a different kind of review. In this section, however, we identify factors raised in our research that may need to be considered when developing models of care for women with gynaecological cancers.

7.3.1 Structural Framework (Cancer Control Plans)

The policy framework within which cancer care takes place is undergoing a period of change. The state cancer control plans are in various stages of development but aim to provide a systemic, strategic approach to implementing new models of care based on notions associated with chronic care, patient-centred care, multidisciplinary care, referral pathways and clinical networks. The consultations on this aspect of the review indicated that each state faces particular issues in the implementation of the plans and in their ability to attract and retain the appropriate workforce. Nevertheless, the plans are resulting in workforce efficiencies with respect to codifying referral pathways and clinical guidelines and general improvements in service coordination. There are moves towards skills escalation whereby health professionals work at the top of their skills and knowledge base on tasks that only they can do. However, the plans are also resulting in workforce expansion. New roles (lead clinicians and nurse coordinators) have been created; other occupations
(in allied and primary health care) are having their roles extended into oncology; and services are expected to extend beyond the metropolitan area.

The cancer control plans provide the structural framework guiding the location of services. In the case of gynaecological oncology, surgical services are to be located in metropolitan areas. The plans aim to rationalise services to key hospitals. In states such as South Australia this will mean moving from the current multi-site approach to one where service provision is focused at the Royal Adelaide Hospital. In larger population states, such as Victoria, services are aligned with the area health plans. The plans also integrate follow-up services such as radiation therapy and chemotherapy into a structure aimed at providing care across the illness spectrum. The plans therefore influence the workforce in relation to their location and their coordination.

From our review of the plans and the experiences of health professionals and patients, the coordination of workforce is influenced by three elements of the plans: referral pathways and clinical networks, patient-centred care, and multidisciplinary teams. Referral pathways provide the routes through which women access particular health professionals as they are required. At another level these pathways aim at creating efficiencies in the workforce by ensuring that appropriate health professionals only treat women when their skills (ie skills that only they are likely to have) are required. The development of these pathways for women with gynaecological cancers is still underway (Victoria has a one for ovarian cancer) and understanding the illness trajectory of women with different kinds of gynaecological cancers, and perhaps who present at different stages of their illness, would assist in ensuring the pathways were relevant and effective. There may also be some scope for transferring knowledge about referral pathways, and models of care more generally, across the states. Issues relating to patient-centred care and multidisciplinary teams are discussed in separate sections below.

7.3.2 Patient-Centred Care

At a broad level there appeared to be some confusion over the terminology associated with patient-centred care. For some health professionals, patient-centred care meant thinking about the patient as a person rather than a tumour; others indicated that it meant involving women in decision-making about their illness; while for others it was about providing women with the opportunity to access services at a local level – ie near their home. From the cancer control plans it would appear that the term refers to all of these ideas. That is, one of the central tenets of the plans is to develop a model of patient-centred care which takes account of equity, access, agency and cultural relevance. Research conducted for the review indicates that this is an area that raises significant problems for gynaecological cancer treatment and patients.

Women experience gynaecological cancer differently and a truly patient-centred approach would have the flexibility to accommodate these differences. To a certain extent this is the goal of working within multidisciplinary teams and this is discussed further in section 7.3.4. Some of the broader issues relating to patient-centred care for women with gynaecological cancers are discussed here as a means of bringing
together areas that need consideration in the future development of a patient-centred model of care.

a) **Gender of health professionals:** While the majority of women indicated a preference for female health professionals, gender was not the defining factor in satisfaction with their care, except for remote Aboriginal women who have a strong preference for a female health professional. With only one-third of radiation oncologists or medical oncologists, and less than one-fifth of gynaecological oncologists being female the recruitment of women into these fields could have benefits.

b) **Co-locating patients with gynaecological cancers:** Currently this decision appears to be beyond the sphere of influence of individual gynaecological oncologists or tumour boards. Partly, this would be associated with the relatively small numbers of women with gynaecological cancers being admitted to hospital. This lack of a ‘critical mass’ may mean that having a dedicated ward or bay is impractical. However, the alternative of having women spread throughout several wards or located in wards that were seen as inappropriate by the women (obstetrics, mixed sex wards), affected patients’ satisfaction with their treatment and care. Not only is it uncomfortable for the women, but there are also workforce development issues. For example, nurses are unlikely to acquire experience or specialised skills in working with gynaecological cancers, or be exposed to the field for long enough to want to develop an interest in it. It would also be easier to coordinate multidisciplinary care and systematically involve a broader range of health professionals if patients were co-located.

c) **Psychosocial/sexual and allied health care:** There was little evidence that health professionals address the psychosexual needs of women or that there is any provision for the emotional impact of gynaecological cancer. While the cancer control plans advocate meeting these needs, the implementation is currently limited. For example, there are inconsistencies in which disciplines participate in care and the extent to which women can access these types of care. There is therefore a need for a more systematic approach to ensuring that women are offered appropriate access to these services at different stages of their illness trajectory.

d) **Continuation of care:** Women were generally satisfied with their care during the acute phase of their illness, however difficulties with the coordination of ongoing care following discharge from hospital were identified by several women as a problem. The major breakdown in team work was between the hospital health team and the woman's GP. Where the GP was included in post-operative care the outcome was a positive experience for the women. This was more likely to occur when there was a gynaecological oncology nurse coordinator. There is a need for a systematic process for ensuring the involvement of GPs in care plans.

e) **Involvement of family/carers:** In the absence of having a GP or other health professional available to communicate with about any health concerns, the woman’s carer inevitably became the case manager. The research identified
an increasing dependence on patient’s carers – usually family and friends – to provide ongoing emotional care, physical care and material support to women with gynaecological cancer. The roles of these carers appeared to be rarely acknowledged or taken into consideration when developing care plans. At a minimum providing them with protocols about what to do in adverse events would give them more confidence in their caring role.

f) **Services for rural women:** Service delivery for rural women was viewed as problematic by health professionals, state planning authorities and patients. Women in rural areas often had poor coordination of care as well as issues in accessing appropriate care. The availability of the PAT (patient transport) scheme was used by some women but appeared to have anomalies which may need addressing. As all women requiring surgery need to travel to a metropolitan centre, the availability of transport (and accommodation) for themselves and family is an issue throughout the care trajectory. In relation to accessing local care, WA and NSW had implemented measures specifically for rural women. In WA, a gynaecological oncology nurse coordinator provided a referral and advisory service and liaised with regional nurse coordinators to ensure that women had access to services. In NSW a list of contact people covering every rural town is being developed to assist women returning home after surgery. A variety of models of care are needed to assist rural women with evidence suggesting that these are still evolving.

g) **Services for Aboriginal women:** Implicit in our reporting on the cultural needs of Aboriginal women is the requirement for female health professionals; doctors, nurses, allied health professionals, Aboriginal Health Workers and hospital liaison workers. Beyond this we are hesitant to make specific recommendations given the principle in indigenous health that *one size does not fit all.* The rural Aboriginal women interviewed had strong ideas on racism and the desire for family support during illness, but were not focused on more specific cultural issues such as the desire for a female doctor. On the other hand the reports from female doctors in the NT noted the need for female doctors, nurses and other health professionals for women from remote communities. They also noted the value of employing Aboriginal staff, but qualified this by noting that given the sensitive nature of gynaecological cancers, this may at times be inappropriate. Given the differences, designing a culturally specific model of care would not meet the needs of all women and would assume the culture was static and homogenous. What is needed is resources for ensuring the principles of culturally appropriate care are in place. Despite the best intentions this will not always be possible, but the employment of Aboriginal liaison health workers, or community nurses that operated as brokers to ensure a smooth pathway, would be of assistance here. Gynaecological oncology nurse coordinators who already provide such services (ie in WA) suggest that an appropriate allocation of time and money for coordination will influence the outcomes for remote Aboriginal women with gynaecological cancer.

General principles for effective and culturally safe care are well known. They include:
• Employment of Aboriginal staff in clinics and hospitals.

• Recognition of Aboriginal women’s sense of modesty and ‘shame’ around gynaecological issues where ‘illness’ may be interpreted by others as a sign of sexual promiscuity and result in stigma. This requires considerable tact, discretion, and sensitivity as to whether it is appropriate or not to bring local Aboriginal staff into the picture. It is not always appropriate given the need for confidentiality and the fact that Aboriginal staff may be relatives or neighbours.

• Ensuring clinics in remote settlements, or towns, are women only.

• The use of qualified and appropriate interpreters. Where women are evacuated to a major capital city the interpreter should accompany them. This was a practice in the past in the NT.

• Use of PAT scheme to pay for family members to accompany woman to major capital city for treatment.

• When women from remote areas are in capital cities for surgery and treatment they should have continued support from Aboriginal liaison staff to ensure personal issues are dealt with while away from extended family. This care should be extended to the family member who accompanied them.

• Ensure woman and family member have access to money for necessities.

• Appropriate and well coordinated discharge with transport to airport, support on arrival, transition accommodation and assistance in getting home without undue distress.

• Opportunity for patients to access traditional healers/ceremonies before evacuation or surgery.

• While in hospital in capital city or large rural town, ensure Aboriginal female patients (especially those from remote communities) are in woman only wards/bays etc at all times and treated by female doctors, nurses at all times. This principle would have implications for gynaecological oncologists, most of whom are men.

• Timely and detailed medical notes to be sent to home clinic. The major issue here would be to ensure that visiting medical officers and visiting remote area nurses had access to data so this will require some coordination. In some rural and remote areas, teleconferencing and video links are being used to assist with the coordination of care.

7.3.3 Multidisciplinary Teams

The cancer control plans encourage the development and use of multi-disciplinary team (MDT) care for people with cancer. Multi-disciplinary teams are viewed as an efficient means of coordinating care and managing ongoing care across an illness
trajectory. The shift in models of care toward MDTs was identified as an important issue by Cancer Australia and as such it formed a line of inquiry across the review. In providing a mechanism for coordinating the workforce, MDTs have implications for workforce planning with respect to the development of particular competencies and skills, whether the designated occupational groups have access to MDTs and are available to participate, and how roles and referral pathways are delineated.

Different models and definitions of MDTs were identified from the consultations. Finding a common language for speaking about multidisciplinary care and multidisciplinary teams would ease the confusion in this area and help to clarify what kind of multidisciplinary team is being used or advocated for specific purposes. Three levels of patient-related MDT care were identified: the tumour boards, ward care and post-discharge care. Each of these teams were comprised of different health professionals, although there was overlap, and they met for different purposes. The tumour boards focused on the removal of the tumour and follow-up treatment of the tumour site (e.g., radiation therapy or chemotherapy). MDTs in the ward would involve a broader range of health professionals focused on assisting women through the acute phase of their illness. This team might include gynaecological oncology nurse coordinators, dieticians, physiotherapists, palliative care nurses, social workers and other allied health workers. MDTs for post-discharge care focussed on assisting women to manage their illness once they had returned home. This team might include GPs, community nurses and local allied health professionals. There were issues with the coordination of the latter two forms of MDT to the extent that the approach was more aligned to multidisciplinary care rather than team.

MDTs are usually led by gynaecological oncologists, although they might be coordinated by a nurse coordinator or registrar, and are predominantly found in the public sector. In the private sector multidisciplinary care was coordinated by the gynaecological oncologist via collegial networks, although there appeared to be variability in the extent to which this systematically occurred. Some participants expressed concern that there were (financial) disincentives to participate in MDTs in the private sector. Coordination of multidisciplinary care across private and public health services, as might occur with specialist outreach services, was an issue for the care and treatment of women in rural and remote areas. On a positive note, several innovations were discussed in relation to facilitating a more inclusive MDT approach in these areas through the use of video and tele-conferencing.

All incidences of gynaecological cancer are brought before a tumour board during the acute phase of care to manage and coordinate surgical and medical (particularly chemotherapy and radiation therapy) interventions. The use of MDTs beyond the tumour board varied across states and health services. Patients reported experiencing multi-disciplinary care as they were visited by various specialists (mainly anaesthetists and gynaecological oncologists) while in hospital and were then referred to other specialists post-operatively. However, it was rare for women to be privy to the impact of MDT decisions on her care and there was evidence of a breakdown in the coordination of care upon leaving hospital, particularly for women in rural areas. The extent to which this is a systemic problem cannot be ascertained from our research. As discussed above, where GPs were involved in care plans following a patient’s discharge from a health service, the outcome was more positive. Although patients were largely unaware of the coordination of their care by MDTs,
this was largely an effect of the lack of patient inclusion rather than the absence of MDTs.

Issues for consideration when developing a model of care based on the multidisciplinary team approach include:

- ways of adapting MDTs for use in rural and remote areas;
- a systematic process of involving GPs, nurse coordinators and allied health professionals in the MDT approach at particular stages of an illness trajectory as relevant to patient needs;
- a clear delineation of roles and referral pathways within MDTs;
- ways of ensuring that patients and their carers are informed and consulted about treatment / care options discussed in MDTs and that support is available to enable them to access health services;
- a process for inducting new members into the MDT;
- the extent of formalisation (with consequent financial incentives for participation) and administrative support; and
- the impact of duplication on workload where health professionals are required to be members of multiple MDTs

Some of these issues were reinforced in our analysis of the academic and grey literature on MDTs in Australia and comparable Anglophone countries. In this analysis some evidence was found regarding the preferred composition of MDTs, but very little on the required competencies. One Australian study had developed a set of principles for the establishment or extension of MDT care and one international study had taken a competency-based approach to MDTs. The analysis of the literature revealed tensions between providing flexible management plans that are responsive to patient’s needs at various stages of the illness trajectory, and having a systematic approach to MDTs that identify particular membership and competencies. As a result many MDTs are idiosyncratic, thereby making it difficult to measure and compare outcomes. The evidence-base for using MDTs in gynaecological cancer care is therefore relatively weak, although no evidence was found that indicated it was detrimental to outcomes for women.

In addition to their importance for the treatment of women with gynaecological cancers, one of the suggestions from the review is that MDTs could also be used as arrangements for staff training and retention. MDTs undoubtedly already serve some training purposes, particularly for specialist medical staff. However, where our interviewees suggested skill deficiencies amongst medical staff treating gynaecological cancer patients, these were most often in relation to other staff. These staff included some ward and theatre nurses, and junior medical staff. Such staff are amongst those for whom specialised formal training in gynaecological cancer care and treatment is likely to be limited. Their acquisition of specialist skills and knowledge in relation to gynaecological cancer therefore occurs largely directly through their work. In these circumstances, the organisation of work through MDTs
may appropriately be viewed as an important dimension of the on-the-job opportunities for skill acquisition experienced by these staff. Modification of some aspects of MDTs is likely to arise from such a view. For example, tumour board meetings tend currently to be focused around specialist medical staff, and their input. In some centres, other staff are involved. Viewing these meetings, and the coordination of care arising from them, as training opportunities for non-specialist staff may have real benefits. It is possible that this would have flow-on effects to the organisation of care within health services.

7.3.4 Enablers Of Change

To be effective, a model of care needs to be implemented. Experience with the implementation of the cancer control plans indicates that there are specific enablers in bringing about widespread structural change. These include:

a) **Support from government** by way of funding, advocacy by relevant ministers and bureaucrats, or in the ways in which proposed changes intersected with broader government reforms. Where the cancer control plans clashed with other health reforms or were being superimposed on top of existing services, problems arose.

b) **Commitment from clinicians** gained through extensive consultation, involvement in key decision-making structures (e.g. clinical networks) or appointment in lead roles such as lead clinician roles or state-wide gynaecological cancer nurse coordinators. While getting ‘buy-in’ from clinicians is essential, their high workload and long work hours made this difficult. Other issues constraining clinician involvement were their inability to see the benefits of proposed changes and the protection of professional autonomy.

c) **Support of relevant organisations** which had the power and resources to undertake strategic roles in the implementation process.

d) **Clearly structured process** that allowed different sections of the plan to be strategically and simultaneously implemented.

e) **Relevant data** is required to base decisions about appropriate models of care. Currently a system of recording patient data is in development in each of the states. Some concern was expressed that such systems needed to be national.

f) **Workforce capacity** to implement the change requires ensuring that the workforce has the required skills and competencies to undertake new roles, work within different structures and provide the level of service being advocated.

7.4 Implications For Workforce Planning

The findings in this report have a number of implications for planning for a future medical workforce that will have the capacity to meet the needs of new models of care in gynaecological cancer. These implications need to be taken into consideration as new models of care are developed. The most significant implications are:
• Any future model of care is likely to remain focused around the specialist gynaecological oncologists, who will remain a small, highly specialised segment of the medical specialist workforce. It is therefore important that their training and practice remain of the highest order. However, it may be appropriate to give some consideration to moderating the time and demands of the gynaecological oncology training program, especially to increase the number of women practicing the sub-specialty. The small number of specialists is also likely to mean that acute treatment will remain concentrated in metropolitan areas.

• Future models of treatment and care for gynaecological cancer patients will continue to involve medical staff for whom gynaecological cancer work is not necessarily career-defining. For some, gynaecological cancer work will be a major part of their duties for some time, for others it will always be a small part of their work. For most of these staff, formal education and training is, at best, a partial solution to developing the specialized skills that are optimal for their roles. To the extent that they currently do develop the necessary skills, they do so largely on-the-job. At present, much of the skill acquisition that occurs in this way is a side-effect of how work is organized with other goals in mind (notably, treating patients). Future care provision is likely to be improved if work organization in gynaecological care, including ‘models of care’, is understood as having effects on skill acquisition amongst these staff, as well as determining how treatment and care are provided to patients. For example, there are likely to be benefits to the overall skill level of non-specialist staff involved in gynaecological cancer treatment and care if these non-specialist staff are more consciously included in MDT activities like tumour board meetings.

• Any policies or initiatives aimed at developing workforce capacity will need to be cognisant of the wider organisation of the healthcare system. In particular, it will need to achieve accommodation with the exigencies of hospital organisation, and the key role of medical specialists in the design and day to day functioning of any model of care. For example, the exigencies of hospital organisation may create incentives for hospitals not to guarantee co-location of gynaecological oncology patients if there are few of them in the hospital at any given time. This affects the potential for on-the-job skill acquisition in the gynaecological oncology area amongst ward nurses. Ignoring the constraints that lead hospitals to locate gynaecological oncology patients inappropriately (from the point of view of patient comfort and the development of staff expertise) is unlikely to lead to successful arrangements.

• Workforce planning and the development of future care models are likely to benefit from paying particular attention to the collegial relationships amongst specialist and non-specialist medical practitioners. It appears that these relationships are particularly important in coordinating care where more formal organisational processes or linkages are absent or ineffective. They are likely to be particularly relevant for the treatment and care of women in rural and remote areas, especially since acute gynaecological oncology services are likely to remain focused in metropolitan areas.
• The relationships between the public and private provision of gynaecological cancer treatment and care must be attended to in developing future workforce capacity for new care models. Gynaecological oncologists almost universally practice in both systems. How they organise their private practice has significant impacts on the organisation of services in the public system. Although we cannot be certain, it seems likely that, at present, these differences impact particularly on women in rural and remote areas who use the public healthcare system. For these women, relevant local services that may be available through the private system are not always available in the public system, so they are faced with a choice between the high costs of the private system and the considerable expense, disruption and inconvenience of accessing public services in distant centres. Even in metropolitan areas, the organisation of public services is sometimes affected by the need to accommodate specialists’ private practices.

• There is wide agreement amongst the current workforce and patients that greater provision of psycho-social care and support would improve women’s experience as they face life threatening gynaecological cancers. This involves, first, simply providing services not presently available to all women. In some cases this means adding psycho-social services as a component of gynaecological oncology services, while in others it involves developing these services. In particular, there was a common view that providing these services beyond the acute phase of care would be useful. Secondly, improving the provision of psycho-social services involves paying attention to how those providing these services develop the specialist skills and knowledge that will most benefit patients. Since gynaecological cancer work is unlikely to be career-defining for most of those providing these services, much of their specialist skill acquisition will be on-the-job, and it is therefore likely to be beneficial to organise their work with this in mind.
Appendix A: Consultations for the Review of Existing Data

The organisations, government department, hospitals and universities that we contacted seeking for data on the gynaecological cancers workforce are listed below. The first list is of the organisations that were contacted and which provided us with relevant data that was subsequently reported on. The second list is of those organisations that were contacted and received responses from, but did not directly provide us with data that could be used in the review of the gynaecological cancers workforce.

Contact List 1

Faculty of Radiation Oncology, Royal Australian and New Zealand College of Radiologists (RANZCR)

Labour Force Unit, Australian Institute of Health and Welfare (AIHW)

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

Royal College of Pathologists of Australasia (RCPA)

Contact List 2

Allied Health Professions of Australia (AHPA)

Australia New Zealand Gynaecological Oncology Group (ANZGOG)

Australian Nursing Federation (ANF)

Australian Psychological Society (APS)

Cancer Clinical Network SA

Cancer Council South Australia

Cancer Nurses Society of Australia (CNSA). CNSA is the nursing arm of the Clinical Oncological Society of Australia (COSA).

Clinical Oncological Society of Australia (COSA)

Department of Health SA

Discipline of Nursing, University of Adelaide

Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne

Gynaecological Oncology Network, Greater Metropolitan Clinical Taskforce (GMCT), NSW Health
Library, Royal Australian College of General Practitioners (RACGP)

Medical Education Branch, Mental Health and Workforce Division, Commonwealth Dept of Health and Ageing

Medical Oncology Group of Australia (MOGA)

National Breast and Ovarian Cancer Centre (NBOCC)

Nurses Board of South Australia

Oncology Social Work Australia (OSWA)

Public Health Information Development Unit, University of Adelaide

Research Centre for Reproductive Health, University of Adelaide

Research, Planning and Data Project Team, National Health Workforce Taskforce (NHWT)

Royal College of Nursing, Australia (RCNA)

Rural Health Workforce Australia (RHWA)

School of Nursing, Queensland University of Technology (QUT)

School of Nursing and Midwifery, Flinders University

School of Nursing and Midwifery, University of South Australia

School of Paediatrics and Reproductive Health, University of Adelaide

Sydney South West Area Health Service

University Statistics Unit, Policy and Analysis Branch, DEEWR

WA Cancer and Palliative Care Network. Also a Senior Gynae Oncologist and member of ASGO.

WA Cancer and Palliative Care Network

Westmead Hospital, Sydney

Workforce Distribution Branch, Mental Health and Workforce Division, Commonwealth Dept of Health and Ageing

Workforce Infrastructure Branch, Mental Health and Workforce Division, Commonwealth Dept of Health and Ageing

Workforce Mapping Section, Mental Health and Workforce Division, Commonwealth Dept of Health and Ageing
Appendix B: Consultations for the Review of the Cancer Control Plans

<table>
<thead>
<tr>
<th>Consultations for Each State</th>
<th>In-text reference</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW Policy (a)</td>
<td>CEO, Cancer Institute NSW</td>
<td></td>
</tr>
<tr>
<td>NSW Policy (b)</td>
<td>Hunter New England Health</td>
<td></td>
</tr>
<tr>
<td>NSW Clinician</td>
<td>Director, New England Centre for Gynaecological Cancer</td>
<td></td>
</tr>
<tr>
<td>QLD Policy</td>
<td>Program Manager, Cancer Control Team, QLD Health</td>
<td></td>
</tr>
<tr>
<td>QLD Clinician</td>
<td>Director of Gynaecological Oncology, Royal Brisbane and Women’s Hospital</td>
<td></td>
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<tr>
<td>SA Clinician</td>
<td>Gynaecological Oncologist, Queen Elizabeth Hospital</td>
<td></td>
</tr>
<tr>
<td>SA Policy (a)</td>
<td>Manager Clinical Service Planning, Statewide Strategy, SA Health</td>
<td></td>
</tr>
<tr>
<td>SA Policy (b)</td>
<td>Director, Royal Adelaide Hospital Cancer Service</td>
<td></td>
</tr>
<tr>
<td>VIC Clinician*</td>
<td>Surgical Oncologist at Peter MacCallum Hospital; Chief Clinical Adviser for Cancer</td>
<td></td>
</tr>
<tr>
<td>VIC Policy</td>
<td>Acting Manager, Integrated Cancer Services Team, Cancer and Palliative Care Unit, DHS</td>
<td></td>
</tr>
<tr>
<td>WA Policy (a)*</td>
<td>Director of Nursing, Cancer and Palliative Care Network, WA</td>
<td></td>
</tr>
<tr>
<td>WA Policy (b)</td>
<td>Project Director, Cancer Redevelopment, WA</td>
<td></td>
</tr>
<tr>
<td>WA Clinician</td>
<td>Director, WA Cancer and Palliative Care Network</td>
<td></td>
</tr>
<tr>
<td>TAS Policy</td>
<td>Chief Medical Officer, Dept Health and Human Services</td>
<td></td>
</tr>
<tr>
<td>TAS Clinician</td>
<td>Gynaecological Oncologist</td>
<td></td>
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</tbody>
</table>

* Dual roles in policy and as a clinician
Consultations With Professional And Advocacy Organisations / Stakeholders

In-text reference  Organisation or area of interest

DN #  Gynaecological Oncologist, Deb Neesham
CCWA  Cancer Council of WA
RANZCP  Royal Australian and New Zealand College of Psychiatrists
GMCT (NM)  Greater Metropolitan Clinical Taskforce, Network Manager for Gynaecological Oncology and Nuclear Medicine
GMCT (C)  Greater Metropolitan Clinical Taskforce, Consumer, Gynaecological Oncology
CPCN (WA)  WA Cancer and Palliative Care Network, Nurse Co-ordinator, Gynaecological Cancer
CoN  College of Nursing
CK #  Gynaecologist, Chris King
RCNA  Royal College of Nursing Australia
NBOCC  National Breast and Ovarian Cancer Centre
NH #  Gynaecological Oncologist, Neville Hacker
DAA  Dieticians Association of Australia
AGPN  Australian GP Network

# Although all of the people with whom we consulted were accessed via an organisational contact, some requested to be identified personally, rather than as a member or representative of that organisation
## Appendix C: Multidisciplinary Teams

### Table A.1: Summary of Information about Multidisciplinary Teams from the Literature

<table>
<thead>
<tr>
<th>MD team</th>
<th>Title</th>
<th>Principles</th>
<th>Structure</th>
<th>Meetings</th>
</tr>
</thead>
</table>
| AUSTRALIAN | The Australian Cancer Network and National Breast Centre (2004), Multidisciplinary Management of Women, In Clinical practice guidelines for the management of women with epithelial ovarian cancer, Camperdown, NSW. | “The Clinical practice guidelines for the management of women with epithelial ovarian cancer, aim to:  
Improve the quality of healthcare for women;  
Educate those involved in the care of women with epithelial ovarian cancer;  
Assist the decision-making process by women with epithelial ovarian cancer and their doctors; and  
Facilitate the optimal treatment of women with epithelial ovarian cancer.” | MDC may vary across Australia depending on the local availability of resources and arrangements with larger MDC units  
“The minimum standard, regardless of location includes the presentation and discussion of individual women’s cases at a Multidisciplinary care meeting, with expert pathology review and input from a gynaecological oncologist.....in all cases the outcome of the discussion should be relayed directly to the woman and her referring doctor.” | Gynaecological oncologist  
(certified)  
Gynaecological pathologist  
Medical oncologist  
(special experience in ovarian cancer)  
Radiation oncologist  
(special experience in ovarian cancer)  
GP’s  
Specialist nurses  
Physiotherapists  
Pharmacists  
Psychologists, social workers  
Palliative care specialists  
Geneticist  
Genetic counsellors |
<table>
<thead>
<tr>
<th>MD team</th>
<th>Composition (competencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEETINGS</td>
<td>Oncology nurses</td>
</tr>
<tr>
<td></td>
<td>Psychologist/social worker</td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
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<tr>
<td></td>
<td>Dietician</td>
</tr>
<tr>
<td></td>
<td>Data manager</td>
</tr>
<tr>
<td></td>
<td>Gynecological oncologist</td>
</tr>
<tr>
<td></td>
<td>Radiation oncologist</td>
</tr>
<tr>
<td></td>
<td>Medical oncologist</td>
</tr>
<tr>
<td></td>
<td>Gynaecological pathologist</td>
</tr>
<tr>
<td></td>
<td>Palliative care physician</td>
</tr>
<tr>
<td></td>
<td>General medical expert</td>
</tr>
<tr>
<td></td>
<td>Anaesthesiologist</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>AUSTRALIAN</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hacker, N.F.</td>
<td>Presidential Address IGCS: Organization of gynaecological cancer care: a time for change,</td>
</tr>
<tr>
<td></td>
<td>International Journal of Gynecological Cancer, 8 (1), 1-5.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th></th>
<th>Title</th>
<th>Principles</th>
<th>Structure</th>
<th>MD team</th>
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<tr>
<td></td>
<td>AUSTRALIAN</td>
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<tr>
<td>MD team</td>
<td>Structure</td>
<td>Composition (competencies)</td>
<td>Meetings</td>
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</tr>
<tr>
<td><strong>UNITED KINGDOM</strong></td>
<td><strong>Title</strong></td>
<td><strong>Principles</strong></td>
<td><strong>Cancer Unit:</strong> responsible for initial diagnostic procedures, surgery where the risk of malignancy is low, and referral to specialist gynaecological oncology team at the associated Cancer Centre</td>
<td><strong>Lead gynaecologist</strong> (interest in gynaecological cancer)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“the optimum management of gynaecological cancer requires co-ordinated teamwork between three levels of service: primary care, Cancer Units and Cancer Centres, as described by Calman and Hine.”</td>
<td><strong>Lead pathologist</strong> (interest in malignant gynaecological disease)</td>
<td>• Discuss management of individual patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Radiologist</strong> (interest in malignant gynaecological disease)</td>
<td>• Follow documented local clinical policy</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td><strong>Nurse</strong> (interest in gynaecological cancer)</td>
<td>• Decisions are recorded and reported to patients and their GP’s.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Audit of processes and outcomes</td>
</tr>
<tr>
<td>UNITED KINGDOM</td>
<td>Title</td>
<td>Principles</td>
<td>Structure</td>
<td>Composition (competencies)</td>
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</tr>
<tr>
<td>UNITED KINGDOM NHS Executive. (1999). Continued…</td>
<td>Cancer Centre (specialist gynaecological oncology team): a specialist multi-professional team where all members have a special interest in gynaecological cancer for the treatment of less common or more difficult to treat gynaecological cancer. One member should take managerial responsibility for the service as a whole.</td>
<td></td>
<td>2 gynaecological oncologists Radiotherapy specialist (clinical oncologist) Chemotherapy Specialist (medical oncologist or clinical oncologist) Radiologist Histopathologist Cytopathologist Clinical Nurse Specialist</td>
<td>- Meet weekly to discuss management of individual patients - Joint or parallel clinics involving different disciplines - Close contact with other professionals who are actively involved</td>
</tr>
<tr>
<td>UN</td>
<td>Title</td>
<td>Principles</td>
<td>Structure</td>
<td>MD team</td>
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</tbody>
</table>
| | | | General multidisciplinary team | **CORE:**
| | | | | Gynaecology oncologists
| | | | | Clinical oncologists
| | | | | Medical oncologists
| | | | | Histopathologists
| | | | | Cytologists
| | | | | Radiologists
| | | | | Registrars
| | | | | Senior house officers
| | | | **OTHER:**
| | | | | Medical director
| | | | | Lead cancer nurse
| | | | | Clinical nurse specialist
| | | | | Representative nurse from the gynaecology oncology ward
| | | | | Cancer data manager
| | | | | MDT coordinator
| | | | | Medical & nursing students

| UNITED KINGDOM | Jeffries, H., & Chan, K. K. (2004). Continued... | Holistic multidisciplinary team | Director of Gynaecology Oncology  
Clinical nurse specialist  
Ward manager or nurse,  
physiotherapist  
Dietician  
Occupational therapist  
Social worker | • Weekly meeting lasting 30-40 mins  
• Patients discussed include current inpatients, those about to be admitted, recent discharged patients, those who had contacted the clinical nurse specialist for advice or support |