Victorian Cancer News

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COUNTRY CHAIRMEN'S CONFERENCE ISSUE

Cancer welfare and education in country centres were the topics for discussion at the First Conference of Chairmen of Country Cancer Committees, held in Melbourne on 30th November, 1959. One hundred delegates from the country attended the Conference, which was opened by the Rt. Hon. the Lord Mayor of Melbourne, Cr. Bernard Evans, President of the Anti-Cancer Council of Victoria.

Cr. W. J. Kilpatrick, Chairman of the Cancer Service Committee, introduced Sir Peter MacCallum, Chairman of the Executive Committee, who welcomed the delegates on behalf of the Anti-Cancer Council.

The Lord Mayor commended the country committees for their splendid work in raising £300,000 during the 1958 Cancer Campaign. He found it gratifying that they were continuing to assist in the fight against cancer.

The morning session of Conference, under the chairmanship of Cr. Kilpatrick, whose responsibility it was to organise the country committees, discussed welfare problems of cancer patients in the country.

Problems of public education on cancer formed the theme of the afternoon session. Mr. W. A. Dick, Chairman of the Public Education Committee, was in the chair and led discussion on plans for 1960.

The Chief Health Officer of the State Health Department, Dr. K. Brennan, attended the Conference with the Department's Medical Officers. The Anti-Cancer Council is grateful to the Department for its assistance in promoting the country programme.

The Cancer Institute Board (Peter MacCallum Clinic), was represented by its Medical Director, Dr. W. P. Holman, who contributed to the Conference programme.

WELFARE

"THE ORGANISATION OF WELFARE SERVICES IN COUNTRY AREAS"

Cr. W. J. Kilpatrick, C.B.E., Chairman, Cancer Service Committee

I would like to tell you briefly what has happened in the cancer field since the Cancer Campaign closed, so that you will see the whole picture in its true perspective.

It is history now that we raised by our combined efforts one million four hundred thousand pounds. I have not the slightest hesitation in saying that a very material factor in raising that amount was the tremendous personal effort and the financial support given by the country people. You will be interested to know that the combined overwhelming result inspired not only all the people of Victoria, but also people throughout Australia and indeed in other countries to get behind the cancer cause and do something about it.

We have advised most States in Australia at their request on how to marshal a cancer campaign, and we are also advising Japan, Great Britain, and Israel at this moment, again at their request. My belief is that with resolute people working on this problem all over the world we should be able to find, somewhere, somehow, sometime, a complete answer to the cancer problem.

You will recall that it was arranged that the money raised by the Campaign would be spent under three main headings: Research into cancer 75%, help to cancer sufferers 12½%, and education on cancer, both lay and medical, 12½%. On the research side, since the Campaign closed £200,000 in round figures has been allocated for research into cancer, and is in process of being spent during 1959 and 1960. The promise for the intensification of research has therefore been carried out. As more projects are marshalled and more research workers obtained, so will that programme continue to be intensified.

The Rt. Hon. the Lord Mayor, Cr. Bernard Evans, opens Conference. Seated left to right: Mr. W. A. Dick, Dr. K. Brennan, Cr. W. J. Kilpatrick, Dr. W. P. Holman, Dr. E. V. Keogh.

CANCER CONGRESS

Another important point is that in August of next year a Cancer Congress is to be held in Melbourne. It will be the first Congress of its kind ever held in Australia. The fundamental purpose of the Congress is to enable men in the medical and research fields throughout Australia to exchange ideas with our medical men in Victoria, but overseas experts have also been invited by the Anti-Cancer Council. It is tremendously important that this exchange of ideas should go on, not only within Australia, but on a global basis, and I want you to know that we are fulfilling the promise we made to exchange ideas with research workers all over the world.

As far as medical education is concerned, two important conferences have already been held in Melbourne. They were highly successful symposia dealing with the medical treatment of cancer. Other similar conferences are in process of being arranged. You will see, then, that the question of medical education on cancer is being tackled.

I do not plan to deal with the question of lay education now because Mr. Alan Dick is in charge of Public Education, and he will be dealing with that subject in detail this afternoon.

WELFARE SERVICE

That brings me to the question of services to cancer sufferers. The Anti-Cancer Council decided that this subject was so important that a committee should be formed to implement the promises made during the Campaign. That Committee comprises Dr. John Lindell, Chairman of the Hospitals & Charities Commission, Dr. E. V. Keogh, Medical Adviser to the Anti-Cancer Council, Dr. W. P. Holman, Medical Director of the Peter MacCallum Clinic, Mrs. Thomas, the Almoners' representative, and Mr. Wilson, President of the Graziers' Association. I was very happy to act as chairman of the Committee at the request of the Anti-Cancer Council.

The first thing the Committee did was to examine what need exists, both in the city and the country, for service to cancer sufferers, and it was found that one of the gravest problems was the care of terminal cancer patients.

The almoners in the great city hospitals were brought together and a plan was worked out whereby they obtain private hospital accommodation for terminal cancer sufferers for whom public hospital beds are not available. The Anti-Cancer Council meets the bills or charges where the need arises for us to do so.

This was only a temporary expedient and it was considered that a measure of hospital care especially devoted to cancer sufferers was necessary. It was decided that the Caritas Christi Hospice in Kew was a proper place to give this particular type of service — that is, for cancer sufferers who have received all possible known treatment and now are coming to the end of their journey. The Council has therefore allocated £50,000 to permit Caritas Christi to be extended as a hospital for this purpose. In return we will receive the use of 25 beds in perpetuity for cancer patients.

In addition to this help, the Anti-Cancer Council has also found quite a substantial sum of money for the Melbourne District Nursing Service, to help with the nursing care of patients who elect to go to their homes in the terminal stages of the disease.

Briefly, these are some of the types of help which are being given to cancer sufferers. That brings me to the point of why you have been invited here today. What is happening in the country? What services are available to country people?

COUNTRY COMMITTEES

The Committees established to raise the money have been invited to carry on with anti-cancer work in their own areas. We have received very helpful assistance from the Hospitals & Charities Commission and from the State Department of Health and the Chief Health Officer, Dr. Brennan. Eleven regional committees have been set up, based on Ballarat, Bendigo, Geelong, Hamilton, Horsham, Mildura, Sale, Shepparton-Mooroopna, Wangaratta, Warragul and Warrnambool.

Since there are many other towns and shires throughout Victoria which also require these services, it was decided that sub-committees be set up in these centres within the regions to report to the regional cancer committees. Most of the sub-committees have now been formed and the remainder will be formed shortly. So we should be able to say soon that even in remote parts of the State any cancer sufferer who needs help will be able to get it. Funds have already been provided to the regional committees to take care of emergencies, and will be replenished by the Anti-Cancer Council when necessary.

The main reason, or one of the main reasons, why you are here today is that we want to know what problems you are meeting with in the country, what type of help you want, how we can best help you within the ambit of this scheme. We invite your help and your co-operation in telling us just what you need in the country to help cancer sufferers. The main point of control and co-ordination of the whole scheme is, of course, the Anti-Cancer Council offices at 410 Albert Street, East Melbourne. Your best point of contact is the Medical Adviser, Dr. Keogh, or our Almoner, Mrs. Esson.

"SOME ADMINISTRATIVE PROBLEMS"

Dr. E. V. Keogh, Medical Adviser to the Anti-Cancer Council.

I want to raise for discussion the relation between the central executive and the country committees. At least half and probably more of the patients cared for in Melbourne come from the country, so that to set up a good organisation in Melbourne is directly useful to country patients.

We try to keep our overhead down by having a small but expert paid staff and by having voluntary people to help.

You will understand that a policy decision made by a local committee can commit all the other committees and the Council. For example, difficult questions have been referred by committees to outside bodies like the B.M.A. or the Health Department, instead of to the Secretary of the Anti-Cancer Council. If you write to us, we contact those other bodies if need be. This procedure saves time and trouble.

Only last week a Federal member of Parliament wrote to the Minister of Health about a cancer patient who had died and left several children. He asked the Minister of Health whether any of the funds subscribed to cancer in Victoria were available to help this patient's children.

We could have dealt with that letter in a number of ways; we could have written to the Federal member direct. Actually, what we did was to refer the letter to Mrs. Esson, our almoner, who wrote to the local committee and asked them to deal with the case. We know that the local committee will investigate the circumstances fully and will advise the Federal member.

DISCUSSION

Mr. Linaker — Ballarat: I was very interested to hear that the Council is subsidising the Melbourne District Nursing Service. Could you give us some details?

Mr. Kilpatrick: The Melbourne District Nursing Service is giving help to some 65 cancer patients per week. This service is really supplementary to the nursing service of the Peter MacCallum Clinic. As certain cases are not covered by the Peter MacCallum Clinic for a variety of reasons, we decided to make a contribution towards part of the costs of the Melbourne District Nursing Service, to meet a proportion of the charges not already met by Government agencies and by public subscriptions. At the end of a year, we will review the position and consider to what extent we should continue the subsidy.

Mr. Hackett — Sale: Is that service available to country sufferers?

Dr. Keogh: There is no marked shortage of beds for cancer patients in country areas, whereas in Melbourne we have to rely to some extent on nursing in the homes by the Peter MacCallum Nurses and the Melbourne District Nursing Service. All the hospitals that I have seen in the country have said that they have no difficulty in admitting cancer patients. There may well be a good reason why certain patients in the country should be nursed at home rather than in hospital. Then it is the committee's responsibility to examine the circumstances and to decide whether assistance is needed for nursing services in the home.

Mr. Williams — Ballarat: I think Mr. Linaker was questioning whether the Anti-Cancer Council could consider a subsidy to such organisations as the Ballarat District Nursing Service in the country?

Mr. Kilpatrick: If a specific request is made in respect of any particular area such as Ballarat it will receive consideration by the Anti-Cancer Council.

Senator Sheehan — Castlemaine: What is the cost to the patient who is being treated in his home?

Mr. Kilpatrick: It depends on the patient's ability to pay. We try to supplement the services which are already available through the Commonwealth and State Governments, etc., but there is no reason why any cancer patient in Victoria today should suffer undue hardship.

Mr. Blackburne — Berwick: If the necessity arises, may private nurses be engaged to look after country patients?

Mr. Kilpatrick: It would be advisable to refer a specific case to our almoner, but I assure you it would receive every consideration.

Mrs. Dickens — Bright: What is your opinion of the desirability of mobile clinics which might tour country areas to educate people in early diagnosis?

Dr. Holman: Later on this morning I propose to describe the country clinics which are organised by the Cancer Institute Board and which now visit 19 country centres. This question of early diagnosis is being followed up from the medical practitioner's point of view. For myself, I feel very strongly that when people are educated in the signs and symptoms that may mean cancer, their early diagnosis can best be established by their own doctors.

Mr. Williams — Ballarat: Is there any provision made by the Anti-Cancer Council for payments of transportation costs of patients to regional base hospitals and later possibly to the Peter MacCallum Clinic?

Mrs. Thomas: Patients who are going to the Peter MacCallum Clinic are cared for by the Clinic's almoners. As far as other country patients are concerned, most certainly there is help available for people needing transport.

Sir Peter MacCallum chats with Country Chairmen.
Left to right: Mr. N. J. Oliver (Bendigo), Mr. H. Randall (Horsham), Mr. Mac. Steward (Warragul), Sir Peter MacCallum, Mr. G. Blackburne (Berwick).

As always in the welfare service of the Anti-Cancer Council, we use existing services first before using our own funds. Most of you know that free rail travel, including a stretcher if necessary, and free travel for a dependant is available for any indigent person needing hospitalisation. Difficulties arise when the patient needs to be transported more quickly or perhaps more comfortably. It then becomes a matter for very quick consultation and I think most committees would like to refer this problem to the almoner at the Anti-Cancer Council.

We have had a good example where there was a grave problem of transportation from a distant country area. The doctor in charge of the patient felt that she was not well enough to withstand a long train journey and the only way was to bring her by air. We failed to get free air travel for her, but the local committee was able to use its funds to bring that patient to hospital.

So I would say that with patients coming from the country to the public hospitals, the free service of the Victorian Railways should be considered first. I think in each of your regional committees you have sample application forms which should be sent to the General Health Branch of the State Health Department.

Mr. Bilson — Colac: In the case of a housewife sufferer, is it your intention in necessitous cases to provide home help?

Mr. Kilpatrick: It might not be a bad idea if the question waits until the Almoner Services have been dealt with by Mrs. Thomas and Mrs. Esson. Broadly speaking my view is that help should be given in the home to permit a mother to have an operation or to recuperate from an operation.

Mr. Hackett — Sale: How do you get in touch with these terminal sufferers or people who require these services? Many patients who probably need these services are reluctant to come forward and declare themselves.

Mr. Kilpatrick: We have arranged with the State Department of Health that their Medical Officers will co-operate with our committees in every way. I would think that the means of securing the information would be that the Medical Officer in a particular area would bring the matter to the committee's attention. Perhaps Dr. Brennan would elaborate that point.

Dr. Brennan: I think that all local committees will have a local medical adviser who will know the district health officer. Anything of a medical nature can be brought either to the Anti-Cancer Council's notice or dealt with directly in the country by the district health officer in collaboration with the patient's doctor.

Mr. Oliver — Bendigo: Would it be possible for some negotiations to take place between the Anti-Cancer Council and the Commonwealth Social Services Department to ensure prompt attention to any enquiries we might make to the Social Services Department? Sometimes we feel that there is unnecessary delay in arranging social service assistance to people.

Mrs. Thomas: Part of the delay is due to the processing of applications which is necessary for the protection of the community. I doubt very much whether an approach from the Council to the Department of Social Services could improve the situation very much, but there are several things we can do. One of them is to make sure that all the relevant information is provided to the Department.

Sometimes you may wonder why these particular questions are asked, but they are asked for very good reasons. In the case of Sickness Benefit, which is the main statutory provision for income maintenance, there must be a slight delay after the application is received while it is checked. The employer is then asked to fill in a form stating that the applicant was employed until a particular date. Unfortunately it is not the Department of Social Services, but the employers who are often at fault.

In cases like this, frequent contact with the particular officer in the Department of Social Services will usually result in a reminder to the employer to speed up his reply.

Mr. Farnsworth — Avoca: In the event of a sufferer needing financial assistance would a means test be applied, and would any time limit be set?

Mr. Kilpatrick: Broadly, we have found that, if a person really needs help, neither time nor the amount of money has been the controlling factor.

Mrs. Thomas: If the Committee in consultation with the Central Office has established the need, then the general principle is that help would not arbitrarily be limited or withdrawn. I think it would be wrong at this stage for me to suggest a time limit or a sum. This is a very important question because it has opened up the whole question ot the individual nature of the problem we are dealing with.

Cr. Jensen — Yallourn: Could you give us details of the establishment of sub-committees? Will information be sent to the chairman of the sub-committees to help with the task?

Mr. Kilpatrick: The first thing obviously was to get all these committees or sub-committees established, and this is now well under way. After this conference today, a copy of the proceedings will be sent to members of all committees. You will find it a fairly comprehensive guide to the working of the whole organisation. The purpose of this conference today is to find out just what you need in the country to make the plan work.

"THE ROLE OF THE CANCER INSTITUTE"

Dr. W. P. Holman, Medical Director, Peter MacCallum Clinic, Cancer Institute Board

I propose to give you a brief history of how the Cancer Institute was established, followed by a summary of the provisions in the Act, and then to tell you something of what we are doing.

Cancer, of course, is a matter of public health and therefore it is of interest to all States. As far as Australia is concerned, it was the initiative of the N.S.W. Government in 1943 which brought out two eminent specialists from England, Drs. Ralston and Edith Paterson of Manchester, to advise that State on the management of cancer. Through the initiative of people like Sir Peter MacCallum, the Victorian Government was persuaded that the idea of improving services to cancer patients, particularly radio-therapy, which involved substantial expenditure, was something that the State should be interested in.

In 1948 the Victorian Government passed an Act which established the Cancer Institute Board and some two years afterwards it set up its own organisation. That portion of the Institute which was concerned with the treatment of patients was designated the Peter MacCallum Clinic, in recognition of Sir Peter's part in its inception. Since then the growth has been quick and quite dramatic. The fact is that when a service is provided in a community it always turns out to be required by more people than expected.

RESEARCH FACILITIES

The first provision in the Act is to provide facilities for research and investigation with respect to the causation, prevention, diagnosis and treatment of cancer and allied conditions, and so we have specialised in research relevant to the use of radio-therapy. This is fundamental research. What concerns us more today is what is called clinical research, that is, the effort to draw sensible deductions from the management of patients, watching them over long periods of time, analysing the methods of treatment and so trying to improve treatment for the future.

Good records obviously are essential and we have developed a first class system of recordings, so arranged that it can be duplicated if necessary for a metropolitan or country hospital. It does lend itself to very quick analysis and many case histories are now available for such analysis.

Of particular interest is the Central Cancer Library which is jointly subsidised by the Anti-Cancer Council and the Cancer Institute Board. This is a cancer library rather than a radio-therapy library and is available to all workers in the cancer field. It includes journals and books which touch on every aspect of the cancer problem.

We also have a research Dietician who, in addition to the ordinary dietetics work which is an essential part of a modern hospital, is investigating special dietetic aspects of cancer.

We have hastened slowly and the fruits of the clinical side of our research are now becoming available in the form of some published papers.

PATIENT CARE

The next aspect I would like to speak about is our second responsibility, the care and treatment of patients. Patients are accommodated nowadays both as in-patients and out-patients. Our hostel at Heidelberg is an example of co-operation between the Anti-Cancer Council, which purchased the building, and the Clinic which now owns and manages it. This is of particular interest to country people because it does provide an ideal way of accommodating people who do not require hospital accommodation, but who need to stay in Melbourne for a period of weeks for treatment. The hostel at present has 12 beds and we look forward to the possibility of doubling that accommodation in the future.

The first person a patient meets at the Clinic is a medical social worker. Social workers in many respects determine the atmosphere in which patients are treated. They establish an atmosphere of confidence and of being amongst friends, which helps to relax a patient who may sometimes require a tedious course of radio-therapeutic treatment.

The visiting nursing service was started when we had very few beds indeed. At one stage we had 12 beds, now we have 90. The visiting nursing service now consists of 10 nurses with their own characteristic uniform and driving Institute cars. The establishment of this service has been one of the best single decisions of the Cancer Institute Board.

These nurses are available to care for any cancer patient who is referred to them by any doctor in or near Melbourne within a radius of approximately 12 miles. They do not tend our patients only, but are available for cancer patients of all doctors.

RADIOTHERAPY

The next aspect I shall consider is treatment. Our particular concern at the Clinic is radio-therapy, and this Department is a very large and costly one. We first installed nine deep-therapy machines and three superficial therapy machines. As radio-therapy improved, we put in our first megavoltage machine, the linear accelerator. This is the first major technical advance in radio-therapy since the 1920's and it is completely altering the picture of this form of treatment. It used to be said that about half the patients with cancer might require radio-therapy at some stage of their illness. It is quite clear from our own experience that this figure now should be 75% of patients with cancer. The Cancer Institute Board has recently purchased a second linear accelerator which we hope will be installed late in 1960.

POSTGRADUATE TEACHING

The Act also requires us to promote the education of people concerned with the treatment of cancer. The education of doctors in this rather narrow specialty was our first concern. Since 1952 we have helped 14 medical practitioners obtain a post-graduate diploma in radiotherapy.

We have found it possible to teach at other levels too. Thus we are teaching technicians, and we have in our training school at present 43 students and a tutor technician. Similarly the nurses have a post-graduate diploma course in radio-therapeutic nursing which has just finished its second year.

Undergraduate medical students are also taught, and the time has now arrived when we can provide good material for post-graduate medical teaching.

In a hospital like ours where radiotherapy is such an overwhelmingly important method of treatment, we cannot work without science graduates. The whole of the treatment planning has to be done in a meticulous and accurate style, and our medical phsics department is an essential part of the service.

COUNTRY CLINICS

We are now in a position to provide clinics at certain base and district hospitals in country areas and to provide a consultative service for the local medical profession.

There are two other virtues of these clinics. In cancer it is of vital importance that the patients should attend what we call follow-up clinics. It is therefore a great boon if they can have their follow-up examination at a centre close to home and this is perhaps the most obvious advantage of our clinics.

Finally we do look forward to expanding actual treatment facilities in these country clinics wherever possible. As you probably know, superficial X-ray therapy equipment has been installed at some centres and is staffed by our technicians.

Finally, I would like to remind you that this very large institution — where within five years the number of outpatients has grown enormously, where until this year we have been in a position of working with too few doctors, where buildings and staff and especially equipment represent a very large capital expenditure — is the responsibility of your State Government. The Cancer Institute and Peter MacCallum Clinic is wholly supported by the Treasury, and we are responsible primarily to the Minister of Health.

I personally believe that in communities like ours this particular type of institution cannot be established except as an instrumentality of the State. It is something to be proud of, I think, that in the State of Victoria we have the best of State aid, as exemplified by the Cancer Institute, and the best of voluntary effort, in the Anti-Cancer Council, to supplement the State's efforts where necessary.

"THE BASIS OF THE SOCIAL WELFARE PROGRAMME"

Mrs. B. Thomas, Senior Almoner, Alfred Hospital,

I propose this morning to look at the fundamentals in our programme of helping people through the Council's welfare service.

It seems to me that there are three steps in this helping process. The first is to discover the individual or the family who is in need of help as a result of cancer. The second is to make some kind of an assessment of the nature of the problem, and the third is to find the most appropriate and constructive way of relieving that problem. I say relieving because sometimes it is not within our power to solve it, but we can at least relieve.

REFERRAL OF PATIENTS

The first step, then, is the discovery of people who need our help. Most of the referrals to the committees come through the local doctors. A close tie-up between the regional committees and the local doctors is absolutely essential. The local doctor is the first person to know the patient's diagnosis. He also has some idea of the incapacity that is likely to result, and generally, he should know something of the patient's social and economic circumstances. There are other sources from which referrals may be made — friends and relatives, business men, other professions and sometimes even the patient himself will ask for help.

Now it might be thought that committees should wait for people to ask for help. I believe that we should reach out a little towards people. In our community, sturdy independence is regarded as a great virtue, and it is often exceedingly difficult for normally self-supporting people to ask for help. So when I say seek out the people who might need our help, it is to overcome the problem of putting the onus on the patient to come, more or less cap in hand, asking for assistance.

CASE ASSESSMENT

The individual or the family in need once found, we then move on to making some estimate of the problem. In every problem there are many similar factors, but these factors are put together in different ways, so we can say that each problem we are presented with is unique.

The factors that are common to every problem are the personalities of the people concerned and the availability of personal and material resources. Some families are much better equipped to cope with crises than others. But some problems are so overwhelming that, regardless of the strength of personal character, or the abundance of material resources, the family cannot deal with the crisis without help. I mention this because unhappily cancer is one of those crises which may overwhelm even the most responsible and self-reliant family.

APPROACH TO THE PATIENT

It is one of our special responsibilities to see that no person who comes to the Anti-Cancer Council Welfare Committees for help, remembers it as a degrading or a frightening experience. Where money is the way to help a particular family, we might keep in mind that money was given by these very people. Where some other kind of help is appropriate, we might remember that we are very blessed if we have it to give.

People are often very shy about revealing their needs. They may start with what seems a simple request, but if you listen carefully with what has been termed the "inner ear" you will know that behind that simple request lies something much deeper. It is part of the job of all committees to learn to listen to these requests with the "inner ear".

ORGANISATION OF ASSISTANCE

Having made some assessment of the problem, we move to relieve it; to integrate the network of social services, statutory and voluntary, that are available in this community. I will not discuss in detail the statutory benefits that are available as each regional committee has information regarding those most commonly used, but do remember that the money in the hands of the committee is meant to *supplement* services already existing. It would be poor economy if we were to duplicate or multiply any of the existing services.

One of the greatest gaps in our knowledge of what is available in the community is the lack of a local directory of services in each region. It seems to me a very proper function of each of the regional committees and the district subcommittees to undertake the compilation of a social service directory covering its own district. Not only would this mean a better deal for the patient, but also you would be doing a great community service.

I wonder if you realise that you represent a unique organisation in Australia — a network of voluntary service throughout the State of Victoria dedicated to serving the needs of cancer patients. Every time we successfully relieve a need in a cancer patient, we show many other people that should they be smitten with cancer, they need not fear social and economic insecurity.

"THE WORK OF THE ALMONER AT HEAD OFFICE"

Mrs. M. Esson, Almoner,
Anti-Cancer Council

When I was appointed part-time almoner at the Anti-Cancer Council we did not know how the work would develop. It was a new field of social service, but we accepted the important guiding principle that each claim would be considered on an individual basis. However, some policy decisions were made and I shall remind you of these briefly.

The social, economic or personal distress which we seek to relieve must arise from cancer. Anti-Cancer Council funds are intended to supplement existing social services and for this reason we always need to explore community resources before using Council funds. Two more particular matters of policy were that private hospital fees would only be paid when no bed was available at a public hospital, and that the Anti-Cancer Council should not meet public hospital charges or fees for private medical treatment.

In speaking with several members of committees I have felt sometimes that they seem to be seeking a blueprint for action. By the very nature of our work this is not possible, since we are dealing with all sorts of people and all sorts of situations. However, in every case we do act on definite information — that is, if we provide financial assistance it is because we have evidence of economic hardship. This implies that evidence must be gathered and hardship assessed. Then we have to decide what assistance shall be given and how.

In speaking briefly to you this morning, I thought I would take several statements that have been put to me by members of committees and comment upon these.

It has been said that what you do for one, you must do for another. We have recently had two cases in Melbourne, both widows, both with children and both receiving the same income. One widow derived her income from the various statutory benefits available to her while the other was gainfully employed. We gave quite a large sum to the first widow and quite a small sum to the second.

In the first case the widow had debts which she would have striven to pay off, but could not have done so without depriving herself and her family. Those debts were paid so that she would be given a new start. In the other case there were a few debts which were taken over by another organisation. Her children became wards of Legacy, and we gave a small amount to start her on her way.

SELECTION OF CASES FOR AID

I wonder whether you have found, as I have, that some people tend to regard these funds as a sort of dividend or bonus for those who, after contributing to the fund, have become the unfortunate victims of the disease. For all who suffer from cancer there will be hardship and expense — but there will still be cases when aid must be refused.

As far as the family is concerned, I have found that a simple explanation of what we are doing, and what our views are, will usually be accepted. We can concern ourselves only with those cases where there is no money at all to meet the demands made upon the family by the illness; where the family's economic stability will be endangered if aid is not given; or where, although the expense can be borne to a limited extent, a long illness will be so crippling that the family will take a long time to recover.

If we have met those who expect something from us as a right, we have also tragically met those who will not ask for help, who struggle to pay their way and come to us only when their resources are at an end. I feel we must be careful about thinking in terms of equality of need and equality of aid.

Another comment I have heard is that it is hard to enquire into a person's financial position. We can and must enquire about a patient's financial position, although some of us will find this difficult. However, we have a right and a responsibility to ask. We are disbursing public funds and most people seeking or being offered our help realise that we have a right to know what their resources are.

As Mrs. Thomas has said, we can learn much by listening in a spirit of sympathy and understanding. Sensing this, the patient or relatives will usually give the necessary information. It is, of course, a basic principle of social work that all information obtained is confidential and should never be divulged without the consent of the person concerned.

PROVISION OF HOME HELP

Other questions which have been raised concern matters such as provision of home help and payment of debts. I know of two country cases where help has been provided in the home. In one case, the committee thus enabled a mother to be with her family in the final stages of her illness. Without that help she would have had to remain in hospital, and it meant a very great deal to her and to the family that she could be with them. In the other case, a young mother, recovering from an operation, is being given some domestic assistance.

I understand that the municipal or shire home help services in the country are often inadequate, but I would suggest that we make formal application to the authorities for help even though we know we shall have to arrange it privately ourselves. Social services which are now inadequate may be improved as a result.

Where home help is provided, we have suggested that it be given for a limited period, usually a month. The matter can then be reviewed and help continued if necessary. The problem should be discussed with the family, and if they feel like contributing towards that expense, we should allow them to do so.

PAYMENT OF DEBTS

The payment of debts is another question on which we have had some discussion. Like everything we do, it is considered on an individual basis, but in general we want to hear about cases long before they reach the debt-paying stage, in order to give our aid when and where it will be most effective. When it is felt that debts should be met, we suggest that the creditors should be asked to make some reduction in their accounts as they are being paid from Anti-Cancer funds. We can usually arrange for hire purchase payments to be deferred or reduced until such time as the family can take them up again.

In giving financial assistance from the Central Almoner Fund, we have to relate this to some expense which is occasioned by the illness. For example, we are currently paying rent in Melbourne for a woman who has had to take a room to be near her husband in hospital and is unable to afford rent both in the country and in the city. Before doing so, the matter was discussed with the regional committee and also with the hospital almoner.

You may be interested in a case that came to us recently which helps to illustrate the tie-up between the sub-committees, the regional committees and Head Office. We had an enquiry from one of the newly formed sub-committees. The material given to us was very complete. We knew that the patient was a widow in hospital in Mebourne. We knew her income, her family, the marital state and what was being done for the children while she was in hospital. It was sent by the sub-committee to the secretary of the regional committee who, in turn, referred the letter to central office.

We then discussed it with the almoner at one of our hospitals, and we noticed that there was no reference in the statement of her income to any amounts being received from the Children's Welfare Department. The almoner at the hospital concerned took this up with the patient and it is now being attended to. The patient has since transferred to the Peter MacCallum Clinic and is now in the care of the almoners there.

This brings me to my last point, and one about which I feel very strongly. We have not only financial aid to offer, although I know that those of us who disburse these funds and those who receive them are deeply grateful for this help. It is a fact that people do not know much about the social services which our community offers and for which many of the people coming to us are eligible. We need, therefore, to be familiar with social service facilities at Commonwealth, State, municipal and regional levels. It is by experience that we become familiar with these services, and some of you have had that experience already.

Bringing the services before the people, giving them the appropriate forms and letting them know where to go and how to fill them in, helping them with the mass of detail they are often asked to supply, and which is necessary if the request is to go through the proper channels as quickly as possible, is a very important part of our work.

Lastly, we should always remember that the support and understanding that we can give to patients and relatives in times of suffering is a real and valuable contribution. This I feel should be our central function and it is this which gives significance and meaning to our work.

DISCUSSION

Mr. Kilpatrick: The meeting is now open for discussion. I shall deal first of all with Mr. Bilson's question. I think it was made clear by Mrs. Esson that, in certain circumstances, home help will be given. If cases arise where domestic help is necessary, the procedure would be to clear that with the Anti-Cancer Council through Mrs. Esson. Mrs. Esson has made it clear, too, that in certain circumstances we have taken up debts for a widow whose husband has died from cancer, but I think everyone will agree that we can't take it too far.

Mr. Saunders, Mildura: Mrs. Esson made mention of the fact that payments from the Anti-Cancer Council's funds are not to cover private hospital fees or medical attention if public hospital accommodation is available. However, a patient who is referred by a private practitioner to a hospital for attention is required to enter an intermediate or private ward if he is to be attended there by his own doctor. What is the position if a patient finds himself in severe financial circumstances as a result and then comes to our committee for assistance? Are we to say we cannot help him?

Mrs. Thomas: The fundamental point here is that such a case need not be specific to cancer. Any patient with a long illness who is being treated by a private doctor in an intermediate or private section of a hospital is in exactly the same position, and there is no reason why we should deal with it any differently because a cancer patient is concerned. This is one of those occasions when the feeling is that since "cancer money" is available we should single out the cancer patient who has amassed these debts and give him help. But that is not so. Normally this sort of problem is resolved by consultation between the individual, the relatives, the doctor and the hospital and a satisfactory arrangement made between them.

Dr. Keogh: This is one of our most difficult questions, and I agree entirely with Mrs. Thomas. In the case that was put up, both the patient and the doctor, I think, were in the wrong. The patient should not go to a private or intermediate ward if he sees no way of being able to pay the doctor's fees, and if there is a public ward to which he can go. Naturally everyone would prefer to have a private doctor and private accommodation, but that is not practicable. We have to be very careful with money which has been given to us on the promise that we use it properly.

Senator Sheehan, Castlemaine: Has the Council considered subsidising the cost when a patient is in an intermediate or private ward, like the Commonwealth Hospital Benefits Scheme where a certain amount is paid, irrespective of the particular type of hospitalisation?

Mr. Kilpatrick: I think Dr. Keogh answered the question, but I would say that the answer is "no". We are trustees for these funds and they are to be made available for necessitous cases after all existing facilities have been explored. People are perfectly entitled, whether in country or city, to the benefits of public hospital treatment. If a public hospital bed is not available, we will put patients into private hospitals ourselves, but it must be on the basis of necessity.

Mrs. Thomas: I should like to add that public hospitals in their public wards have by law the right to remit charges. The hospitals are heavily subsidised from public funds and this is one of the times that those funds come to the assistance of the patient.

Mr. Stewart, Warragul: The problem we face in my area is to get the first information from the doctor to the regional chairman. I think a few doctors are afraid that regional committees will direct the patient to the Peter MacCallum Clinic or elsewhere and that they will lose part of their practice.

Dr. Keogh: We are only just starting this service. Doctors and others may at first be suspicious of our aims and the regional committee's aims, but as we go on they will see that there is nothing but benefit to the patient and to themselves. This prejudice will soon be overcome.

Mr. Hamilton-Smith, Wodonga: Can you tell me whether the services and benefits presented to us this morning are available to residents of N.S.W. living along the river who supported us generously during our campaign?

Mr. Kilpatrick: The answer is "no". The activities of the Anti-Cancer Council of Victoria are controlled by a State Act, in the same manner as the activities of the N.S.W. Cancer Council are controlled by a N.S.W. State Act. Legally we are obliged to spend our money within our own State.

Mr. Bell, Maryborough: We have heard regional committees emphasised a great deal today. We have been told that funds are available in regional centres, but I think most of us here will be sub-committee chairmen. Do sub-committee chairmen need to refer to regional committees first and then on to headquarters?

Mr. Kilpatrick: Funds were placed in the hands of the regional chairmen so that emergency cases could be dealt with without red tape. If an emergency case arises, ask your regional chairman first if he will deal with it urgently. If for any reason this is not done, by all means get in touch with the almoner or with our H.Q. We believe that this scheme can best be handled by the country people on the spot. We are not trying to run it from Melbourne at all, and I feel very strongly that you are better off dealing with your own regional chairman. But we are not going to make it a matter of rigid rule. At all times be guided by what is good for the cancer sufferer.

(No name given): I would like to know what cost is charged to a patient in the Peter MacCallum Clinic. Is it on a public basis with no charge, or is it an intermediate rate?

Dr. Holman: There are two categories of patients attending the Peter MacCallum Clinic. It is the patient's own choice whether they are there as intermediate (or private) patients. As public patients their costs are the same as for public hospital patients.

Mr. McKenzie, Mildura: If an almoner were appointed at a base hospital such as Mildura, would the Anti-Cancer Council be able to subsidise the appointment?

Dr. Keogh: If a hospital committee asked for our help it would be for our Executive Committee to decide. But on the whole I would say "no", for this reason: We exist to fill in the gaps. The care of cancer patients is undertaken by the Hospitals and Charities Commission and the Cancer Institute Board, and the State provides the money. Any hospital, such as Mildura, gets most of its funds from the Hospitals and Charities Commission to provide that service.

Mr. Kilpatrick: This is obviously a matter of State health and I would like to hear Dr. Brennan's view on the question.

Dr. Brennan: To come back first of all to the housekeeper problem. The housekeeper service is established by local municipalities and is subsidised by the Government. The payment of those housekeepers is primarily the responsibility of the person who employs them. If the latter's economic state is such that he cannot pay, the local council determines the amount that he can contribute, and the State Government subsidises the council for four-fifths of the remainder. I do not think the Anti-Cancer Council need be brought into that matter at all. On the question of hospital staffing, I think that is purely a matter for the hospital. As to whether the Anti-Cancer Council should subsidise such almoners, that is for the Council to decide.

Dr. Keogh: There is one matter I want to mention before we adjourn. Next year we are holding a Cancer Congress which will be largely scientific. There will be five sections, four of them entirely medical and one open to lay people who are interested in the cancer problem. As we want to deal with cancer problems which are specifically Australian, one session of congress will be on Cancer of the Skin — one of the commonest cancers in Australia.

Since we have little exact information about skin cancer, the Health Department will make a survey of some 6,000 people in Victoria. Cancer of the skin differs from other types in that it is often preceded by recognisable precancerous conditions. We propose to examine adults from 21 to 60 or 70 years of age to see to what extent these precancerous conditions exist in the different age groups. Supposing we decide to examine a group of people in a country centre, I would like to know if members of regional committees could arrange for persons to attend for a simple examination of the hands and face by a doctor at, say, the town hall, on a given day.

We feel that if we had local support the survey could be better organised in country centres. Such a survey has not been made anywhere in the world before and we would like it to be a highlight of our Congress.

THE PROCEEDINGS OF THE AFTERNOON SESSION ON PUBLIC EDUCATION WILL APPEAR IN THE NEXT ISSUE OF "VICTORIAN CANCER NEWS".

FEATURE ARTICLE

THE LINEAR ACCELERATOR

Its Operation and Use in the Treatment of Cancer

by

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Towards the end of 1960 a second Linear Accelerator will be installed in the Peter MacCallum Clinic, Melbourne, which will then become the first radiotherapy centre in the world to have two of these highly complex and expensive units for the radiation treatment of disease.

The Linear Accelerator is a machine designed to produce X-rays of very high energy and deep penetration, and it enables adequate X-ray dosage to be delivered to deep-seated tumours. Until a few years ago the X-ray equipment commercially available usually operated at a maximum of 250,000 volts, and the most penetrating X-ray beam from such units becomes reduced to half the initial intensity in passing through only about three inches of tissue. Since healthy skin can tolerate only a certain amount of X-radiation this lack of penetration frequently made it difficult to deliver a sufficiently high dose to the tumour to destroy it.

The Linear Accelerators, installed and to be installed at the Peter MacCallum Clinic, operate at an energy of four million electron volts and the resulting X-ray beam penetrates about six inches of tissue before becoming reduced to half the initial intensity. Furthermore, the dose rate from the Linear Accelerator is several times that of the 250,000 volt units. This enables the treatment time to be reduced, and an increased number of patients can be treated each day.

Although the Linear Accelerator as a physical instrument has been known for over 30 years, it is only in recent years that it has been developed into a practical and compact unit for the production of X-rays, largely as a result of the outstanding developments in radar techniques during and since the last war.

The main source of energy in the Linear Accelerator is a special valve called the "Magnetron" which feeds high frequency radar waves into a long straight corrugated tube called a wave guide. The corrugations in this wave guide have been so designed that the speed at which the waves travel down the guide is accelerated. Hence the term Linear Acceleration. Electrons are injected into the wave stream at one end of the wave guide and are accelerated with it. There is an apt analogy — it has been said that the electrons surf-ride on the crests of the radar waves.

When they have attained an energy of four million electron volts at the far end of the guide, the electrons strike a gold target, and high-energy X-rays are produced. The X-rays then pass between two pairs of adjustable thick lead shields which absorb any unwanted X-rays, and a beam of the required geometrical size is obtained.

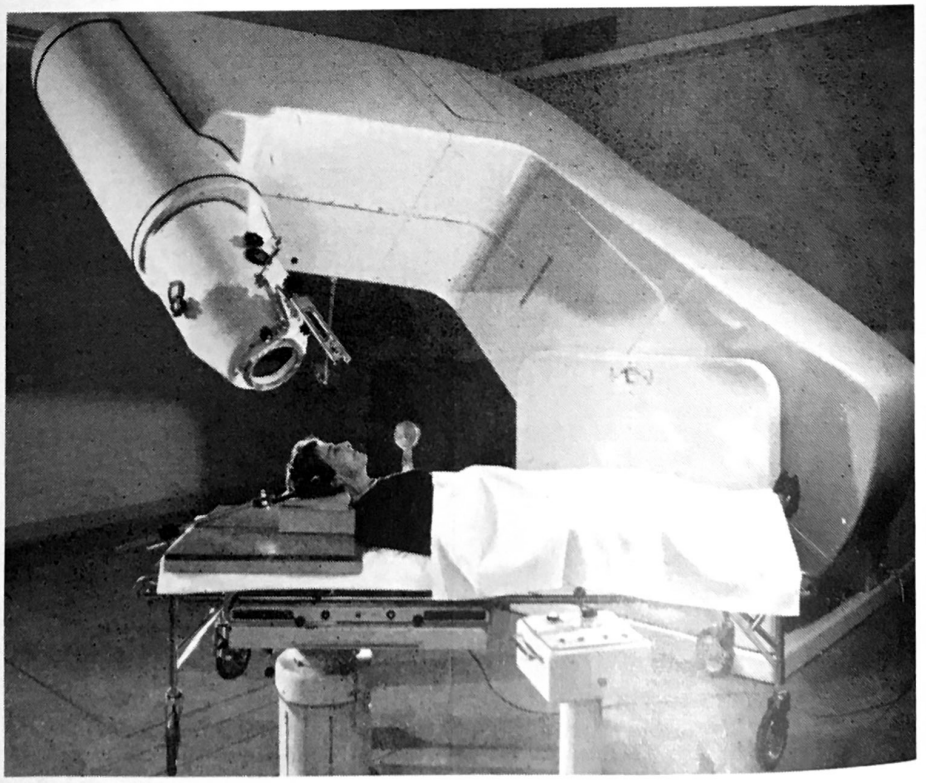
An interesting feature of the beam is that it is not continuous, but is produced in very brief beats or pulses of two-millionths of a second duration, several hundred times a minute.

The electronic equipment associated with the Linear Accelerator is very complex and is housed mainly in a separate room adjoining the treatment room. The acceleration part of the unit is mounted in the treatment room on a large gantry which can be rotated so that the X-ray beam can be adjusted to the required angle for treatment.

All radiotherapy treatments have to be planned and carried out with the greatest attention to accuracy and detail. With the high output of the Linear Accelerator the treatment time is reduced to only a few minutes, whereas a considerably longer time may be required to prepare the patient for treatment. In order to make the fullest use of the unit, special preparation rooms are associated with it where the preliminary preparation of the patient can be carried out on a treatment couch. The couch and patient are then wheeled into the treatment room and the final stages of preparation are completed. This system enables many more patients to be treated than would be the case if the complete preparation was carried out in the treatment room.

To improve the service further, a special planning room is being developed which will contain a simulator, with all the movements and adjustments of the Linear Accelerator, so that the setting-up details of a patient's treatment can be checked more readily. This simulator will possess a small diagnostic X-ray unit so that radiographs can be taken when necessary to ensure maximum accuracy.

The development of the Linear Accelerator and other megavoltage therapy machines has meant a big step forward in radiotherapy and affords much more effective treatment in certain types of disease.



4 Million Electron Volt Linear Accelerator at the Peter MacCallum Clinic.