




Professor Shelley Dolan - Transcript

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Candid
conversations
on cancer
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Richard: So. Welcome, Shelly.



Shelly: Thank you.



Richard: It's just fabulous to have you here. I have to start with this question because I've been intrigued with it since we read anything about you that you did an honours degree in English literature. Yes. And then went punk and and signed up as a nurse in full punk regalia. And is that folklore or is that fact? That's really the question.



Shelly: So it's partly folklore and partly fact. So I started out when I left school at 18.

I did a bit at art college and then I trained as a nurse. And after or about two or three years as a nurse, I thought my passion has always been caring with people and English. English literature, English plays, etc. And so I then went and did an English degree. And yes, I was. I lived in London during the punk era. It was so exciting. So yeah, I was in the full regalia. But I realized after my English degree that I wasn't talented enough to be a play or film director. So I went back to nursing, which I absolutely adore. It wasn't a difficult decision.



Richard: Yeah, I'm sure it would have been. It's just a wonderful image that.



Shelly: Shaved hair, pink and various studs. Yes.



Richard: That's fantastic. And you chose intensive care and then. Yes, to cancer.



Shelly: Yes.



Richard: Not an easy path.



Shelly: Yeah, well, I loved intensive care. As soon as I when I was a third year student nurse, my one of my last placements was intensive care and I loved it and I would love it today. And the I think the reason is you get to concentrate on the person for the whole shift. So you're able to dedicate everything you do to that one person and their family. So it's a bit like a luxury in a way. So I loved that. And I also loved and that's the key for me, that you work in a team very much in intensive care.

And the reason I was interested in cancer was that we had a fair number of young hematology patients coming through any intensive care unit you work in. And when they got better, I would speak to them and their families and the patients themselves would say to me, What's my count? What are my platelets doing? How's my clotting? And they were the most well informed patients, and in fact, at that stage in my career, they knew more than I did about their blood counts and about cancer treatments. So I was really keen to learn from them. And then I was very lucky to be working next door to the Institute for Cancer Research, and they opened out

their seminars for for all clinicians. And then I was fascinated by the science of cancer. So I felt really lucky to be working in with people with cancer who are acutely ill. And that that love of the science and using the science all the way through to hoping to improve outcomes is is something that's really important to me now.



Richard: You've been remarkably successful coming through the nursing ranks into an executive position. It must have meant at some point leaving the specifics of nursing behind. Was that a difficult decision?



Shelly: Oh, very, very I absolutely loved nursing and indeed, I don't think I've ever left it. It's still always present in everything I do. So I was an intensive care nurse consultant working in Big Cancer Hospital, the Royal Marsden in London. And when I was asked if I would apply for the chief nurse role, I remember saying to the then chief nurse, Oh, I don't want to move out of the dark side. And he winced and I thought, Oh, that wasn't, that was a bit of a career limiting move.

So I think when you're a nurse, you're thinking about the needs of that patient and that family. Then when you become a nursing sister or a nurse unit manager here, you're thinking about the whole ward and the whole unit. And he said to me, Now it's your chance to think about the whole organisation. And that's what you need to, you know, you need to see that gap for the whole all of the patients in the hospital and make a difference to all of them. And then when I became chief executive, but also when I led part of the cancer networks across England, it was the same thing, seeing the gaps in the whole system, but always with patients and their families. Right, kind of right front and centre.



Richard: Yeah, it must be, it must be quite amazing and it must have had its had its moments in. I mean it would be, it would not be a stretch to say that, that, that the health system and particularly clinicians is largely patriarchal it must have had its moments where you have fighting fighting a way to equivalence or. Yes, it is.



Shelly: Yeah.



Richard: It's a challenge.



Shelly: Absolutely. So I guess two things. First of all, being a nurse and secondly, being a woman. And there were times when you would struggle to make your voice heard, particularly because I worked in intensive care and with the person with cancer. Acute deterioration is something that the nurse often sees first. Actually, sometimes the family sees first because they're often with them. And being able to package up that information in a way that influences clinicians was something I learnt very early on and indeed my PhD was all around helping nurses to find a way, particularly with junior doctors to or doctors in training, to convince them that that not right-ometer that a nurse often knows because she's been with that patient day in, day out. She knows that or he knows that before necessarily different physiological parameters change. So it so I think it's got better but I and I'm I worked with some of I have worked with some of the most amazing clinicians in the world, both male and female. And I feel immensely lucky that I've had hugely brilliant influences in my life. But there I think it is important to recognise that for those hierarchies exist, they're not as bad as they were, but they're still there sometimes. So it is really important to kind of call it out. And I think if you're lucky enough to be in a leadership position, you have to be true to that and call it out when it happens.



Richard: Yeah, it's it's fascinating because it's easy for me to empathise because one of the things that that we strive for when we first started as Australia was to be an equal in the room.



Shelly: Yes. And yes.



Richard: I was, you know, used to say if you if you want, if you want a token patient. Yeah. Good luck. That's not what we are.



Shelly: Yeah, absolutely.



Richard: And I think it's it makes for a better system if the voices are equal and they're all heard.



Shelly: Absolutely. Yes.



Richard: You are now chief executive of Peter Mac.



Shelly: Yeah.



Richard: And it's it's a huge beast. Can you give the viewer some kind of an overview or an understanding of it.



Shelly: Yeah. Well, it's the most I think the most incredible special place. Obviously, I thought that because we've I've uprooted my family. We've all come a long way across the world. And so we have we're the only public hospital in Australia dedicated to cancer. And we are so lucky because the unique thing about Peter Mac is we have all of the laboratory and research scientists here as an a very, very big medical research institute dedicated to cancer within a building that cares for people with cancer and teachers. So we have the best of all worlds. Where I worked in the UK was the most wonderful hospitals dedicated to cancer, but the research institutes were separate and here they're all together. So we treat about 40,000 people a year and we have about three and a half thousand staff working here and about 750 researchers, about 40 laboratories. And we. We combine everything. So the really fantastic thing is that we have scientists working on the most fundamental science, looking at, you know, cellular changes that may predict cancer. And then we have people working on drug pipelines that more closely translate into a treatment for cancer. And then we have people working on health services research. So how do we work better on survivorship or the mental health of people with cancer? So it's all here. And the brilliant thing around it is that you can see scientists and clinicians meeting together. And in those moments, you know, that's when ideas are born.

I guess the key thing for me is making sure there's not too many layers between what happens closest to a patient and their family and me. Because you want always to know how it really is. And if there are too many layers, that gets kind of filtered out. So when I'm on the wards or in corridors, I always trying to find out how things really are not dressed up and kind of filtered for my hearing.



Richard: Yeah, I can imagine that would be the boss is coming through the halls.



Shelly: Yeah, exactly. Yeah. Yeah.



Richard: And another question that's always intrigued me is around organisations like Peter Mak is that you have your own formulary. Yes and yes. And for those watching who don't know what that is, that is your own supply of medicines independent of the PBS. Yes. And and there are times when you have treatments that are not on the PBS and there are times when you do. And how does that does that all? Yeah, it must be amazing and yes, incredibly complicated to try and work and manage and and work out what's PBS funded and what's not. And yeah.



Shelly: Yeah. So we have we're very, very lucky. We have a brilliant chief pharmacist, Senthil, and he works with the clinical director for medical oncology particularly, but with all of the other clinical directors, hematology, oncology as well as you can imagine. And it's all about providing the widest access we can to the most drugs that we can. And we're very lucky because we run about 500 clinical trials at any one time. We are able to provide drugs through a trial. We also have a compassionate access program, and that's really, really important because in any jurisdiction and any country, there can be a delay between when a drug finishes its trial and then when it gets listed on the PBS here. So it is really important that we fund that compassionate access program, and we're very keen to do that. And we do that through advice,

through. Our chief financial officer, but also through our clinicians, so that we it's really all driven by clinicians and that's important for us.



Richard: Yeah, it's there are some on this side of the table who would say that the PBS should be more driven by clinicians. That would be controversial.



Richard: I have to ask you for comparisons whether there's things we could do better and whether there's things that we're well ahead in.



Shelly: Australia's cancer outcomes are brilliant when matched with the rest of the world. So they, you know, Australia is really outstanding in its outcomes. But the key thing for me and for Peter Mack is that that's not all Australians. And so for me it's the equity piece and that's what I guess a lot of my last few years has been about. How can we ensure that? And of course this is true in London as well, but because of the tyranny of distance here, it's much, much more of a challenge. So and you know this and but for me, those stark differences between the outcomes for people who live in Metro Australia, to those that live in then regional and then rural, but even more so for people from an Aboriginal and Torres Strait Islander background. And as you know, for the difficult to treat cancers. So, so for me it's great that the outcomes are generally brilliant, but let's make sure that all Australians have access to that.



Richard: Yeah, I think that's, that's right. And I think from memory at any one point in time you've got like 200 clinical trials or so.



Shelly: Yes, that's right.



Richard: Yeah. And if you happen to live more than a tram ride away from here, there is no financial support for patients to come to participate in those trials. And and that's challenging. And in a sense, there's a way that's something that's I find troubling, is that people tend to dismiss it and say, well, we're doing we're moving trials out to the regions. We're doing tele trials, but not there yet. And there are certain trials that have to be run here. Is that.



Shelly: Fair? It is fair. So I think more and more, all of us must grab every opportunity to think about trials that can be locally led. And there are many that can be. But the first in human studies will nearly always need to be at a centre. And I think it's hard to imagine a time when that wouldn't be the case really because of the impost of the pharmacokinetics that have to happen sometimes 24 hours a day. So it is hard because it is a very long distance for people to come. So what we're trying to do across Australia and as you know, the Dorothy and Cancer Australia are getting up this national cancer plan and we're really hoping to establish a network of comprehensive cancer centres, but that will still not take everything out to somebody who lives, you know, hundreds of kilometres away. So we do always need to think so. So how are they going to manage if they have to come into the centre, where will people stay? And, you know, it's kind of makes you frightened and anxious and you need somebody with you often. So it is important for all of us to think how can we fund better, acknowledging where we are and these huge distances that people will always need to travel?



Richard: If we think about how to solve it, I mean, there's a kind of do we end up with lots of little Peter Max in Bendigo or Ballarat or, you know, other parts of the country? Or do we how do we how do we start to make it better?



Shelly: Yes. So and I'm not the world's expert on Australia, but I've listened a lot since I've been here. I don't think I don't think it's possible to repeat lots of little comprehensive cancer centres. It's there's it would just be unaffordable and there also wouldn't be the workforce. So but I do think fantastic care can be and is given now regionally and rurally. The key issues, though, are the workforce, aren't they? And that's, of course, is more acute now than it has been over the last 2 to 3 years. So I think it is about looking at ecosystems and looking at coordination. So one beautiful thing that telehealth in its best form is where you're working with clinicians might

be a GP, might be a cancer specialist in Mildura for example, in Victoria, where you're where a clinician here is working with a clinician in a rural area and with the patient and their family. And by doing that you're giving support, you're offering some education where it's needed, but you're also extending reach. And I think we can do that digitally, but more and more we need to do it with people. And I think that's where for me, some of the advanced practice roles in nursing and in other allied health professions. So non-medical roles can really, really help. And I think there's more to be done there as well.



Richard: That's quite fascinating because I know there's a huge conversation going on around navigation.



Shelly: Yeah.



Richard: Patient navigation. Yeah. And it means everything from I know there are navigators here that help people with the logistics of treatment. And then there's the kind of McGrath Foundation model is nurses helping patients. And then there's what is our cancer model, which is really the psychosocial social worker. And I loved what Dorothy said about that, which she said she wasn't going to try and pick a model. She was going to try and work out what the navigation needs were.



Shelly: Yes and yes.



Richard: Because they are complex.



Shelly: Yeah, they are. They are. And I think people need different things at different times. What what is very clear. So some research that we conducted in the UK a few years ago now showed that it was you had a statistically significantly improved experience of cancer care if you had a clinical nurse specialist for example. And I think it's a huge impost on a person to take on a diagnosis which is still, even though we have fantastic outcomes now, it's still the most fearful words that people will hear. And then to navigate quite complicated, even the diagnosis now is complicated. You know, the molecular genome typing, you know, you think you know what you've got. And then the clinician says, but we're actually going to look even closer and find out what, you know, the specifics of your genome typing. I mean, that is incredibly tricky to understand.

And then matching that with your treatment and then your treatment might not be just one modality. It might be surgery and immunotherapy and radiotherapy and having to navigate all of that and the symptoms that come with some of the treatments, but also with the cancer, but then also navigating. So who what is the person that I you know, I was this person before I had this diagnosis. And now I'm a kind of hospital number. I'm a person in a queue. I'm a person with all these side effects. My body feels different. How do I get to be that person again when I come out the end of all of this? And then what's survivorship all about? So it would be an extraordinary person who didn't need some help along the way. And I what I have learnt by listening to I guess thousands of patients and families is it's not all one thing to everybody and. It's and your needs change over time. But there are needs I am absolutely sure about so and we don't always get it right. And I think we the key thing is to keep listening and to keep asking people what they need and and doing it in bite sized chunks. I think something that patients have always said to me when they're diagnosed, when they're sitting in that clinic and the words kind of go, you know, it's almost like, you know, you're underwater and these words are coming, but you cannot hear them properly because it's so terrifying. You can't take in information. And then we're trying to bombard people with all sorts of information. And I think the move to provide recordings of, you know, outpatient clinics, etc., so that you can play it again when you get home and you can listen to it and think, oh, yes, she did say that that was what she said. And so I think it's really important to give information and support all the way along the journey, but it will be different at different times and may need to be provided by different types of people.



Richard: ...as that journey continues, sometimes the level of financial stress just...



Shelly: Absolutely. Absolutely.



Shelly: Yes.



Richard: It's interesting you said about the recordings. I'm really pleased to hear that we developed an app with questions very early on. And and what we found and I found this from personal experience was it was it's it's a tough call to push your phone across the table to the clinician and hit hit record and say, now we're now we're on the conversation. It's very it's a bit confronting for both sides of the table, but it's really helpful.



Shelly: Hugely helpful. And it's a bit I always think about that. When I was a novice nurse, it was really frightening when families would say, What's this and what's that? And you didn't have enough confidence to answer their questions and you felt very awkward and yet confront it as you get more experienced. You welcome families being there all the time. You welcome that you're working in partnership. You're in a you're you're invited into somebody's world. So we must always think that we're not there by we're not there as the sort of supreme important person. We are there as a partner, and we have the privilege of working with people. So I've always, you know, what a very wonderful clinician, Professor Martin Gore, once said to me, anyone who is a real leader in their field never minds a patient asking for a second opinion and never minds the family being there and never mind the recording of the outpatients. And I think that's right. You know, if you know what you're doing, you it's not a worry, is it.



Richard: No. And I think it's the ultimate definition of do you understand your topic, if you can explain it to someone completely, if you can't deconstruct it down, you get away from the jargon and perhaps the problem is yours.



Shelly: Completely, you know.



Richard: That's really, really important.



Richard: So in in in 2020, we wrote a report called Vision 2030, which was kind of the catalyst for the Australian Cancer Plan. The target that it set was 90%, five year survival for all cancer patients.



Shelly: Yeah.



Richard: Do you think we'll do it?



Shelly: So I think, I mean, as you know, Richard, there really there are some cancers that are still you know, we've got a long way to go still. Um, so I think 2030 might be tricky. Do you think we've made, I mean, even in my lifetime in working with people with cancer, we have made such huge strides, you know, and I now see people who I think, you know, in the future may not need sequential blood and marrow transplants, might have one CAR-T transplant, you know, and that will be it.

So not only are we seeing more cure, we're also seeing more cure with less damage to the person. And that's so important. But, of course, there are cancers that are still very difficult to treat. You know, ovarian cancer, pancreatic cancer, brain tumors. You know, there's still there's still a way to go there in this, but, you know, brilliant science happening. So I'm a real optimist and but I'm also very stubborn and determined. And unless we treat those really difficult to treat cancers, identify them early, get them treated successfully, then we've still got a lot of work to do, haven't we?



Richard: We do. We do. So we thank you so much. It's been wonderful. Really, really great to do it.



Shelly: My pleasure. Thank you, Richard. Thank you.