
Surgery Down Under:

Report of the 2006 Australia and New Zealand Travelling Fellow

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“Take frequent vacations from active work, to attend clinics and walk hospital wards. See things for yourself; reading alone is not enough.”

—Dr. William J. Mayo,
graduation address,
Rush Medical College,
June 15, 1910

It was those words of Dr. William J. Mayo that inspired me to apply for the American College of Surgeons Australia and New Zealand (ANZ) Travelling Fellowship. The ANZ Travelling Fellowship was a chance for me to walk the wards and interact with surgeons who had a different style of training in a totally different health care environment. This would be an opportunity to see what was different; but as I found out, it was more of an experience that demonstrated how similar we are.

Newcastle

After approximately 23 hours of flying time, I arrived at my first stop in Australia, Newcastle, New South Wales. I had been invited to speak at the Hunter Valley Surgical Society annual meeting. As I rode into town from the airport, evidence of Newcastle's industrial past was clearly evident. Large industrial sites lay in



Dr. Cima catching his lunch in the beautiful waters off Newcastle, New South Wales.

disrepair and there were enormous mounds of coal along the river's edge. However, a closer look revealed a city undergoing a renaissance. The city's waterfront is being revived with new restaurants, shops, condominiums, and green spaces. Newcastle has become a popular place for Australians to relocate. Just approximately two hours north of Sydney, there is a lower cost of living and less crowded environment without forsaking beautiful views of the ocean and a river. Also, the

city sits in the center of the gorgeous countryside, which is home to some of Australia's finest vineyards.

My host, Dr. Gerard Coren, FRACS, a general surgeon in a community hospital about 60 minutes further north of Newcastle, met me the next morning to bring me to the large regional medical center, The John Hunter Hospital. I was introduced to one of the colorectal surgeons. It was here that the question that I had in the back of my mind about this

whole trip—“How much would we have in common?”—was answered. To some extent, we had almost everything in common. We talked about the common problems I assume surgeons everywhere share: not enough time in the operating room, too long of turnover time, too much paperwork, not enough help, less resident coverage, and too much government bureaucracy.

The Hunter, as it is called, is the regional referral center for trauma, highly complex surgery, or critically ill patients. It was here that I began to notice a theme that repeated itself throughout my travels in Australia and New Zealand. Resource allocation and regionalization of care is affecting all the hospitals in ways that may not have been intended. In Dr. Coren’s smaller community hospital, there has been a shift in resources that has left it understaffed in many critical areas. This change by necessity requires more patients—even patients who could be treated in his hospital for such diseases as acute appendicitis—to be transferred to the Hunter for treatment, which, in turn, taxes the personnel and resources of the regional center for care that could and should be provided closer to the patients’ homes. This was a very important learning point, as I continue to hear about the ongoing discussions and debates about regionalization of care in the U.S.

The Hunter is a large teaching hospital that provides nearly all the tertiary care in the region. I had the great



A view of the magnificent Sydney Harbor Bridge.

opportunity to meet with the junior and senior registrars to review cases. I presented a few complex inflammatory bowel disease cases. Most memorable was a comment from one of the junior registrars when asked what he would do for a very complex case of multiple enterocutaneous fistulas. His response was that although he didn’t know what to do, he certainly would “love to be at the operation”—surgeons are surgeons no matter where they practice, and I felt right at home.

Hunter Valley Surgical Society

The Hunter Valley Surgical Society meeting had a number of very stimulating presentations and discussions about the care of patients with intestinal malignancies. I gave two talks at the conference. The first presentation was on my

institution’s multidisciplinary approach to advanced colorectal cancer, and the second was a discussion of how to assess surgical quality. There was a presentation by a medical oncologist about the new chemotherapeutic regimens for colon and rectal cancer. Although the talk was informative, the most important and telling point was in the discussion that followed. It was here that I was introduced to another theme that I would see again during my visit: the important role evidence-based medicine has on the allocation of resources in Australia and New Zealand. Nothing highlighted this more than discussing the role of the new biologic therapies in the treatment of advanced colorectal cancer and the astronomically high cost relative to the benefits in survival. This point led to an animated roundtable



Northshore Regional Hospital, one of the main public hospitals in Auckland, New Zealand.



A small sample of the beautiful western New Zealand coastline on the Tasmanian sea.

discussion on how to deliver quality care with limited resources and some of the very unique challenges that the Australian government faces.

It was fascinating for me to learn how the Australians are trying to deliver prenatal and obstetric care to a region the size of a couple of New England states but with a population of only 250,000 people. Although I am used to hearing about access problems in the U.S., this was a very unique situation that, although difficult, the Australian government and the Royal Australasian College of Surgeons (RACS) are trying to solve with ingenuity and by taking advantage of new communication technology. I will be very interested to see how they solve this problem because I think there will be a great deal to learn that could be used in the U.S.

Although it may sound as if I spent most of my time touring hospitals and talking, Dr. Coren and his colleagues certainly showed me a wonderful time with a festive dinner at which I sampled a number of the outstanding regional wines. The next day was spent touring the region after a morning on the ocean where we caught our lunch. Dr. Coren was kind enough to bring me to his beautiful home in the countryside where we grilled our morning catch and I could visit with his family. I could not have asked for a better start to my traveling fellowship.

Sydney/RACS congress

After three great days in Newcastle, I headed to Sydney for the annual RACS scientific con-

gress. The congress was held at the Sydney Convention Center on Darling Harbor. It was four days of lectures, seminars, and presentations. Having a limited number of obligations, I was free to attend many different lectures. The diversity of topics was outstanding. They ranged from the newest information on colon cancer genetics, to the history of military surgery in Australasia, to discussion of how to train residents and how to assess quality outcomes. Again what I was most struck by was that the issues discussed on nearly every level were similar to talks or discussions that I had heard discussed at the American College of Surgeons' Clinical Congresses over the last few years. It seems that the challenges facing American surgery are not unique to us but rather to the practice of surgery in general. From what I heard in Sydney, there is much that we can learn and share with our colleagues Down Under.

There were a number of highlights for me at the congress. Certainly, the biggest was giving the Chapter of the American College of Surgeons' lecture at the President's plenary session. I discussed the evolution of the ileal-pouch anal anastomosis procedure and the current state of laparoscopy for this procedure. It was a distinct honor that I will always remember. Three other memorable highlights occurred over food and drink. I was asked to join the colorectal surgeon's banquet held in a facility overlooking the Sydney skyline. Here I was able meet with colleagues that I



The entrance of Christchurch Women's Hospital in Christchurch, New Zealand.

knew in my specialty and many of the famous—or, as they like to refer to themselves, “infamous”—colorectal surgeons from Australia and New Zealand who I had known about from reading their multiple important publications. I also

attended the Chapter of the American College of Surgeons luncheon. Here I met Stephen Deane, MBBS, FACS, the Past-President of the chapter, and Ross Blair, MB CHB, FACS, the current President. It was a wonderful lunch. Through



The headquarters of the RACS in downtown Melbourne.

existence. The most fascinating thing I learned was that the founders of my institution, the Mayo Clinic, were personally involved in initiating the process that led to the formation of the RACS.

Auckland

After the Congress was over, I headed for Auckland, New Zealand. My host in Auckland was Dr. Eva Juhasz, FRACS, a colon and rectal surgeon at North Shore Hospital, one of three large public hospitals in the metropolitan area. I had contacted Dr. Juhasz because she had completed a portion of her colon and rectal surgery fellowship at the Mayo Clinic. During my day with Dr. Juhasz, I observed her doing a completion proctectomy for Crohn's disease, toured the hospital during her ward rounds, and attended the hospital's multidisciplinary colorectal tumor board.

This experience was really my first opportunity to get a brief glimpse of operating room procedures and of the hospital system in Australia and New Zealand. Again, what impressed me was the emphasis on measuring quality and efficiency for continuous process improvement. The issues that were being discussed such as operating room safety and patient outcomes are all the same things that U.S. surgeons are focusing on at this time.

One of the many processes I observed and internalized was a specific method of "counting" sponges, which I have brought to my operating room to see if it might be a practice that

our conversations, I discovered the members of the chapter are particularly proud to be members of the RACS as well as the American College of Surgeons.

The last social function was a gala dinner for the congress. It was a formal affair held across Sydney Harbor at Luna Park. We crossed the harbor at night on one of the harbor ferries. Although Sydney is a particularly beautiful city during the day,

the view of the skyline, the famous harbor bridge, and opera house at night was spectacular. The dinner was highlighted by performances by members of the Sydney Opera. During this wonderful evening, I met Dr. John Royale, FRACS (retired), who was a former president of the RACS and is the current unofficial historian for the RACS. It was a great opportunity to learn about the structure of the RACS and how it came into

could be implemented to try to further improve our OR's safety and quality.

I spent two days in Auckland before driving south on the North Island. I spent a morning visiting with Dr. Blair in Hamilton at his clinic and learning how the private versus public system of care works in New Zealand. We then went on a walking tour of the city. The highlight of the tour was visiting the Maori Heritage Museum. This was a fantastic place to learn about the exceedingly interesting history of the indigenous people of New Zealand and how their culture and way of life were changed by the establishment of European settlements.

After leaving Hamilton, I headed to the geothermal hot springs in Rotorura. This region is certainly worth the day and a half that I spent there, as I have never visited any place quite like it. I guess I could say that it is perhaps one of the most geographically diverse and shockingly beautiful places I have ever visited. In a matter of a few hours, I traveled through an arboreal forest, to a rain forest, finally arriving on a black sand beach.

My tour of the North Island ended in Wellington, the capital of New Zealand. From Wellington, I took the car ferry across to the South Island. Along the way, the ferry was accompanied by dolphins that followed us all the way to our port along an inland waterway. As luck would have it, the ferry dropped me off in one of the best wine regions of the world. The Marlborough region is world-renowned for



The three chairs given to the RACS by Dr. Charles W. Mayo to commemorate the formation of the RACS.

its wonderful white wines. However, I must say that I found many of the red wines to be outstanding, much to the dismay of many of my Australian colleagues who I was to meet later in the trip.

Christchurch

Although I could have stayed in the wine region for a few more days, I pressed on southward toward Christchurch, a beautiful city, to visit with Dr. Frank Frizelle, FRACS. The Christchurch Hospital is a very large tertiary referral center. I spent the day with Dr. Frizelle, touring the hospital, going on rounds with his fellows, and visiting the colorectal research facilities.

My visit to Christchurch was a little different than the one others might experience. I arrived in the city during a frenzy

of activity. As it turned out, the weekend of my visit was the same as the championship rugby match for the Australia and New Zealand Rugby Union. The championship was between two New Zealand teams, one from Christchurch and the other from Wellington. Rugby was completely new to me but, as I quickly learned, this match was the equivalent of the Super Bowl, the World Series, and the National Collegiate Athletic Association Final Four basketball tournament, all rolled up into one. I enjoyed the match with Dr. Frizelle and his family after a delightful dinner, although I had no idea what was happening on the field.

Melbourne

Having finished my tour of New Zealand, I headed to my last stop, Melbourne. During

my brief stay in Melbourne, I was scheduled to meet with the colorectal surgeons at Cabrini Hospital. Two members of the group had done a portion of their colorectal training at the Mayo Clinic. After catching up on some gossip, we set about touring the hospital, the endoscopy suite, and the operating theaters. The day in the hospital ended with a mixer with surgeons from other hospitals in the city and the surgical clinical research staff at Cabrini. To end the evening, we enjoyed a fabulous dinner at the home of Dr. Paul McMurrick, FRACS. The food was outstanding, the conversation was even better, and the Australian red wine was superb. When I mentioned my fondness for a number of New Zealand red wines, I was quickly and loudly informed that obviously my ability to discern high-quality wine was questionable.

I spent the next day touring the RACS headquarters. My tour guide was Dr. Royale. We visited all the meeting rooms, which housed a collection of beautiful antiques and paintings given to the RACS. Every one of those items had a fascinating story. I was also allowed to browse through the Gordon Craig Library, which contains an extensive collection of antique medical books.

Lastly, and most personally interesting to me, Dr. Royale laid out the history of how the RACS came into existence. As it turns out, an important impetus to its formation came from a deep friendship between the famous Australian surgeon, Hugh Devine, and

the Mayo brothers, Charles and William. Both brothers, representing the American College of Surgeons, had toured Australia and New Zealand in 1924. The next year, Dr. Devine spent time in Rochester, MN, at the Mayo Clinic, where he traveled down the Mississippi River on the Mayos' riverboat. To make the story complete, John showed me the chairs presented to the RACS by the Mayo Clinic in honor of its formation when Charles W. Mayo was made an honorary member of the RACS. These three ceremonial chairs were for the president, vice-president, and secretary of the college. They currently sit in one of the large meeting rooms in the RACS headquarters in Melbourne. Again, this small bit of history only further reinforced what I had learned since arriving in Newcastle: although we may be separated by more than half a world, we share more similarities than differences.

Lessons learned

Overall, my time in Australia and New Zealand as the American College of Surgeons Australia and New Zealand Travelling Fellow was one of the most rewarding personal and professional experiences that I have ever had. To be able to see such beautiful places and to interact with such wonderful people who happen to be very passionate about surgery and quality medical care was truly a unique opportunity. I learned that many of the problems relative to medical care and surgery that we are dealing with in the U.S. are

similar to issues being dealt with in Australasia. The RACS' past and current emphasis on the "audit" or surgeon-specific outcomes measures should be a model for the ACS' push toward outcomes analysis of its members in order to improve quality of care. Although the same problem may have different solutions or approaches for different groups, it is important to note what others have done to determine if their solution is appropriate for us.

Lastly, the most long-lasting impact of this fellowship was the relationships formed. It is one thing to fly into a country to give a talk, but it is an entirely improved experience to also spend time "walking the wards," and sharing a meal turns colleagues into friends. Already I was able to return the favor by hosting Dr. Deane at my institution before his visit to the Clinical Congress in October. For these relationships and experiences I had while visiting Australia and New Zealand, I am truly grateful to the American College Surgeons and the RACS Chapter of the American College of Surgeons for selecting me as the 2006 ANZ Travelling Fellow.

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