

Report of the 2009 Australia and New Zealand Traveling Fellow

by *Richard J. Bold, MD, FACS*

It is with a tremendous amount of honor and pleasure that I am providing the report as the ACS Australia and New Zealand (ANZ) Chapter Traveling Fellow for the year 2009. It was indeed a memorable experience to travel to Australia, meet a variety of our Australian colleagues throughout the country, and visit with them during their annual Scientific Congress of the Royal Australasian College of Surgeons. I had the opportunity to experience firsthand the surgical environment within Australia and to develop what I hope will be long-lasting friendships. This opportunity clearly demonstrated that many of the issues we are facing within the profession span international boundaries, as my Australian colleagues are struggling with the same complex circumstances in practice and delivery of quality surgical care to patients.

Brisbane

The initial part of my journey was centered around The annual Scientific Congress for 2009 of the Royal Australasian College of Surgeons. This meeting was held in Brisbane, Australia, beginning May 6, and lasted for four days. Prior to my arrival, I had worked with the three conveners responsible for organizing the



At the Congressional dinner of the Royal Australasian College of Surgeons. Front row, left to right: Dr. Finch, Raechelle Finch, Dr. Modlin. Back row, left to right: Dr. Bold, Kristine Bold.

various scientific programs of the meeting. These included Rob Finch, MB, FRACS, an upper GI and hepatobiliary surgeon from the Royal Brisbane Hospital, responsible for organizing the hepatopancreatobiliary and upper GI surgery section; Andrew Barbour, MD, FRACS, from the Greenslopes Specialist Clinic, Queensland, who organized the surgical oncology section; and Daniel De Viana, MB, from the Gold Coast Health Care Center

in Southport, Queensland, who organized the breast cancer section. With the help of these three conveners, I became integrated into the scientific program of the meeting. In addition, my host, John Buckingham, MB, FACS (President of the ANZ Chapter), facilitated my travel. One of the topics of the ANZ Chapter meeting was focused on potential mechanisms to foster young surgeons joining the chapter, and Dr. Buckingham asked that I offer

my view of a surgical career from the perspective of a young surgeon.

Dr. Finch was the most gracious of hosts, beginning with my arrival in Brisbane and throughout the entire meeting. My participation in the hepatopancreatobiliary session included three lectures that paralleled the theme that he had established regarding pancreatic diseases. Dr. Finch also invited Irvin Modlin, MD, from Yale University, New Haven, CT, to give the keynote lecture on pancreatic neuroendocrine tumors. I provided an additional lecture on the surgical strategies for pancreatic neuroendocrine tumors. Although I had never met Dr. Modlin prior to the meeting, his work had impressed me, and as a direct consequence of this meeting, I think I have developed a great friendship with him. I was fortunate enough to have my family accompany me as part of my traveling fellowship, and at the congressional dinner, Dr. Finch and his wife, Raechelle, hosted my wife, Kristine and me, as well as Dr. Modlin (see photo, page 27).

Two additional sessions that I participated in during the meeting focused on pancreatic adenocarcinoma. My ACS lecture to the surgical congress was entitled Population-Based Outcomes in Pancreatic Cancer, and detailed the investigation into the epidemiology, as well as outcomes, of patients with pancreatic adenocarcinoma in the state of California. There are a number of similarities between Australia and the state of California, including



The ACS lecture at the Annual Scientific Congress of the Royal Australasian College of Surgeons. Left to right: Dr. Bold, Dr. Cameron, and Dr. Buckingham.

ethnic diversity, geographic diversity, and access to health care, that made this lecture very relevant to the audience. Unbeknownst to me, and with very little fanfare, John Cameron, MD, FACS, President of the ACS, was attending the congress as well. On the day prior to my ACS lecture, Dr. Cameron gave his personal perspective on the treatment of pancreatic cancer. I truly enjoyed the opportunity to meet Dr. Cameron and to have our two lectures juxtaposed as part of the meeting (see photo, this page).

As part of my final presentation in the overall topic of pancreatic adenocarcinoma, I discussed Optimal Staging in Patient Selection: Where Are We Now? This session led to a very spirited debate among

surgeons involved in treating pancreatic cancer, in which, regardless of national boundaries, we struggle with the same difficulties in the management of this deadly disease.

My participation in the surgical oncology section detailed the implementation of telemedicine resources at University of California (UC) Davis Cancer Center to facilitate community-based interaction in the multidisciplinary care of cancer patients. This lecture was entitled Multidisciplinary Clinics and the Community Surgeon, and it related the development of a virtual tumor board with real-time video and data conferencing to allow four regional cancer centers to participate in the disease-specific tumor boards at UC Davis. Given



The Pancreatic Cancer Research Group at the Garvin Institute. Front row, left to right: Chris Scarlett, Emily Colvin, Amanda Mawson, and Mary-Ann Brancano. Back row: Andrew Biankin, Johana Susanto, Mark Pinese, Emily Stoddard, David Chang, and Dr. Bold.

the vast geographic diversity of Australia, this concept was very intriguing to this group of surgical oncologists for the facilitation of disease management and referral, as well as optimal patient treatment and consequent outcomes. The remainder of this session focused on ongoing clinical trials in surgical oncology, for which we have used our telemedicine platform to disseminate information, and even to identify patients remotely for clinical trials accrual. This concept had significant traction for this group of investigators and there is some degree of hope that this mechanism can facilitate ongoing patient accrual in these types of clinical trials.

Dr. De Viana asked me to participate in the section related to sentinel lymph node

biopsy for breast cancer. This was a delight, as this session was truly high-powered, with involvement by Pat Whitworth, MD, FACS, from Nashville, TN, as well as Emil Rutgers, MD, from Amsterdam. My lecture, entitled Impact of Implementation of Sentinel Node on Stage and Survival in Breast Cancer, reviewed the impact of sentinel lymph node biopsy on upstaging of early breast cancer, and the potential impact stage migration may have on disease-specific outcomes. Again, the audience's discussion was quite spirited, as is typical of breast cancer sessions, and it became clear that while sentinel lymph node biopsy is well entrenched in the current management of breast cancer in Australia, the evolution is proceeding similarly to that of the U.S.

The clinical trials discussed as ongoing in Australia paralleled the clinical investigation performed worldwide.

Sydney

From Brisbane, I traveled to Sydney for a visit that was coordinated by Andrew Biankin, MB, FRACS, of the Bankstown Hospital and the Garvin Institute. Dr. Biankin first had me visit the Bankstown Hospital, during which time I participated in their Gastrointestinal Tumor Board. This visit was followed by a lecture entitled Clinical Management of Pancreatic Cancer, offered to this multidisciplinary group of clinicians involved in treating pancreatic cancer.

From there, I participated in their ward rounds, which made me realize that while hospitals throughout the world may have different external facades and internal configurations, the teams of health care providers are all committed to the highest level of patient care. It was interesting to note that we struggle with the same issues. For example, I saw patients who had undergone futile exploratory laparotomies for presumed pancreatic cancer that was, unfortunately, found to be unresectable at exploration. Furthermore, issues of outpatient hospital care, whether in skilled nursing facilities or residence-based sites, paralleled the complexity of discharge management that I encounter on a weekly basis.

Dr. Biankin then asked me to lecture at the Garvin Institute, a free-standing facility dedicated to biomedical research.

My arrival at the center occurred simultaneously with the announcement that the federal government of Australia had awarded \$70,000,000 (AUS) to the Garvin St. Vincent Campus Cancer Center to enable construction of an expansion of their biomedical research facility. While I thought the enthusiasm exhibited by the audience at my lecture was due to the subject matter, it was really excitement related to the fact that the Australian federal government had deemed the Garvin Institute a site of excellent biomedical research and worthy of further expansion. In any event, I provided their research seminar entitled *Autophagy in Cancer* to the community of biomedical investigators at the Garvin Institute.

Following this, Dr. Biankin asked me to participate in his laboratory research conference (see photo, page 29). During that time, he had organized a variety of short presentations from his research group, including various graduate students and postdoctorates, as well as collaborators. Dr. Biankin and I are two birds of a feather, in that we are both pancreatic surgeons focused on the clinical care of patients with this deadly disease, but we're also very strongly invested in benchtop research, as well as clinical outcomes research, to further the progress in the management of this disease. During this half-day research meeting, we shared similar thoughts and opinions on barriers to furthering progress, and hopefully developed a lifelong relationship.

Melbourne

From Sydney, I traveled to Melbourne, where I was hosted by Bruce Mann, MB, FRACS, of the Royal Women's Hospital of Melbourne. Dr. Mann has coordinated a group of breast cancer surgeons from throughout the Melbourne area who are engaged in ongoing educational meetings to consolidate the treatment of breast cancer, as well as promoting progress in these patients. To that end, Dr. Mann hosted me at their clinical lecture, during which I spoke on *Current Controversies in Breast Cancer*. As discussed at the breast cancer section of the Royal Australasian College of Surgeons, the management of breast cancer here remains very complex, with multiple levels of nuances related to the intricacies of disease management. It became apparent that despite attending this meeting in a foreign country, I had often had the same discussions with my surgical partners, as well as with breast cancer colleagues at UC Davis Cancer Center.

Dr. Mann was a most gracious host, in that he opened up his home and allowed me to visit with his lovely wife (Julie Miller, MD, FRACS), as well as with his family, during my visit in Melbourne. I also had the opportunity to attend the weekly morbidity and mortality conference of the general surgery division at the Royal Melbourne Hospital, and, subsequently, to participate in its Hepatobiliary Tumor Board meeting. The similarities to my own environment were overwhelming, and I was once again reminded that the

delivery of general surgical care is independent of geography.

Performance measurement

From this last visit at the Royal Melbourne Hospital, I had the opportunity to springboard into a discussion with Dr. Mann that illustrated the importance of examining surgical outcomes. The practice of general surgery in Australia is undergoing an evolution, and this was most apparent in Melbourne and Sydney, where the surgeons related their ongoing struggles to balance elective practice with emergency practice, and coordination of academic effort with private practice—all while maintaining optimal patient outcome. The National Surgical Quality Improvement Project, coordinated by the ACS, allows for the evaluation of individual patient outcomes in subsequent benchmarking. This concept is currently not implemented in Australia, but, throughout our discussions, it was apparent that it had the potential to be broadly embraced.

A subject of significant debate during my visit to Australia had to do with the recent recommendations regarding the implementation of pay for performance, issued by the government's National Health and Hospital Reform Commission. Indeed, a common ground shared between American surgeons and those internationally is the relationship between physicians and state or federal governments as significant payors of medical care. Evaluation of optimal outcomes and subsequent re-

warding of physicians compliant with parameters linked to improved outcomes remains a controversial issue. While this has already been implemented in the U.S., the absolute benefit of the improvement of health care delivery has yet to be fully realized.

As I left the U.S. for my journey, the state of California was struggling with an increasing budgetary deficit. The potential consequence of this deficit could be reduced payment to health care providers through MediCal, the state-funded health care program, as well as reduced support for academic medical institutions within the University of California. In addition, many universities throughout the U.S. have suffered a significant decline in their endowments, which support various aspects of academic medicine, including faculty retention, expansion of infrastructure, and occasional subsidization of the research environment. Upon my arrival in Australia, the impact of the recession was clearly evident, as many of the major universities had suffered significant declines in their endowment portfolios. While the recession in Australia may not seem severe to some, it will clearly have an impact on the practice of academic surgery. This situation fostered some shared commiseration regarding the impact the economy can have on surgical practice.

Practice differences

Despite all of these similarities, there are dramatic differences in the way our Australian

colleagues practice surgery compared with my current practice at UC Davis. While I am an academic surgeon with a single site of practice, it is much more common for our Australian colleagues to practice at multiple-site hospitals—while maintaining an academic affiliation. Australian health care is essentially a two-provider system in which the majority of patients have federal insurance, with an additional minority supplementing that with a private payor source. Many academic surgeons will engage in a parallel private practice to supplement their income, but also to ensure sufficient clinical volume to maintain necessary competence.

As was evident in Sydney, the high-volume center and tertiary referral source for pancreatic adenocarcinoma was directed toward Bankstown Hospital by non-university-affiliated clinical sites. In fact, the university sites within Sydney would be viewed as low-volume providers within the arena of pancreatic cancer, and it is for this reason that Dr. Biankin has aligned himself with Bankstown Hospital. This hospital provides him with a clinical outlet, as well as a resource for his ongoing translational investigation in pancreatic cancer.

One surgeon that I had met at the Royal Melbourne Hospital was affiliated with 11 different hospitals. He would frequently travel between these sites within the duration of a week, and even within a single day. While this type of practice would ensure proximi-

ty of clinical care to the patient residents, we are confronting the possibility that outcomes may be improved through the regionalization of resources, especially within the cancer arena and complex surgical procedures.

Opportunity of a lifetime

After a whirlwind tour of Australia visiting the cities of Brisbane, Sydney, and Melbourne, meeting and interacting with numerous Australian physicians, and providing the previously described lectures, it is with genuine sincerity that I report this experience was a once-in-a-lifetime opportunity. I am tremendously grateful to the ACS for the opportunity to serve as the 2009 ANZ Traveling Fellow. It is clear that many of the issues facing the delivery of surgical care, the finances of health care delivery, and the impact of the economic recession transcend our national borders.

It is with fondness that I reflect on the long-lasting relationships that I have developed with the surgeons in Australia, most notably, Rob Finch, Andrew Biankin, Bruce Mann, and John Buckingham.

As an ambassador of the American College of Surgeons, I hope that I have served its constituents well in representing American surgery to our colleagues in Australia.

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