

First Recipient of the International Observership in Hepato-Biliary-Pancreatic Surgery

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I had the honor of receiving the first International Observership provided by the Japanese Society of Hepato-Biliary-Pancreatic Surgery and went to the U.S. for 1 year, from April 1997 through March 1998. I observed hepato-biliary-pancreatic surgeries and participated in in-hospital morbidity and mortality conferences, surgical grand rounds, and department digestive organ surgery conferences. I also reviewed clinical records and images of pancreatic cancers diagnosed over the past 5 years at three American hospitals and compared them with the pancreatic cancers we are currently seeing in Japan. Overall, I was given a valuable opportunity to observe American medical care from the “inside” and Japanese medical care from the “outside.” I have already written about my experience on the Society’s webpage; some of what I write here may overlap. This time I write mainly about how the Observership has helped me in clinical practice after my return to Japan.

1) Universality

The United States is a “melting pot” or “salad bowl” comprising many ethnic groups that live and work there. In clinical research and clinical practice, global standards are essential. In large hospitals especially, U.S. and foreign residents and surgeons work together, so we need to have a standard that extends beyond culture. I felt that this “universality” attracted doctors from many different countries to the U.S. It is not advantageous to adhere to surgical techniques or limit ourselves to research studies that apply only to a particular country. While the decision to perform a particular surgery may be regarded as a contract between the physician and his or her patient, the physician must remain mindful of internationally recognized indications and risks. I visited three hospitals and was surprised that the residents and fellows at all three used the same methods. Every year, hospitals report the number of surgeries performed as well as their surgical complication rates. Naturally, patients do not choose surgeons with a record of frequent complications, leading the hospitals to terminate these

doctors' employment contracts the following year. In the U.S., each doctor is like the head of an independent company in that he/she must sign a contract with the hospital and another with an insurance company. Termination of employment by the hospital is a serious and complicated matter that affects both the hospital and the individual physician.

All three hospitals that I visited held important 7 AM breakfast conferences. The rationale is that it is best to get things done in a short time in the morning when our brain is sharpest. There is scientific evidence that holding a conference in the early morning is three times more effective than doing so in the evening, so I thought the schedule was sensible. Honestly though, I found it difficult to go to these 7 AM conferences on cold winter days, but I was surprised that no one was late and that the meetings always began on time.

The hospital in Japan where I currently work has 500 beds and 8 super-rotation residents. When we perform surgery with residents, we practice basic "textbook" procedures. We have a 1-hour, 7 AM study session with residents, and, with the hospital's permission, we conduct Basic Clinical Teaching (BCT) and Resident Case Conference Conferences (RCCs). In these ways, we are gradually trying to set up an environment for residents at our hospital that is close to that in the U.S. I also read my old textbooks and have noticed that the standard [the standard pertaining to what exactly?] in Japan is very different from the global standard.

2) Practicality

Dr. Traverso, my host at VMMC in Seattle, repeatedly told us that we are practicing physicians, NOT clinical researchers. He also said that research conducted by clinical physicians must be simple and applicable to any hospital and that research that is far from clinical practice belongs to basic science. I noticed this trend at all three hospitals, as well as when I attended annual academic/medical meetings held in the U.S. Basic medical research requiring money and time was not performed by practicing surgeons but rather by residents who are working on an advanced degree in basic medical science or by fellows who have gone into basic medical science from surgery. I also noticed that there were few surgeons who have become a fellow of American College of Surgeons (FACS) and earned a Ph.D. in addition. Americans recognize that FACS refers to a clinical surgeon who has acquired essential surgical skills and that a Ph.D. holder is one who has acquired the skills necessary for long-term scientific investigation. As I was leaving Seattle, Dr. Traverso gave me the following message: "A splendid surgeon will make significant contributions to our clinical and surgical science." I cherish this message, and even after returning to Japan, I have made a habit of asking myself whether what I am doing is useful for conference presentations and papers or can be applied to clinical practice.

3) Back-up

When the U.S. President leaves the White House by helicopter, an identical helicopter takes off simultaneously to reduce the risk of the President being targeted. This second helicopter is called a back-up, and I think the same strategy can be applied to medicine. Surgeons are not always able to perform the ideal surgery, so they predict the worst-case scenario and are ready to take necessary alternative steps. Fellows, therefore, learn the surgical skills and techniques of the staff surgeons so that they can substitute for them. I was surprised that the surgical techniques of the fellows at Mayo were exactly like those of Dr. Sarr. Our hospital is not a university hospital, so the number of surgeons is limited, and a surgeon must often perform major surgery with the assistance of a resident. For these cases, I make sure that residents perform even a simple shadow operation prior to the actual surgery. This also helps me re-train myself and realize what to change and what needs attention.

4) Surviva

Few people finish a 5-year residency. Mayo Clinic has 82 residents, including 5 chief residents. UCLA has 77 residents, including 4 chief residents. Residents at both hospitals were trying very hard to complete their programs. They can advance to the next “step” each year, but many drop out. Those with a poor attitude and those who do not fill out patients’ records accurately do not return the following year. I was stunned to hear the usually gentle Dr. Reber scolding a resident who made a critical mistake, “Go back to medical school!” This tension, I think, is the foundation for development of good surgeons. Both residents and supervising doctors learn from each other to improve and provide patients with quality medical treatment.

Only residents and fellows with sufficient surgical experience are allowed to give presentations at conferences. They are trained to present at various conferences in the hospital, and clinical fellows who complete their residency may attend receptions at international conferences to market themselves. I realized that conferences in the U.S. are not only for giving and listening to presentations but also for networking. In Japan, conferences include receptions, but we usually mingle with those within our own circle and do not really interact with doctors outside of our university or hospital group. Could this be the result of Japanese introversion and social habits?

There are many Japanese doctors who go to the U.S. to conduct research. They are very enthusiastic researchers, but most of them live in a “Japanese” neighborhood, travel with other Japanese, and sometimes avoid interacting with Americans, non-Japanese, and other persons of other ethnicities. Thus, non-Japanese do not think well of them. The Observership enables us to participate in a clinical program and attend surgeries and morbidity and mortality conferences, which are very difficult at times. In the end, I realized how much I learned from this program. I highly recommend that young

doctors apply to this program to gain the same valuable experience I gained.

In closing, I thank Dr. Tadataka Takada for making this wonderful program possible.