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HAS MEDICAL DIPLOMACY REACHED AN INFLECTION POINT?

A Dedication to Vladimir Zelman MD, PhD, DSc

Stephen F. Sener MD FACS

Presidential Address for the 56th Annual Meeting of the Midwest Surgical
Association

Delivered at Traverse City, Michigan

July 30, 2013

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4 **HAS MEDICAL DIPLOMACY REACHED AN INFLECTION POINT?**
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6 *A Dedication to Vladimir Zelman MD, PhD, DSc*
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11 Stephen F Sener MD, FACS
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14 Presidential Address delivered at Midwest Surgical Association 56th Annual
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16 Meeting, Grand Traverse Resort, Michigan, July 30, 2013.
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21 To my colleagues in the Midwest Surgical Association, distinguished guests,
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23 ladies and gentlemen: thank you for the honor and privilege of serving as your
24
25 president for the last year. I must also pay homage to three giants in the field of
26
27 surgical oncology, upon whose shoulders I stand today to make my remarks:
28
29 Edward F. Scanlon MD, Murray F. Brennan MD, and David P. Winchester MD.
30
31 Without their patient guidance, I would never have had a successful career as a
32
33 surgical oncologist and as an educator. I also thank my longstanding colleagues
34
35 at Northwestern University, Evanston Hospital, and the University of Southern
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37 California (USC). Their friendship has carried me through some of the interesting
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39 times that I will describe today.
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48 I am especially grateful to Susan Eisenhower, Emeritus Director of the
49
50 Eisenhower Foundation, for providing the inspiration for my remarks. In a speech
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52 she gave at USC several months ago, she described two events which occurred
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54 75 years ago, little known or recognized at the time but which, as they gathered
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56 momentum, reached an inflection point past which they would have endured
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4 regardless of the motivating forces behind the concepts. The year was 1938, and
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6 the news was consumed by coverage of Adolf Hitler and the annexation of
7
8 Austria to Germany. However, in that same year, the process of nuclear fission
9
10 was identified. Interesting enough, fission was discovered in Germany, but it was
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12 Leo Szilard and Enrico Fermi in the USA, who appreciated that it could be
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14 contained in a nuclear chain reactor and harnessed to create a uranium bomb.
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16 Within four years after the discovery of fission, an atomic pile was functioning
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18 under Stagg Field at the University of Chicago. From discovery until fission's use
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20 in the atomic bomb, only seven years had elapsed. In the same year of 1938, oil
21
22 was discovered in Saudi Arabia. And, although it took many years longer, few
23
24 could argue the importance of oil as a current global geopolitical issue. So, the
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26 question that I pose today is whether medical diplomacy has reached an
27
28 inflection point, past which its importance as a global force cannot be argued.
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38 ***The Groundwork for Modern Diplomacy***

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40 Henry Kissinger, in his book, *Diplomacy*, described the origins in post-medieval
41
42 history beginning in the 17th century with the French Cardinal Richelieu, who
43
44 introduced the modern approach to international relations.¹ During the next two
45
46 centuries, European diplomacy was dominated by Great Britain, which was
47
48 responsible for the concept of the balance of power. In the latter 19th century,
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50 Austria's Metternich reconstructed Europe, and shortly thereafter Germany's
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52 Bismarck dismantled it, reshaping European diplomacy into a very hard
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54 proposition of power politics.
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7 But, it is post-World War II history that laid the groundwork for the modern
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9 concept of *medical* diplomacy. When the Soviets launched Sputnik in October
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11 1957, Krushchev actually believed that a serious change had occurred in the
12
13 balance of power between countries of socialism and capitalism, in favor of the
14
15 socialist nations. He sought to translate this perceived change into a diplomatic
16
17 advantage; his target was Berlin. During 1958, Krushchev delivered a series of
18
19 ultimatums, challenging the formal arrangement between the United States,
20
21 France, Great Britain, and the USSR for the control of Berlin. By the time John
22
23 F. Kennedy took office in January 1961, nearly three years had past and nothing
24
25 had happened in Berlin, reducing the credibility of Krushchev's threats. However,
26
27 with the Kennedy Administration's failure to overthrow Castro in Cuba and its
28
29 indecision regarding intervention in Laos, Krushchev viewed Kennedy as weak.
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31 At a meeting with Kennedy in June 1961 in Vienna at the Hotel Imperial,
32
33 Krushchev issued his final ultimatum regarding Berlin, which began the most
34
35 intense period of confrontation of the Cold War. On August 13, 1961, West
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37 Berliners awoke to find that a true "Berlin Crisis" existed, as a barbed-wire fence
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39 had been built around the entire city, isolating the Soviet sector from those
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41 occupied by the three Western countries.
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53 This huge dilemma was followed on October 16, 1962 with photographic
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55 evidence, convincingly demonstrating that the Soviets had placed missiles with
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57 nuclear warheads in Cuba. In his book, *Thirteen Days*, Robert F. Kennedy
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4 described in graphic detail John F. Kennedy's belief that the "Cuban Missile
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7 Crisis" could have culminated in a nuclear war.² This was a frightening time.
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9 Krushchev and Kennedy had to use all of the diplomatic maneuvers that they
10
11 could conjure to prevent an armed conflict between the USA and USSR,
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13 including a late night stealth meeting between Soviet Ambassador Dobrynin and
14
15 Robert Kennedy in Washington, DC.
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21 ***Armand Hammer MD, the Prototype Medical Diplomat***

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23 Enter onto the stage an unlikely intermediary, Armand Hammer MD, born in 1898
24
25 in New York to Russian-born Jewish immigrants.³ His physician-father, Julius,
26
27 had moved in 1875 to the Bronx, where he ran a medical practice and owned five
28
29 drugstores. Julius was an avowed socialist, and in 1907 he met and developed a
30
31 lifelong deep friendship with Vladimir Lenin. After graduating from Columbia
32
33 Medical College in 1921, Armand used his father's connections and his
34
35 entrepreneurial skills, developed exporting pharmaceuticals to the newly-formed
36
37 USSR, to broker a deal in the Soviet Union with Lenin to send a shipment of
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39 surplus American wheat to the USSR. While living there in the 1920's, Hammer
40
41 brought medical supplies to assist in a typhus epidemic, developed a large
42
43 business manufacturing pens and pencils for use in the Soviet Union, and even
44
45 convinced Henry Ford to create a plant in the USSR to manufacture the
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47 "Fordson" tractor.
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4 When he returned to the USA in 1930, Hammer participated in a diverse array of
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6 business endeavors, including investing in US oil production efforts. He
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8 subsequently parlayed these investments into a controlling interest of Occidental
9
10 Petroleum Company. In the midst of these engagements, he met and developed
11
12 a longtime friendship with Al Gore, Sr, Senator from Tennessee. Throughout his
13
14 life Hammer continued personal and business relationships and had significant
15
16 cache with leaders in the Soviet Union, including Krushchev. The relationship
17
18 between Hammer, Krushchev, and Gore Sr played a significant role in brokering
19
20 the 1961 summit meeting between Krushchev and Kennedy in Vienna.⁴
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29 In his later years, Hammer traveled extensively, working for peace between the
30
31 USA and Communist countries. In my opinion, Hammer must be regarded as the
32
33 post-World War II prototype medical diplomat. The Hammer story will come back
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35 around later.
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40 ***Medical Diplomacy during the Second Half of the 20th Century***

41
42 In subsequent years, a number of organizations arose, which took up the cause
43
44 of international humanitarian medical missions. Perhaps the first and best
45
46 organized was Medecins Sans Frontieres (MSF) (aka Doctors Without Borders),
47
48 founded by Bernard Kouchner and Raymond Borel in 1971, in response to
49
50 Biafran secession during the Nigerian Civil War.⁵ This small group of French
51
52 physicians and journalists was motivated by the belief that all people have the
53
54 right to medical care, and that their needs supercede border considerations.
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4 MSF's first mission was in Managua, Nicaragua, where a 1972 earthquake killed
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6 between 10,000 and 30,000 people. MSF received the 1999 Nobel Peace Prize
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8 in recognition of continued efforts to provide medical care in acute crises and to
9
10 raise international awareness of humanitarian disasters. Last year, over 26,000
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12 volunteer medical professionals and water/sanitation engineers provided medical
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14 aid in over 60 countries, funded for the most part by individual private donors.
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21 Another example is the Bill and Melinda Gates Foundation, which was founded in
22
23 1994 and is the largest private foundation in the world, with an endowment of
24
25 over \$36 billion (\$28 billion from Bill Gates).⁶ In 19 short years, the Foundation
26
27 has grown into three grant-making programs, including Global Health, Global
28
29 Development, and US-based grants. The Global Health program funds service
30
31 grants in AIDS, infectious diseases, and immunizations, among others. The
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33 Global Development program funds financial services for the poor, agricultural
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35 improvement, and earthquake Relief.
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43 ***Public Health Efforts to Control Tobacco***

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45 Perhaps the most sustained and largest global public health effort to date has
46
47 been the attempt to control the use of tobacco products. King James I provided
48
49 royal opposition to the new addiction as early as 1604, describing smoking as "a
50
51 custom loathsome to the eye, hateful to the nose, and dangerous to the lungs."⁷
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53 Even though the relationship between smoking and lung cancer was described in
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55 Germany in the 1930's, it was not until Sir Richard Doll (UK) in 1950 and the
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4 subsequent Hammond-Horn Study (USA) put a fine point on the causal link
5
6 between the two, that worldwide efforts at tobacco control began.⁸⁻¹⁰ In 1964, the
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8 US Surgeon General, Luther Terry MD, released the first report of the Surgeon
9
10 General's Advisory Committee on Smoking and Health, which concluded that
11
12 cigarette smoking was a cause of lung cancer.¹¹ Shortly thereafter, the US
13
14 Congress adopted the Federal Cigarette Labeling and Advertising Act of 1965
15
16 and the Public Health Cigarette Smoking Act of 1969. These laws required health
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18 warnings on cigarette packages and banned cigarette advertising in the
19
20 broadcasting media. Tobacco control advocates quickly banned together from
21
22 government agencies and nongovernment voluntary health organizations, such
23
24 as the American Cancer Society, to form the National Interagency Council on
25
26 Smoking and Health. Multi-pronged, comprehensive tobacco control policies
27
28 were then developed. One of the most visible successes of this advocacy
29
30 movement was the passage of the Federal Aviation Act with the Durbin
31
32 Amendment in 1988, making domestic air flights of less than two hours smoke-
33
34 free.¹² During the next year, Senator Frank Lautenberg (D-NJ) took the battle to
35
36 the Senate to make longer flights smoke-free. And after years of internal debate,
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38 Delta Airlines took the bold step to make all flights worldwide smoke-free in 1995.
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50 Shortly after the Surgeon General's report was issued, tobacco consumption in
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52 the USA began to drop significantly from its peak of 200 packs per capita per
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54 year.^{13,14} But, it was not until 1990 that age-adjusted lung cancer death rates
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56 began to fall in men. With the implementation of comprehensive tobacco control
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4 programs, the per capita annual consumption in the USA dropped even further,
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6 with greater declines in states with strong programs, such as Massachusetts and
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8 California.¹⁵ The lung cancer death rate among US women, who began regular
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10 cigarette smoking later than men, has just peaked nationwide and has begun to
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12 decrease in California.
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15 16 17 18 19 ***The Framework Convention on Tobacco Control***

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21 But, the tobacco industry realized that there was a huge international market for
22
23 their products, and systematic saturation with private-public collaborations
24
25 marked the steep growth of tobacco consumption worldwide in the 1990's.
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28 Fueled by the success of the anti-tobacco movement in the USA, the global
29
30 response of international tobacco advocates was to become more organized into
31
32 a confederation through The World Conference on Tobacco or Health (WCTOH).
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35 But, it was a master stroke of diplomacy by Ruth Roemer, Allyn Taylor, and
36
37 Judith Mackay, when their proposal for a multilateral treaty regarding tobacco
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39 control was adopted as a conference resolution at the 9th WCTOH in 1994.¹⁶ The
40
41 next year, the World Health Assembly resolved to create an instrument adopted
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43 by the United Nations calling for an international convention on tobacco control,
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45 the Framework Convention Alliance. When Gro Harlem Brundtland, a Norwegian
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47 physician, was elected director general of the World Health Organization (WHO)
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49 in 1998, there was finally enough diplomatic momentum that the WHO fully
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51 supported the concept of a binding multilateral treaty on tobacco control, the
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53 Framework Convention on Tobacco Control (FCTC). Negotiations for the treaty
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4 began in 1999 and were most notable for the *unprecedented* inclusion of
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6 nongovernment organizations throughout the drafting processes. As a past
7
8 national president of the American Cancer Society (ACS), I am proud to say that
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10 members of the ACS, such as Thomas Glynn, were instrumental in forging a
11
12 concept, which represents the present day pinnacle of diplomacy on behalf of
13
14 global public health.
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21 Much of the groundwork for economic justification of the FCTC was done by the
22
23 World Bank, which asserted that tobacco control would not harm evolving
24
25 economies.¹⁷ Despite the vigorous attempts of the tobacco industry and the
26
27 International Tobacco Growers' Association to thwart the efforts of the drafters of
28
29 the FCTC, the treaty was adopted by the World Health Assembly in 2003. It is
30
31 the first United Nations treaty to address a public health issue, offering the best
32
33 chance to globally address tobacco control, and it will continue to generate
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35 tobacco control advocacy in every country in the world. The FCTC became
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37 international law in 2005 when 40 countries had ratified it. Currently, 168
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39 countries have signed and ratified the FCTC, representing 86% of the world's
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41 population. Alas, the USA is one of 9 countries, which have signed but not
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43 ratified the treaty, as neither Presidents Bush nor Obama have had the political
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45 will to send the treaty to the Senate for ratification. The major provisions of the
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47 FCTC were designed to address cross-border issues and include an advertising
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49 ban, health warning labels, protection from second hand smoke, a ban on sale to
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51 minors, and legislation to control smuggling of tobacco products.¹⁸
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Non-government Organizations and Worldwide Breast Health Programs

On a different but contemporary track, advocacy for international breast health programs was supported by US-based non-government voluntary health organizations, such as Susan G. Komen for the Cure and the American Cancer Society. Breast cancer is the most common cancer in women in the developing world. It is also the most likely reason that a woman will die of cancer anywhere in the world, except the USA.¹⁹ Between 1990 and 2010 in the USA, the age-adjusted death rate from breast cancer dropped 33% because of a combination of utilization of improved detection techniques and better adjuvant therapy.²⁰ But, in developing countries, most women with breast cancer present with locally advanced or metastatic disease. In that setting, one does not need a mammogram to find a breast cancer; a program of breast awareness and clinical exam will suffice in the early phase of a detection program.

In 2002, under the auspices of Susan G. Komen for the Cure, Benjamin Anderson MD and Leslie Sullivan founded the Breast Health Global Initiative (BHGI), which has become internationally recognized for leading the global movement towards clinical improvement and implementation of “best practices” for breast cancer.²¹ Over the past decade, BHGI has produced model approaches for consensus guidelines, which are comprehensive, resource-stratified, and evidence-based.²² The objective was to effectively detect, diagnose, and treat breast cancer in low- and middle-resource countries. These

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4 guidelines were the outcomes of 5 global summits and were produced with
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6 extensive worldwide scientific collaboration. BHGI pilot projects have tested the
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8 feasibility of guideline implementation in the Ukraine, Ghana, Columbia, and
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10 Israel. The last of these feasibility studies identified that the current breast cancer
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12 screening program in Israel is a model for other middle-income countries in
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14 South America and Eastern Europe.
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21 Beginning in the mid- to late-1990's, the American Cancer Society (ACS) began
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23 a more deliberate engagement in international activities, even though the original
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25 articles of confederation dating back to 1913 had mandated a commitment to
26
27 global health problems. The ACS realized that tobacco control had to be waged
28
29 on a global scale. But, it also recognized that cancer is a disease without
30
31 borders. With current international migration and travel patterns, the USA has
32
33 absorbed the world's cancer problems. In 2000, there were 6 million deaths
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35 worldwide from cancer. Murraray and Lopez have estimated that by 2020 that
36
37 number will have doubled, with 75% of all cancer deaths occurring in the
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39 developing world, the countries least equipped to deal with them.²³ The
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41 international program was designed to build capacity for cancer control in the
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43 countries with the greatest need and where ACS could have the most impact.
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53 I was a member of the volunteer group, which pushed the international agenda
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55 for the ACS. My first foray into humanitarian medical missions began in the mid-
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57 1990's, when Mickhail Tolstykh, then a medical student at Moscow State
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4 University, visited me at Evanston Hospital, Northwestern University, for an
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6 elective rotation. One thing led to another, and in May 1999 a seven member
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8 surgical team spent the first week of several over the ensuing years at the
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10 Central Clinical Railroad Hospital Semashko, Moscow State University. Although
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12 we were exhilarated by helping a relatively small number of individual patients,
13
14 we were frustrated by our inability to help the Russian surgeons accomplish
15
16 systematic change to medical care in Russia. This, and subsequent similar
17
18 experiences in Latvia and India, taught me a valuable lesson. In order to have
19
20 the opportunity to make significant change in a country's health care delivery
21
22 system, one must have access to both the medical *and* political leadership. So,
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24 when Dr. Guangwei Xu, the president of the Chinese Anti-Cancer Association,
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26 approached the ACS and me, as president of the ACS, about the possibility of
27
28 creating a screening program for breast cancer in China, I was especially
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30 encouraged by the active involvement in the project by Wu Yi, then Vice-Premier
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32 of China.
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43 In the early 2000's, it was realized that there was a bimodal age distribution for
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45 breast cancer in China, with peaks in women in their 30's and 60's, and an
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47 increasing incidence in urban women. And yet, there was no organized screening
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49 program for early detection. After numerous exploratory and planning meetings,
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51 an ACS delegation, composed of internationally known experts in breast cancer
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53 screening, joined members of the Chinese medical and political hierarchy in an
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55 International Forum on Breast Cancer in Beijing in February 2005 to finalize
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4 plans for a nationwide breast screening program. The result was the One Million
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6 Women Breast Cancer Screening Project, launched in Spring 2005, with the
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8 primary objectives of establishing national breast cancer screening guidelines in
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10 China and creating a platform for clinical research in breast cancer detection. We
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12 realized that there would probably never be another randomized clinical trial of
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14 screening for breast cancer in the USA. And so, any further advances in
15
16 screening research would most likely have to be done outside of the USA. This
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18 was to have been the largest screening program to date comparing
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20 mammography with ultrasound. Because of the large fraction of young women
21
22 with breast cancer in China, women ages 35-70 years were to be screened four
23
24 times between 2005 and 2010. Eighty mobile vans, equipped with mammogram
25
26 and ultrasound units, were created for use in five urban areas. All digital images
27
28 were stored in a PACS unit in Beijing, there was central review of pathology
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30 slides, and further diagnostic workups were completed in the cancer hospitals to
31
32 which the vans were attached. Top Chinese government leadership saw this
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34 project as a focal point for change.
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45 In May 2006, as the program was accelerating, another surgical team
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47 representing the ACS and Evanston Northwestern Healthcare went to Beijing
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49 Cancer Hospital for Chinese-American Surgical Oncology Week, hosted by Dr.
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51 Jin Gu, vice president of Beijing Cancer Hospital. The goal was to highlight the
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53 advantages of breast cancer screening for patient care, demonstrating breast
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55 conserving and sentinel node procedures, ultimately creating a shared learning
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4 environment for US and Chinese surgeons, anesthesiologists, and nurses. Alas,
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6 however, with the retirement of Dr. Xu and Vice-Premier Wu Yi, the breast
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8 screening program was privatized and lost momentum. Another tough lesson
9
10 learned: programs designed to change systems and cultures require *sustained*
11
12 medical and political leadership.
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19 ***Vladimir Zelman, MD, PhD, DSc, an Enduring Model of Medical Diplomacy***
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21 And, now I turn to the man for whom this piece is dedicated, Dr. Vladimir Zelman.
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23 Like many Jewish families in Eastern Europe in the early 1940's, his fled the
24
25 Ukraine, went to Uzbekistan, and eventually settled in Siberia.²⁴ Vladimir grew up
26
27 there and obtained his MD from Novosibirsk State Medical Institute in 1959. Early
28
29 student research work under the guidance of prominent Russian scientists gave
30
31 Dr. Zelman a unique opportunity to prepare himself for a successful career in
32
33 clinical and laboratory research. He became interested in anesthesiology and
34
35 was closely involved in developing new clinical strategies aimed at brain
36
37 protection during open heart procedures. His publications in this field led him to
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39 national recognition in the Soviet Union. He was also a pioneer in developing a
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41 helicopter air ambulance transport system in Northern Siberia. He was then
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43 recruited in 1969 to direct a research program in Moscow as chief of
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45 anesthesiology and critical care under the auspices of the Russian Academy of
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47 Sciences Institute of Neurology/Neurosurgery to study cerebral blood flow auto-
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49 regulation and brain metabolism.
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4 Here is where the Hammer story comes back around. In 1976, Armand Hammer
5 was visiting Moscow and became ill with an intense respiratory virus. Dr. Zelman
6 cared for Dr. Hammer in a critical care unit, and subsequently Dr. Zelman was
7 brought to the USA as Dr. Hammer's personal physician. After completing a US
8 residency in Anesthesiology, Dr. Zelman joined the faculty at the University of
9 Southern California (USC), where he has served in various leadership capacities
10 in his department to this day. However, Vladimir has maintained the especially
11 strong ties that he established within the Russian Academy of Sciences and the
12 medical establishment. He is renowned and revered in Russia for his active
13 participation in humanitarian medical missions, including the Chernobyl nuclear
14 power plant catastrophe with Dr. Hammer in 1986, earthquake in Armenia, and
15 gas pipeline explosion in Bashkortostan, Russia. He has most recently been a
16 key intellectual influence in the development of Skolkovo, a unique model of
17 private-public collaboration with the Russian Academy of Sciences to develop a
18 national basic science research program in Russia.

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43 So, it was no surprise that, when the wife of the chancellor of St. Petersburg
44 University ruptured a cerebral aneurysm some years ago, Dr. Zelman was called
45 to her aid. She survived, neurologically intact. Today, that lady is Svetlana
46 Medvedev, and her husband is Dmitry Medvedev, who went on from chancellor
47 of St. Petersburg University to become president of Russia. Dr. Zelman has
48 maintained a close personal relationship with the Medvedevs. When Mrs.
49 Medvedev was deciding how to create a legacy program as wife of the Russian
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4 president, she sought counsel from Dr. Zelman. As I had recently moved from
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6 Northwestern University to USC, Dr. Zelman was aware of past ACS history and
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8 interest of Dr. Christy Russell and me in international cancer control programs.
9
10 We recommended that Mrs. Medvedev establish a national breast cancer
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12 screening program and HPV immunization/cervical cancer detection programs,
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14 based on the high incidence of breast and cervical cancer in Russian women.
15
16 Finally, with all of the previous lessons learned during international medical
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18 missions, it was apparent that we had come full circle in Russia. This was the
19
20 missing link in our attempts to establish a breast cancer screening program in
21
22 Russia in the late 1990's-access to what we hoped was sustained medical and
23
24 political leadership. Drs. Zelman, Russell, and I embarked on a series of
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26 conversations with Mrs. Medvedev, which to date have resulted in a pilot
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28 demonstration mammogram project and the provision of HPV vaccinations in St.
29
30 Petersburg, robust discussions regarding the inclusion of vaccination for young
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32 boys and girls in the Russian national vaccination program, and plans for a
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34 rehabilitation program after breast cancer treatment.
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45 Everyone who knows Dr. Zelman remains amazed at the depth of his contacts
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47 and understanding of international medical diplomacy. He has my personal
48
49 gratitude for a life of service as a very powerful force for good. Here is a man
50
51 who is not interested in money or glory, just in proving that he is serious about
52
53 changing the world.
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Quo vadit?

So, has medical diplomacy reached an inflection point? Will people like Vladimir Zelman take up the torch in the next generation? All we have to do is look around us in July 2013 to know that this movement will continue. In the June 7, 2013 issue of *SCIENCE*, the Japanese government announced a global effort to contain infectious diseases by forming a Global Health Innovative Technology Fund with the Bill and Melinda Gates Foundation.²⁵ In the June 2013 issue of the *Journal of the American College of Surgeons*, surgeons from Abu Dhabi reported outcomes from data submitted to the American College of Surgeons (ACoS) National Surgical Quality Improvement Program (NSQIP).²⁶ Also, in the June 2013 American College of Surgeons Bulletin, a network of US kidney transplant surgeons, with Guyanese health care professionals and philanthropists, reported on a program, delivering free kidney transplants to patients in Guyana.²⁷

After a nearly twenty-year experience, many issues continue to capture my interest and maintain my enthusiasm for participating in international cancer control programs. However, it simply boils down to this: Margaret Mead's well-worn but apt maxim keeps me coming back. "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."²⁸

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Figure(s)

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Corresponding Author: ___ Stephen F. Sener MD, FACS

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July 15, 2013

Dear Drs. Delaney and Bland,

Attached is my Presidential Address from the 56th Annual Meeting of the Midwest Surgical Association, to be given on July 30, 2013.

I hope it meets with your approval.

Best regards,

Stephen F. Sener MD, FACS

***Structured Abstract**

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4 This is no abstract for this presidential address.
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