

# AWARD ORATIONS

## MEDICAL ONCOLOGY GROUP OF AUSTRALIA (MOGA)/NOVARTIS CANCER ACHIEVEMENT AWARD

### ONCOLOGY AND OPPORTUNITY

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When I started in oncology, it was a relatively new specialty ready for development and I have watched it develop so rapidly that it has now had to sub-specialise. But for me the diversity of oncology has provided opportunities for a career to date that has been rich in experience and satisfaction.

When I went off to interview for a job in the US, after my first year of advanced training in Ian Cooper's unit at the Peter MacCallum Cancer Centre, the data managers there gave me a banner made of a computer printout. It said "Do oncology, see the world". They now call it oncotourism, but at that time it was quite prophetic.

My career has been itinerant. My oncology training was at Peter MacCallum and at the Alfred with Max Schwarz in Melbourne. It was there under his guidance that I published my first supportive care paper when we published the first ever report in man of the use of DMSO (dimethyl sulphoxide) as an antidote to doxorubicin extravasation.<sup>1</sup> I subsequently performed the largest prospective trial confirming the efficacy of this approach, treating patients at both the Peter MacCallum and the University of Maryland Cancer Centre.<sup>2</sup>

I then travelled to Baltimore, because in those days there were no trials methodology workshops like ACORD, and we had to take ourselves overseas to learn the craft of clinical research. For me it was early phase drug trials. In Baltimore, Joe Aisner had given me the project of writing the definitive paper on the methodology of antiemetic studies for the now discontinued journal, *Cancer Treatment Reports*, as they had begun receiving the first of the antiemetic trial papers.<sup>3</sup> I published the paper with Joe Aisner and Richard Simon, a statistician from the National Cancer Institute. That later became the basis of my MD and 30 antiemetic papers mark a career long research interest.



Very few other problems in oncology have been solved within three decades, but with two new classes of drugs, the 5 hydroxytryptamine 3 (5HT3) receptor antagonists largely controlling acute emesis in combination with steroids, and the neurokinin 1 (NK1) receptor antagonists making a significant impact on delayed emesis, this is largely the case for chemotherapy induced emesis.<sup>4</sup>

The challenge of returning to Australia was how to translate the new drugs trials research into the Australian context. We were all National Cancer Institute investigators and were able to apply for investigational new drugs, but it was a difficult process and could take time obtaining Commonwealth Government approval for the trials, although we had some success investigating new agents including Trimetrexate,<sup>5</sup> and Flavone Acetic Acid.<sup>6</sup> However, there was no drug pipeline. We had to be innovative and keep the early phase trials program open by investigating drug radiation interactions,<sup>7</sup> or ambulatory infusion scheduling of drugs when portable pumps became available.<sup>8</sup> A lucky break came when carboplatin was not patented in Australia. The Victorian College of Pharmacy manufactured it in collaboration with Faulding's and we were able to perform early trials of combinations containing carboplatin in head and neck and small cell lung cancers.<sup>9-10</sup> Subsequently, a similar scenario occurred with paclitaxel and we joined in on the early investigations of that drug.<sup>11</sup> With the Baume report and the development of the CTN/CTX scheme, it became possible to investigate new drugs in a timeframe that was internationally competitive and pharmaceutical company sponsored drug trials became increasingly available. The highlight of my early phase drug trial career was the opportunity to perform a first in man study at the Royal Adelaide Hospital of a GM-CSF antagonist, E21R,

which had been developed in the Hanson Centre on that campus.<sup>12</sup>

Returning to Peter MacCallum from the US, I found a wonderful place to work. Multidisciplinary care with radiation oncology was entrenched. Jim Bishop and I set up the first Bendigo clinic, as a medical oncology outreach; and look at it now with a multidisciplinary cancer centre of its own. It was at Peter MacCallum that I was asked to join their ethics committee and sent off on a short course in bioethics run by Monash University. That subsequently led to a PhD. I was fortunate in having one of the great Australian bioethicists as my supervisor, Peter Singer, who didn't agree with a word that I wrote but made me argue my case so rigorously the result was beyond doubt. I subsequently published it as a book exploring the topic, *Is Death Ever preferable to Life?*<sup>13</sup>

The one thing they don't teach in advanced training is politics. I had my first experience of this as a young oncologist at Peter MacCallum, when I came home from work one day to hear on the news that Peter MacCallum was going to be split between the Royal Melbourne and the Repat. There was a spontaneous public objection which soon had the announcement overturned, but I spent much time subsequently with the Medical Director and a small group of clinicians trying to shore up the survival of Peter MacCallum. The centre subsequently did move and I was part of the Victorian Cancer Review that recommended it move on to the Parkville site, but on its own terms as a powerful group in multidisciplinary cancer care. Politics can change your environment, sometimes dramatically, but even if you don't have a say in the shape of the pile, you still have to reach the top of it, and even when you are at your most despondent about what is going on around you, you must remember that the cream will always rise to the top.

In the early nineties, I had the opportunity to move to the Royal Adelaide Hospital (RAH) to become Director of Medical Oncology. Within 18 months as the hospital re-organised, I had the further opportunity to build from scratch a multidisciplinary cancer centre within this large hospital. In those early days I had a great team of people around me and we had good fun building up this centre, always keeping patient care as the primary focus. I wrote the book *Conquering Cancer* to share some of the information that I gave my patients with a wider audience.<sup>14</sup> Some of our patients and their relatives became great supporters. Our day centre, for example, was named for Jessie Bradman following a generous donation in her memory. I even involved my own family in the cancer centre that took so much of my time, with my son Chris' finance Nicole singing at our annual Christmas celebration.

It was in Adelaide that to solve the clinical problem of exporting multidisciplinary care, I began health services research into the use of videoconferencing. Sid Selva and I set up a telemedicine link between the oncology multidisciplinary meeting at the Royal Adelaide and Darwin Hospital. That has been continuous since 1996 and it is very satisfying to see that oncology has developed in Darwin.<sup>15</sup> With a further initiative from the RAH Cancer Centre, radiotherapy will come to Darwin. We also

explored extending the outreach of palliative care to rural South Australia using videophones.<sup>16</sup> During my time at the RAH, I established and ran the outreach clinic at Alice Springs for 13 years. There I gained knowledge of the different ways our Aborigines view cancer and its treatment, and how we can work together to bridge the cultural gap in treating cancer. This was dramatically captured in an aboriginal painting, 'The Cancer Warrior', by a local artist that I was given when I left, along with a spear and boomerangs given by one of my patients because "a warrior needs weapons".

I was also given the opportunity in Adelaide of training an oncologist from India to start an oncology unit at the Christian Medical College Hospital, a large 2000 bed hospital in Vellore in southern India. I have had very rich experiences continuing to visit that unit and subsequently repeating the experience in a similar hospital in Ludhiana in the north.

My research interests had evolved to embrace psycho-oncology because of the qualitative techniques of psychology researchers required to answer the questions posed by my further studies into both bioethics and theology (I have just completed a 1000 patient spirituality study). Again, I was fortunate to develop a great research team trained in the appropriate psychological research techniques. This cross disciplinary research, among many other things, has provided me this year with the opportunity to publish a paper with my son Scott, who is a psychologist.<sup>17</sup> Teaching undergraduates and supervising Masters and PhD students has been a richly rewarding part of my role and I was honoured to address the Australian Medical Students convention in Adelaide at the invitation of my youngest son Robert, and his colleagues.

During more recent times I have been increasingly involved in the big picture national issues. I was involved in the Victorian Cancer Services Review, and their Single Machine Unit Review, as well as a review of the Sydney South West Area Health Service and the South Australian Cancer Plan, and have served on the Boards of the National Breast and Ovarian Cancer Centre and Cancer Australia. During my time as chair of the Medical Oncology Group of Australia my particular focus was on drug availability issues, having previously served on the Australian Drug Evaluation Committee (ADEC) and I set up the first of the annual drug roundtables with all of the key players in drug regulation to discuss issues of mutual interest.

Believing that I had achieved all that I could in South Australia, I was attracted to my current position as CEO, Cancer Council Australia, to pursue a more strategic role. I have a new team and the role has been broad and interesting, with advocacy on cancer policy to the Federal politicians, the excitement of the 20/20 conference in 2008, communicating with and through the media and still being able to pursue psycho-oncologic research. It promises an exciting next phase to my career.

I thank all of those who have supported me, especially my wife and family, all those with whom I have worked and the patients who have enriched my life. However, I particularly value this award because it was awarded by my colleagues and peers. I am most grateful to Novartis and MOGA for this honour.

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## References

1. Olver IN, Schwarz MA. Use of dimethyl sulphoxide in limiting tissue damage caused by extravasation of doxorubicin. (Letter) *Cancer Treat Rep* 1983, 67: 407-8.
2. Olver IN, Aisner J, Hament A, Buchanan L, Bishop JF, Kaplan RS. A prospective study of topical dimethyl sulphoxide (DMSO) for treating anthracycline extravasations. *J Clin Oncol* 1988, 6: 1732-1735.
3. Olver IN, Simon RM, Aisner J. Antiemetic studies: A methodological discussion. *Cancer Treat Rep* 1986, 70: 555-564.
4. Olver IN. Prevention of chemotherapy-induced nausea and vomiting: Focus on fosaprepitant. *Therapeutics and Clinical Risk Management* 2008;4(2) 1-6.
5. Bishop JF, Raghavan D, Olver IN, Reece P, Morris R, Friedlander ML. A phase I study of trimetrexate (NSC 352122) administered by a 5 day continuous intravenous infusion. *Cancer Chemother Pharmacol* 1989, 23: 246-250.
6. Olver IN, Webster LK, Bishop JF, Stokes KH. A phase I and pharmacokinetic study of 12-h infusion of flavone acetic acid. *Cancer Chemother Pharmacol* 1992, 29: 354-356.
7. Olver IN, Hughes PG, Smith JG, Narayan K, Bishop JF. Concurrent radiotherapy and continuous ambulatory infusion 5-fluorouracil in advanced head and neck cancer. *Eur J Cancer* 1995, 6: 867-870.
8. Olver IN, Bishop JF, Baxter H. A phase I dose finding study of prolonged ambulatory infusion 5-fluorouracil with oral leucovorin for colorectal cancer. *J Infusional Chemotherapy* 1994, 4: 131-134.
9. Olver IN, Dalley D, Woods R, Aroney R, Hughes P, Bishop JF, Cruickshank D. A Phase II study of carboplatin and continuous infusion 5 fluorouracil for advanced head and neck cancer. *Eur J Cancer Clin Oncol* 1989, 25 (2): 173-176.
10. Bishop JF, Kefford R, Raghavan D, Zalberg J, Stuart-Harris R, Ball D, Olver IN, Friedlander M, Bull C, Yuen K, Zimet A. Etoposide, carboplatin, cyclophosphamide and vincristine (ECCO) in previously untreated patients with small cell lung cancer. *Cancer Chemother Pharmacol* 1990, 25: 367-370.
11. Olver I, Davy M, Luftner D, Park S-H, Egorin M, Ellis A, Webster L. A phase I study of paclitaxel and altretamine as second line therapy to cisplatin regimens for ovarian cancer. *Cancer Chemother Pharmacol* 2001, 2: 109-114.
12. Olver IN, Hercus T, Lopez A, Vadas M, Somogyi AA, Doyle A, Foster JR, Keefe D, Taylor A, Brown, M, To LB, Cole J, Rawling T, Cambareri B, Myers M, Olszewski N, Bastiras S, Senn C, Hey A, Verma M, Wigley P. A phase I study of the GM-CSF antagonist E21R. *Cancer Chemother Pharmacol* 2002, 50: 171-178
13. Olver IN. *Is Death Ever Preferable to Life?* Kluwer Academic Publishers, Dordrecht 2002
14. Olver IN. *Conquering Cancer. Your Guide to Treatment and Research.* Allen and Unwin, Sydney 1998.
15. Olver IN, Selva-Nayagam S. Evaluation of a telemedicine link between Darwin and Adelaide to facilitate cancer management. *Telemedicine Journal* 2000, 6: 213-218.
16. Olver IN, Brooksbank M, Champion N, Keeley J. The use of videophones to enhance palliative care outreach nursing in remote areas. *Prog Pall Care* 2005, 13: 263-267.
17. Olver IN, Whitford HS, Denson LA, Peterson MJ, Olver SI. Improving informed consent to chemotherapy: a randomized controlled trial of written information versus an interactive multimedia CD-ROM. *Patient Edu and Couns* 2008 Oct 20 Epub ahead of print.