



AMERICAN COLLEGE OF SURGEONS

SURGERY NEWS

Many Medical Practices Ill Prepared for Disaster

BY DOUG BRUNK  
Elsevier Global Medical News

SAN DIEGO — About one-third of medical practices have no emergency medical preparedness plan to deal with disasters such as hurricanes, floods, wildfires, and terrorist attacks, results from a national survey demonstrated.

In fact, more than 60% have not had disaster drills in their practice in the last 12 months and report not knowing how to coordinate actions with federal emergency agencies, researchers led by Christopher D. Stokes reported in a poster session at the annual conference of the Medical Group Management Association.

However, the researchers emphasized that such apparent lack of preparedness is not the sole fault of medical practices. Although the Health and Human Services Department “has made \$1.1 billion available to assist public health departments, hospitals, and other health care organizations to strengthen their ability to respond to public health and medical emergencies, very little money is directed toward medical practices. Government agencies do not seek to assist med-

ical practices in their preparation efforts, but expect them to respond and continue operating in the wake of disaster,” they wrote in their poster.

For the study, the researchers electronically surveyed 188 U.S. medical practices to assess their level of emergency preparedness and their attitudes about the government in disaster planning and emergency preparedness.

The respondents were invited to participate through MGMA’s Legislative and Executive Advocacy Response Network, which conducts research on policy issues that affect medical practices, said Mr. Stokes, program manager at MGMA’s center for research.

The majority of respondents (87%) indicated that there was a moderate to high probability of a disaster occurrence in their community within the next 5 years. Respondents from the Western United States listed earthquakes (77%), wildfires (66%), and floods as the top three most likely disasters to affect

them, whereas Midwestern respondents cited tornadoes (93%), floods (57%), and avian flu (36%). Southern respondents said they were most likely to face tornadoes (80%), hurricanes (60%), and floods (60%), whereas those from the East listed West Nile virus (52%), avian flu (50%), and tornadoes (47%).

Nearly one-third of respondents (30%) reported having no emergency preparedness plan; 62% have not had drills in their practice in the last 12 months; 68% do not know how to coordinate actions with federal emergency agencies; 71% have not participated in drills with a local hospital in the last 12 months, and 84% have not participated in drills with government agencies in the last 12 months.

More than one-third (36%) said they would participate in an all-day disaster drill without full compensation, whereas 55% said they had not considered the issue.

Respondents listed the following ways they would contact their patients if they

had to close their practice because of a disaster: record a message on the voice mail greeting (91%); make human-powered telephone calls (91%); tape a message on the door (90%); make announcements on local radio or TV programs (76%); and use computerized outgoing phone calls (42%) and e-mail messages (24%).

Mr. Stokes and his colleagues concluded that all practices “should have an emergency preparedness plan and the federal government needs to fund medical practice emergency preparation activities.” They went on to note that medical practices “have a mandatory requirement to report communicable diseases, they are often willing to participate in emergencies, and they can quickly disseminate critical health messages to the public. Including [medical] practices in funded preparation activities will strengthen national preparation, improve recovery efforts, and leverage scarce resources.”

The study was funded by the HHS Office of the Assistant Secretary for Preparedness and Response, through the Idaho Bioterrorism Awareness and Preparedness Program.



More than 60% of the practices surveyed had not had disaster drills within the last 12 months.  
MR. STOKES

Morbidity Higher in Obese After Coronary Artery Bypass

BY MITCHEL L. ZOLER  
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TORONTO — Obesity was linked to an increased risk for postsurgical complications in a study of more than 11,000 patients who underwent coronary bypass surgery.

But in this series, obesity did not result in a significantly increased risk for postsurgical mortality, Dr. Mahboob Alam said at the 14th World Congress on Heart Disease.

Obesity also was linked to a significant 38% reduced risk for repeat operations for postoperative bleeding, an unexpected finding that requires further study to understand, said Dr. Alam, a cardiologist at Baylor College of Medicine, Houston.

The retrospective study included 11,417 consecutive patients who underwent coronary artery bypass surgery at St. Luke’s Episcopal Hospital in Houston during 1996-2006. The series included 2,257 patients (20%) who were obese (defined as having a body mass index of 30 kg/m<sup>2</sup> or greater).

The nonobese patients were older, with an average age of 64 years, compared with an average age of 61 in the obese patients. But the obese patients had more comorbidities, with higher rates of unstable angina, coronary artery disease, hypertension, heart failure, and diabetes.

The primary end point for the analysis was mortality

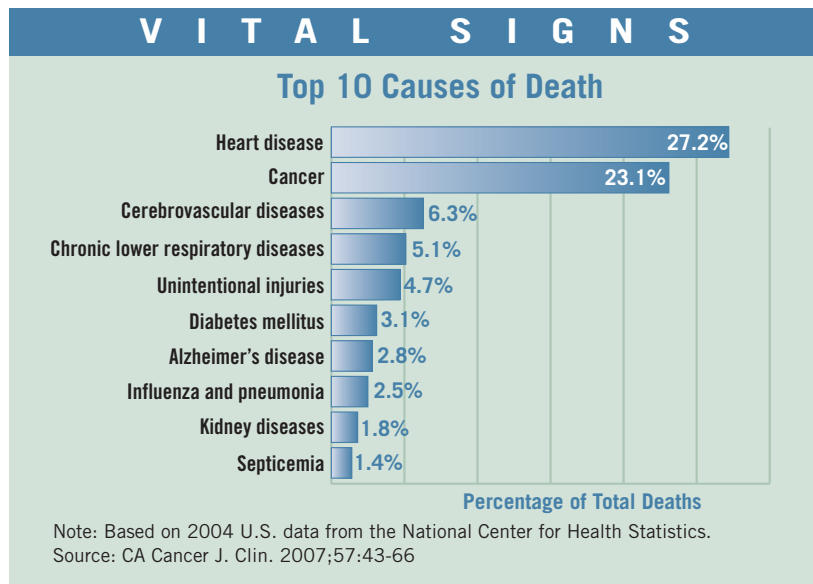
during the first 30 days following bypass surgery, and although the obese patients had an 8% increased risk for death in a multivariate analysis, this difference was not statistically significant relative to the nonobese patients, Dr. Alam said at the congress sponsored by the International Academy of Cardiology.

The multivariate analysis showed that obesity was linked with significant increases in the rate of several new-onset morbidities, compared with nonobese patients following coronary artery bypass, including a 43% increased rate of renal insufficiency, a 71% increased rate of myocardial infarction, a 46% rise in respiratory failure, a 2.9-fold increased rate of sternal wound infections, and a 2.1-fold boost in the rate of leg wound infections.

In addition, obesity was linked with a significantly increased duration of postoperative hospitalization. Nonobese patients spent an average of 10.5 days hospitalized, compared with an average of 11.85 days of postoperative hospitalization for the obese patients.



Obesity also was linked to a 38% reduced risk for repeat operations for postoperative bleeding.  
DR. ALAM





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## SURGERY NEWS

## Preop Radiation for Rectal Cancer Has Pros and Cons

BY NEIL OSTERWEIL  
Elsevier Global Medical News

BOSTON — A short course of preoperative radiotherapy for rectal cancer reduces local recurrences and improves disease-free survival in men and women, but is associated with significantly higher rates of fecal incontinence and male sexual dysfunction than surgery alone.

That finding emerged from an analysis of quality of life (QoL) data from a randomized clinical trial comparing preoperative radiotherapy plus surgery with surgery followed by selective postoperative chemoradiotherapy. Findings from the study of 1,350 patients with non-metastatic, clinically operable adenocarcinoma of the rectum were reported at the annual meeting of the American Society for Therapeutic Radiology and Oncology.

Mean scores on the male sexual function questions of a European Organization for Research and Treatment of Cancer (EORTC) quality-of-life instrument were 65.7 out of 100 among men in the preoperative radiotherapy group, compared with 54.4 among men in the surgery/selective chemoradiotherapy group ( $P = .051$ ). Higher scores on the scale indicate greater degrees of dysfunction.

Surgery itself appeared to be the main factor driving male sexual dysfunction, study investigator Dr. David Sebag-

Montefiore reported, with abdominoperineal resections resulting in higher degrees of dysfunction than anterior resections. Preoperative radiotherapy added further degrees of dysfunction.

Men and women who underwent preoperative radiotherapy also were significantly more likely to report unintentional release of stools at 2 years (52.4% vs. 38.7%;  $P = .015$ ), said Dr. Sebag-Montefiore of the St. James Institute of Oncology in Leeds, England.

He presented updated efficacy information and a preliminary analysis of QoL data from the MRC CR07/NCIC CO16 trial, which enrolled patients from 1998 through 2005. Preliminary results of the trial were first reported in 2006.

The trial randomized patients (73% were men, with a median age 65 years) with nonmetastatic operable cancer of the rectum less than 15 cm from the anal verge to a short course of radiotherapy at 25 Gy in five fractions followed by surgical resection, or to surgical resection—with chemoradiation (45 Gy) reserved for patients with involvement of the circumferential resection margin on postoperative pathology (11% of patients in this arm). Patients received adjuvant chemotherapy according to the policy of the treating institution, but there were no significant differences in this therapy between patients in the two study arms.

The primary end point of the trial

was local recurrence. With a median of 4 years of follow-up, the actuarial 3-year local recurrence rate for all patients in the surgery/selective chemoradiotherapy group was 10.6%, compared with 4.4% for the preoperative radiotherapy group, with a hazard ratio of 0.39 in favor of the radiotherapy protocol ( $P = .000004$ ).

Disease-free survival at 3 years also was significantly better among the radiotherapy patients, at 77.5% vs. 71.5%, with a hazard ratio of 0.76 ( $P = .013$ ). There was no difference in overall survival, however, with a hazard ratio of 0.92, Dr. Sebag-Montefiore said.

All patients in the study were asked to complete the 36-Item Short Form Health Survey (SF-36) and the EORTC QLQ-CR38 to assess quality of life at baseline, every 3 months for the first year, and every 6 months up to 3 years. Scores were normalized to a 0-100 scale, with higher scores indicating worse functioning or symptoms. On the EORTC form, question 20 asks, "Did you have difficulty getting or maintaining an erection?" (on a scale of 1-4), and question 21 asks, "Did you have problems with ejaculation?" (also on a 1-4 scale).

The data were analyzed according to treatment type in an intention-to-treat analysis, and by surgical approach.

Among all male participants, the mean scores on the combined questions 20 and 21 at 2 years were 65.7 for men

in the preoperative radiotherapy group vs. 54.4 for men in the surgery/selective chemoradiotherapy group ( $P = .051$ ). For the subset of men who had involvement of the circumferential resection margin and received chemoradiotherapy, the mean score was 66.6, compared with 57.1 for men with clean margins ( $P = .034$ ).

Male sexual function also differed by type of operation, with men who underwent surgery alone (clean margins) reporting greater sexual dysfunction if they underwent abdominoperineal resection, compared with anterior resection (67.1 vs. 52.8, respectively;  $P = .050$ ).

Among the men who underwent anterior resection, those who received preoperative radiotherapy had worse sexual function than those in the surgery/selective chemoradiotherapy group with mean scores of 65.4 vs. 52.8, respectively ( $P = .024$ ). There were no significant differences in sexual function between the two treatment groups among men who underwent abdominoperineal resections.

Although overall bowel function scores did not differ between the preoperative radiotherapy and surgery/selective chemoradiotherapy groups, the proportion of all patients reporting unintentional release of stools at 2 years was 52.4% vs. 38.7%, respectively ( $P = .015$ ).

The study authors disclosed no financial conflicts. ■

## Intervention Improves Respectful Behavior in the OR

BY DAMIAN McNAMARA  
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ORLANDO — An intervention to foster mutual respect among OR physicians and personnel improved the working environment and reduced reports of verbal and physical abuse, according to annual feedback surveys completed by staff at Maimonides Medical Center in Brooklyn, N.Y.

"There was a history of problems between anesthesiology and surgery, and it was miserable for all the OR workers. There was verbal abuse, physical abuse—there were scalpels being thrown across the room," Dr. Dawn McNiel said in an interview at her poster during the annual meeting of the American Society of Anesthesiologists.

In 2006, the hospital began a monthly lecture training series to improve clinician communication skills. Principles taught in the lectures were based on a book titled "Crucial Conversations: Tools for Talking When Stakes Are High," by Kerry Patterson et al. (New York: McGraw-Hill, 2002).

Staff learned "how to step out of the situation—to avoid personal attacks and... [to] know bad behavior

would not be tolerated," said Dr. McNiel, an anesthesiologist at Maimonides. The lectures were sufficiently successful that they are being used in many parts of the hospital, Dr. McNiel said.

Along with the lectures, the hospital adopted the use of a Code of Mutual Respect developed by Dr. David Feldman, vice chair of perioperative services, and his colleagues from the departments of anesthesiology and surgery. Dr. McNiel likened the code to a "three strikes, you're out" policy.

A first offense leads to a discussion between the people involved, a second leads to a formal complaint in the personnel file, and a third results in suspension from the operating room.

To gauge comprehension of the code and the impact of the intervention, Dr. McNiel and her associates surveyed OR staff at the beginning of, during, and after completion of the workshop series. The survey included the following items, which respondents scored on a scale of 1-5:

► I have a clear understanding of the Code of Mutual Respect.

► I believe the code will positively enhance our workplace and help us provide better care to our patients.



Staff learned how to avoid personal attacks and to 'know bad behavior would not be tolerated.'  
DR. McNIEL

► I believe physicians and staff are held to the same standards of professional behavior.

► I think our leaders handle disrespectful behavior effectively.

► When I see someone violating the code, I speak up.

► Overall, I feel I am treated with respect by those with whom I work.

► I feel I treat others with respect in my daily interactions.

Analysis of the surveys revealed modest improvements in how the staff felt they were treated, Dr. McNiel said. "The only statistically significant finding was people felt they could speak up more without consequences."

The program also features a hotline number for complaints.

All staff who are cited in an alleged violation of the code are subsequently contacted for their reports, Dr. McNiel said. ■