



AMERICAN COLLEGE OF SURGEONS

SURGERY NEWS

Surgeon Survey Scopes Out Career Sore Points

BY ROBERT FINN

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SAN FRANCISCO — Eighty-five percent of surgeons who responded to a survey said they were satisfied with their careers, but 59% said they worked too many hours and more than 90% said they would like to be paid more and sued less.

Those are some of the results from the *Lifestyles in Surgery Today (LIST)* survey, a 56-item questionnaire mailed to board-certified surgeons around the United States. Investigators received completed surveys from 895 surgeons, which constituted a response rate of 26%. Dr. Kathrin M. Troppmann said at the annual clinical congress of the American College of Surgeons.

On average, respondents said that a 50-hour workweek would be appropriate for a surgeon, but they also said they worked an average of 64 hours per week. They reported spending 20 hours per week with family and friends, but only 4 hours on hobbies and recreation.

“Although most were dissatisfied with the total hours worked, it’s interesting to note that the irregularity and unpredictability of those work hours were even more significant,” said Dr. Troppmann, an ACS Fellow with the University of California, Davis. While 74% said that they were dissatisfied with their pay considering the total number of hours they worked, 84% linked the dissatisfaction to schedule irregularity. And 86% said their pay was too low considering the amount of responsibility they bear for their patients’ health.

Forty-five percent of the respondents were general surgeons, and the rest were specialists, notably vascular (9%), cardiothoracic (7%), and trauma/critical care surgeons (6%).

Eighty percent were male, and their

average age was 46 years. Ninety percent were married or living with a stable life partner, and 86% had children.

Twenty percent of the respondents worked at a university or in a Veterans Affairs setting, and 72% worked in an urban location.

The investigators performed a multivariate analysis, controlling for demographic factors, professional factors, practice setting, practice location, and satisfaction with reimbursement. Two

risk factors that emerged as significant independent predictors of career dissatisfaction were pay dissatisfaction (relative risk 5.9) and a nonuniversity, non-VA practice setting (RR 3.3).

The same two risk factors proved to be independent predictors of nonrecommendation of a surgical career to the surgeons’ own children (RR of 3.4 and 2.5, respectively).

Only dissatisfaction with pay emerged as an independent predictor of an inability

to achieve work-life balance (RR 3.0).

When asked what changes would improve their quality of life, respondents cited better pay (93%), less litigation (92%), reduced or minimized emergency call (76%), more vacation time (62%), and fewer administrative responsibilities (55%).

The LIST survey was supported by the American College of Surgeons and the Association of Women Surgeons. Dr. Troppmann had no other disclosures. ■

Female Surgeons Face More Family Life Obstacles

Women who are surgeons are as satisfied as are their male counterparts, but face “profound family life implications” in their chosen profession, according to additional data presented by Dr. Kathrin M. Troppmann at the annual meeting of the Western Surgical Association in Santa Fe, New Mexico.

Comparing responses from 178 women and 698 men, she reported that female surgeons were significantly less likely to live with a spouse or partner—only 80% vs. 93% of male surgeons. And fewer female surgeons had children: just 64% vs. 91% of the men who responded.

Those women who were married did not necessarily have more help at home. More than half of the men, 56%, described their spouses as homemakers, but barely 10% of the women did so. Moreover, among those with children at home, 80% of men but only 27% of women described their spouses or partners as the primary caretaker.

Women were almost twice as likely to marry another professional (44% vs. 23% of men), reported Dr.

Troppmann, an ACS Fellow. They did marry other physicians at a rate similar to that of their male counterparts (18% and 14%, respectively), but a much higher proportion of female surgeons were wed to surgeons (19% vs. 3% of male surgeons).

(Of note, Dr. Troppmann’s coauthors included her surgeon husband, Dr. Christoph Troppmann, also an ACS Fellow with the University of California, Davis, who shared in the duties of presenting the study and tending to their two children during the meeting.)

Female surgeons who were parents waited longer to have the first child, according to the reported responses. More than half of 612 surgeon fathers became parents either in medical school (10%) or during their residency (49%), but nearly two-thirds (62%) of 109 surgeon mothers waited until they were in surgical practice.

More than two-thirds (68%) of women but less than a third (31%) of men said maternity leave is important. And women said ideal leave would be a median of 8 weeks, while men settled on 7 weeks. (Actual leave

taken was a median of 6 weeks.)

The median actual work week was 65 hours for men, and 60 hours for women; both agreed that 50 would be ideal. Although their ranks were small, more female surgeons (6% vs. 2% of male surgeons) worked part time, and two-thirds (67%) of women but less than half of the men (45%) wanted more part-time opportunities. Women also were more in favor of increased full-time shift work (40% vs. 28% of men).

Despite these challenges, Dr. Troppmann reported that women were as satisfied as men were in their choice of careers, with one exception: Significantly more women cited the intrinsic reward of helping others, compared with men (97% vs. 92%). Women also were more likely to say they would choose the surgical profession again (83% vs. 78% of men). This last difference was only a trend statistically, but more women (84%) than men (61%) said they would recommend surgery as a career to women—and this difference was significant.

—Jane Salodof MacNeil

FDA Takes a Closer Look at Xigris Bleeding Events

BY ALICIA AULT

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The Food and Drug Administration said on Feb. 4 that it is working with Eli Lilly & Co. to review the incidence of serious bleeding events and mortality in patients receiving the company’s sepsis drug drotrecogin alfa (Xigris).

The agency will not take any action until it has completed a review, which could take months, according to a posting on the FDA’s Web site.

Bleeding is the most frequently reported adverse reaction with Xigris. The drug was initially approved in

the United States in 2001 and received an updated warning in 2005. At that time, the label was amended to state that the therapy might not be appropriate for patients with single organ dysfunction and recent surgery.

The FDA began its most recent review after a 73-patient retrospective study found that patients with risk factors for bleeding had a significantly higher risk of a serious bleeding event with Xigris (*Crit. Care Med.* 2009; 37:19-25). Thirty-five percent of patients who had a risk factor had a serious bleeding event (7 of 20), versus only 3.8% (2 of 53) of those who did not have a risk factor.

The authors acknowledged that the study had limitations, including that it was retrospective, and the find-

ings are consistent with what’s in current product labeling, said the agency, but the results were enough to prompt the FDA to take a closer look at bleeding events.

Xigris is already contraindicated in patients with active internal bleeding; recent hemorrhagic stroke; recent intracranial or intraspinal surgery or severe head trauma; trauma with an increased risk of life-threatening bleeding; presence of an epidural catheter; and intracranial neoplasm or mass lesion or evidence of cerebral herniation.

Health care professionals and patients should report any side effects to the FDA’s MedWatch Adverse Event Reporting program (www.fda.gov/medwatch/). ■



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Conservative Surgery Effective for Jejunioileal Crohn's

BY JEFF EVANS

Elsevier Global Medical News

Patients with Crohn's disease that involves only the small bowel have remarkably low recurrence rates after 5 and 10 years in areas operated on with conservative surgical techniques, according to results of a large prospective study.

The study confirms the value of strictureplasty for producing low rates of disease recurrence and postoperative abdominal complications, according to Dr. Gianluca M. Sampietro and his colleagues.

Of 503 consecutive patients who were treated for primary or reoperative Crohn's disease (CD) at the Luigi Sacco University Hospital, Milan, during 1993-2007, 393 had small-bowel disease, the investigators said. These 393 patients underwent treatment of 865 jejunioileal segments via 318 minimal bowel resections and 367 strictureplasties (some of which comprised several strictures).

Most of the patients required surgery for occlusive disease (89%), followed by abdominal septic complications (9%) and abdominal symptoms refractory to medical therapy (2%), such as chronic GI bleeding. CD recurred in 17% of the patients at 5 years and in 34% at 10 years. Disease recurred at only 5% of the sites where strictureplasty had been performed—a finding

that is similar to rates reported in other studies. Strictureplasty is hypothesized to break the cycle of bacterial overgrowth, increased intraluminal pressure with submucosal bacterial spread, ulcerations, and further inflammation, according to Dr. Sampietro.

Disease recurred most often at the site of the anastomosis (31%) or in the same area of the bowel in the terminal ileum or jejunum (60%). Another 4% had a recurrence in a new area of the bowel.

In the current report, patients who were diagnosed before the age of 40 years or had CD for less than 5 years before their first surgery had a significantly increased risk of recurrence (*Clin. Gastroenterol. Hepatol.* 2009;7:183-91).

In 279 patients, standard abdominal ultrasound imaging at 12 months showed that bowel wall thickening of 6 mm or greater was associated with greater than four times higher odds of recurrence. Bowel wall thickening "seems to provide reliable prognostic information, identifying patients with aggressive disease, and it is correlated with one of the most intriguing aspects of conservative surgery for CD: the very low site-specific recurrence rate on a strictureplasty, with evidence of radiographic, endoscopic, histopathologic, and cytokine production normalization after surgery," Dr. Sampietro and his coinvestigators wrote.

As a part of a separate trial, about 60% of the patients

in the cohort had been randomized to postoperative treatment with azathioprine or mesalamine. The use of these immunomodulators, compared with other therapy, did not reduce surgical recurrence of CD at 5 years (17.3% vs. 16.6%, respectively) or at 10 years (31% vs. 36%, respectively). However, the current study was not specifically designed to test the efficacy of immunomodulator therapy on postoperative surgical recurrence, the investigators cautioned.

During a median follow-up of 5.2 years, there were no postoperative deaths in the cohort, "confirming [the] general safety of conservative surgery for CD, for which only four deaths are reported in [the] literature in over 1,200 patients," according to the researchers.

Intra-abdominal complications occurred in 5.6% of patients.

No variables pertaining to disease, preoperative therapy, blood values, or demographics were correlated with intra-abdominal complications. The investigators attributed this to the mean age of patients in the cohort at the time of surgery (nearly 40 years), the exclusion of patients with colonic involvement, the absence of emergency surgery for free perforation, and the small number of surgical patients with serum albumin levels less than 2.5 g/dL or hemoglobin levels less than 10 g/dL. Two patients in the cohort developed short-bowel syndrome. ■

Drug-Related Errors Deemed Largely Preventable

BY DAMIAN McNAMARA

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ORLANDO — Medication errors accounted for 3% of nearly 7,000 closed malpractice claims related to anesthesia care spanning more than a decade, according to the American Society of Anesthesiologists Closed Claims Project.

Incorrect dosing, drug substitution, and drug administration despite a contraindication were the most common errors, Dr. Diana Kovacich and her colleagues found when they compared 80 cases involving medication errors with 2,629 other types of medical malpractice cases in the database. (See box.)

The investigators judged errors to be preventable in 62% of medication-related cases versus just 34% of cases related to other types of errors—a significant difference. They also determined that care was less than appropriate in 84% of medication error claims, versus 27% for other claims.

Hospitals should design error reduction systems that focus on dosing and substitution errors because they can be prevented, she said in an interview at her poster during the annual meeting of the American Society of Anesthesiologists.

Excluded from the analysis were claims for acute or chronic pain, adverse

drug reactions, inadequate analgesia, or preoperative patient awareness that did not involve a wrong drug or dose. Accidental intravascular injection of local anesthetic during performance of a regional block was not considered a medication error.

The 6,893 closed malpractice claims included the years 1990 to 2001. Medication error claims were significantly more likely to occur with pediatric patients (14% vs. 6% for adults), but no other significant demographic or clinical differences were observed, Dr. Kovacich said.

Payments were made 69% of the time for medication error cases versus 49% of the time for other claims. Median payments (in 1999 dollars) were \$230,000 for medication error cases, compared with a median of \$140,000 for other claims.

Muscle relaxants (46%) and vasopressors (21%) were the most common accidentally administered medications. In four cases, for example, the muscle relaxant succinylcholine was given to a patient with a contraindication. Also, "there were situations where a surgeon injected a more concentrated form of epinephrine," said Dr. Kovacich, an anesthesiologist at the University of Washington, Seattle.

"We saw a higher incidence of undetected epinephrine [errors]—they did

not always result in brain injury or death," Dr. Kovacich said.

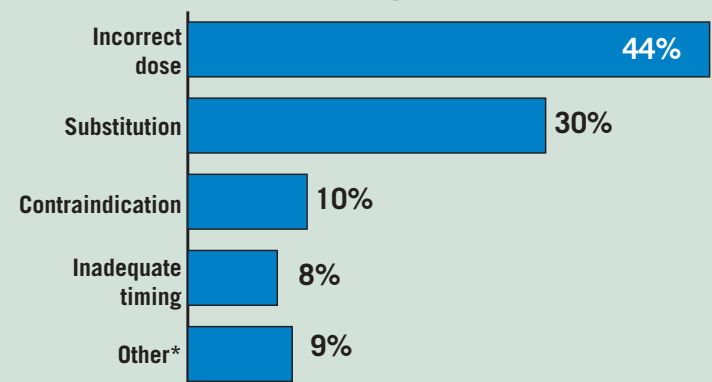
Syringe swaps occurred in 80% of medication error claims; the remaining 20% involved infusion swaps. In seven instances, a sedative was given incorrectly and caused apnea or a respiratory event. Another seven patients reportedly experienced an error attributed to incorrect administration of antihypertensives.

"Within our claims, there were 21

deaths and 13 errors that resulted in permanent brain damage," she said. Permanent brain damage occurred in 16% of claims related to medication errors, and in 8% of other malpractice claims.

Medication errors during anesthesia care have an estimated incidence of 7.5 per 1,000 anesthetics, or 1 error per 133 anesthetics, but most result in no injury or transient physiologic effects (*Anaesth. Intensive Care* 2001;29:494-500). ■

Incorrect Dosing Is the Most Common Error In Medication Malpractice Cases



*Includes errors of incorrect route, omission, and insertion, and unknown errors.

Note: Among 6,893 cases reviewed, 80 medication errors occurred.

Source: Dr. Kovacich