Formal Surgery Curriculum Sharpens Ob.Gyn. Skills

BY SHERRY BOSCHERT
San Francisco Bureau

RANCHO MIRAGE, CALIF. — A formal curriculum for teaching surgery significantly improved the skills of ob.gyn. residents in performing specific surgical tasks, a 6-year study found.

The University of Washington instituted an ob.gyn. surgery curriculum for residents starting in 1997 and compared results of testing in two groups: residents whose 4 years of training included the curriculum in each year and residents who trained earlier and encountered the curriculum only during their last 1 or 2 years of training. Residents in the second group were considered controls.

The curriculum included baseline testing at the start of each academic year, prelaboratory instruction, and twice-yearly surgical skills training sessions for 24 ob.gyn. residents; training involved both inanimate lifelike models and animal laboratories.

At the end of each year, residents were tested on individual bench skills and underwent objective structured assessment of technical skills (OSATS), which served as a means to test their abilities on procedures rather than on single tasks, Gretchen M. Lentz, M.D., said at the annual meeting of the Society of Gynecologic Surgeons.

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DR. LENTZ

Residents who had 4 years of exposure to the curriculum showed significantly better bench skills on both laparoscopic and open surgical tasks, compared with the control group, according to Dr. Lentz of the university and her associates.

OSATS scores also were higher in the intervention group than the control group, but the difference was not statistically significant, perhaps due to the small numbers of procedures that could be evaluated. "We have to change the tasks that they do every year, so that they don't know what we're going to test them on, and it limits our numbers overall," she explained.

A previous survey of 206 ob.gyn. residency programs by Dr. Lentz and associates found only 29% had a formal training program in surgical skills. The optimal format for teaching residents surgical skills, giving them feedback, and evaluating their performance has not been defined.

"Yet our educators in this field have core competencies identified for residents that we should be teaching," she said.

Many educators are calling for new standardized methods for teaching surgical skills, Dr. Lentz added. Some of this is in response to the 80-hour limits on residents' workweeks or in reaction to declining surgical volumes at some institutions. Concerns about medical errors also have increased attention on the training that residents get in operating rooms.

In the University of Washington curriculum, the intensive twice-yearly training sessions lasted 6 hours each, with two residents and one faculty member per animal. "Expert feedback is known to improve training, so we wanted this to be part of our formal program," Dr. Lentz said.

Additional sessions were scheduled throughout the year to work on hysteroscopy, laparoscopy, and cystoscopy and to familiarize residents with new procedures, techniques, or instruments before encountering them in the operating room.

In formal commentary after Dr. Lentz's presentation, Roger P. Smith, M.D., called for more studies in this area. "There can be little doubt of the wisdom of both critically addressing how we teach and learn the craft of surgery and in moving from the apprenticeship model under which we all trained," he said.

He noted, however, that the survey showing that only 26% of ob.gyn. programs had formal surgery curricula also found that 54% of programs provided some surgical experience in animal laboratories. "There may not be as wide a curriculum gap as there appears on first blush," said Dr. Smith of the University of Missouri, Kansas City. Those animal laboratory experiences often consist of a single session, Dr. Lentz said. ■

Fibroid Embolization Pays Off for Radiologists, Insurers

BY KATE JOHNSON
Montreal Bureau

SAN FRANCISCO — Compared with hysterectomy and myomectomy, uterine fibroid embolization actually bolsters rather than bleeds the health care system, Anne Bussard, M.D., reported.

"Fibroid embolization is financially advantageous for the health care system, the insurer, and the radiologist. The only economic loser is the gynecologist, who loses a $1,000 surgical fee every time a woman chooses an embolization over a myomectomy or hysterectomy," said Dr. Bussard of the Jefferson Fibroid Center at Jefferson Medical College, Philadelphia.

'Fibroid embolization is financially advantageous for the health care system,' with only the gynecologist losing a $1,000 surgical fee.

The study, which she presented at the annual meeting of the American College of Obstetricians and Gynecologists, analyzed the costs and reimbursements associated with 299 women at her center who underwent abdominal hysterectomy, 105 who had abdominal myomectomy, and 136 who had uterine fibroid embolization (UFE) for symptomatic fibroids.

The baseline characteristics of all patients did not differ significantly except for their mean age, which was oldest in the hysterectomy group (48 years), followed by the UFE group (44 years) and then the myomectomy group (37 years).

The study looked at direct costs (such as nursing costs and operating room time), indirect costs (such as administrative costs) and hospital and physician reimbursements for each procedure and then calculated a net hospital income. "This is the first study of these treatments of which we are aware that calculated the net hospital income, defined as the total reimbursement from the insurance company minus the total cost," Dr. Bussard said.

Although the insurer's reimbursement was less for UFE procedures ($2,764) than for hysterectomies ($5,135) or myomectomies ($4,961), total hospital costs, direct and indirect, were significantly less for UFE, at $2,707 versus $5,676 for myomectomy and $5,707 for hysterectomy.

As a result, the hospital lost money on both hysterectomies and myomectomies ($572 and $715, respectively), while it made an average of $57 on each UFE.

"Uterine fibroid embolization makes money—and in terms of professional costs, radiologists are reimbursed better than ob.gyns. For a short, same-day procedure, radiologists make $1,306 per embolization, and for a hysterectomy or myomectomy, which can take several hours and 2-3 days of postoperative care, ob.gyns. make $979 to $1,078," said Dr. Bussard, a resident in obstetrics and gynecology.

One study found the cost of UFE to be higher than that of hysterectomy ($8,223 vs. $6,046), but two other studies favor UFE. One comparing UFE with myomectomy found while hospital costs were lower for UFE, compared with myomectomy ($3,193 vs. $5,598) and physician costs were higher ($2,220 vs. $1,611), the overall costs were less for UFE ($6,708 vs. $7,630).

Another study comparing UFE with abdominal myomectomy, total vaginal hysterectomy, or total abdominal hysterectomy found UFE had the lowest cost. ■

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