Gender Bias May Affect Care of People with Osteoarthritis, Study Finds

BY MARIE SANDERSON

Unconscious prejudices among doctors may explain why women complaining of knee pain are less likely than men to be recommended for total knee replacement surgery, a study in a recent issue of the Canadian Medical Association Journal suggests.

Toronto researchers used two standardized or "mystery" patients, one male and one female, both with moderate knee osteoarthritis reporting the same symptoms of knee pain. The patients received assessments from 67 physicians in Ontario. Physicians were twice as likely to recommend total knee replacement surgery (known as arthroplasty) to a male patient compared to a female patient. Overall, 67 per cent of physicians recommended total knee arthroplasty to the male patient compared with 33 per cent who recommended it to the female patient.

"Disparity in the use of medical or surgical interventions is an important health care issue, and this research suggests a gender bias in the treatment of patients who may need orthopaedic surgery," says lead author Dr. Cornelia Borkhoff. Her article is based on her doctoral thesis while in the Clinical Epidemiology Program at the University of Toronto Faculty of Medicine's Department of Health Policy Management and Evaluation.

This new study, the first ever demonstration of physician bias in an actual clinical setting (i.e., with patients during actual office visits with physicians in their offices) involved 38 family physicians and 29 orthopaedic surgeons because the researchers were interested in whether barriers for women exist between the family physician and the patient in obtaining a referral to an orthopaedic surgeon or between the surgeon and the patient in the decision to offer total knee replacement. A male patient was referred to an orthopaedic surgeon 35 per cent more often than a female patient. The study also found that a man was nine times more likely than a woman to be recommended for a total knee replacement.

"Physicians may be at least partially responsible for the sex-based disparity in the rates of use of total joint arthroplasty," says Dr. Borkhoff. "Physicians are susceptible to the same social stereotyping that affects all of our behaviour. Decisions that stem from unconscious biases are not deliberate - physicians would be unaware of their unconscious biases affecting their decisions."
Gender Bias

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"We know that total knee replacements can improve a patient’s overall quality of life, regardless of gender, by dramatically reducing knee pain," says Dr. Hans Kreder, chief of the Holland Musculoskeletal Program at Sunnybrook Health Sciences Centre. “There are many variables that could impact the decision to opt for surgery, including a difference in communication styles and the fact that some people are comfortable in being more demanding when asking for a medical procedure. That said, there is an obvious sex-based discrepancy, which needs to be looked at more closely.”

More than 90 per cent of orthopaedic surgeons recommended total knee replacement to the male patient, which also suggests that surgery is the right decision and represents the best care for patients with moderate knee osteoarthritis for whom medical therapy has failed. “Our results support the need for clinician education programs to better inform physicians of the true risks of total joint arthroplasty, and for whom to consider surgery, as well as, the potential benefits of early treatment,” says Dr. Borkhoff.

"Acknowledging that a gender bias may affect physicians’ decision-making is the first step toward ensuring that women receive complete and equal access to care,” says the principal investigator of the study, Dr. James Wright, a professor at the University of Toronto, Faculty of Medicine’s Department of Health Policy Management and Evaluation. and the Surgeon-in-Chief at The Hospital for Sick Children. “The next step is to develop creative interventions to address these disparities in health care.”

The research team also includes representatives from Women's College Hospital, St. Michael's Hospital and the University Health Network.

Leukemia Research

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He compared them to “dark matter,” an unseen force that astrophysicists have come to accept as not only present in space previously thought empty, but exerting significant influence on cosmological movement. Popular science writers expanded that popular story to include these microRNAs, and solidified their function of a preclinical microRNA gene cluster, mir-17-92, that is encoded by another gene they discovered five years earlier, and implicates disease. The researchers are now estimating that there could be hundreds of microRNAs involved in cancer.

Ben-David’s lab recently identified and characterized the function of a preclinical microRNA gene cluster, min-17-92, that is encoded by another gene they named Flr-3. Flr-3 is in turn a homologue (equivalent) of the human gene c13orf25, which is implicated in B cell lymphomas and other cancers. Hence Ben-David’s excitement over this previously underappreciated class of genes. Though he has studied leukemia and lymphoma for more than 25 years, Ben- David says, “This is some of my best work. We’ve provided the first evidence that these [mir-17-92] genes can cause cancer.”

Of course, the cause-and-effect linkage between these microRNAs and certain cancers is anything but simple: in some cancers they’re overproduced, and in others they’re underproduced. Despite this intricacy, Ben-David says: “We have a good model to study human disease, and we are in the process of developing clinical trials, to translate the work from the bench to the bedside.”

Pages from Sunnybrook’s Past

2008 marks the 60th anniversary of Sunnybrook Health Sciences Centre. Over the next few months, leading up to the official anniversary in June, Sunnybrook News will take you through some of the highlights of our history.

UP AND RUNNING

By 1950, Sunnybrook was quite a magnificent sight. It only took a few years for the hospital to earn an outstanding reputation for patient care, teaching and clinical research - one that still holds true today. Dr. Ian Macdonald, Chief Executive of the New Hospital, was the driving force behind Sunnybrook’s highly acclaimed post-graduate medical education program. To join the teaching staff of the hospital which was then under the ownership of Veterans Affairs Canada, physicians had to be on the University of Toronto faculty. With an educational program comes research, so it is not surprising that in the early 1950s, Sunnybrook opened Toronto’s first clinical investigations unit.

During that time, the hospital’s specialty services included an arthritic unit, the premier paraplegic unit in Canada, physical medicine as well as other services in medicine and surgery. Interdisciplinary collaboration was something Sunnybrook valued from day one. Physicians, nurses and other health professionals, including physiotherapists and occupational therapists, approached patient care as a team and all members enthusiastically participated in patient rounds.

With information from Sunnybrook Archives

Symposium on Infection Control in Health Care Facility Design and Construction

Over 150 professionals from across Ontario specializing in the areas of infection prevention and control including members of the Regional Infection Control Networks (RICNs), local ICN’s or Local Health Integration Networks), corporate planning and development, facilities management, and also architects and contractors attended the full-day workshop focused on education and the practical application of infection control standards and their interpretation in construction design and execution.

Initiated and led by Maja McGuire, Infection Prevention and Control department recently hosted its third and highly successful annual Symposium on Infection Control in Healthcare Facility Design and Construction at the Sunnybrook Estates.

Sunnybrook Lends a Hand

Sunnybrook’s Environmental Services Department recently responded to a call to assist with an infection control outbreak situation at a hospital west of the Greater Toronto Area. “In the spirit of consultative partnerships across healthcare facilities we wanted to help out wherever possible,” says Lou Fernandes, director, Environmental Services Group. After ensuring continued appropriate service support at Sunnybrook, a core team of staff and management arrived at the west-end hospital to lend our high-level expertise in environmental cleaning and disinfection to colleagues who found themselves at a deficit to cope with escalating outbreak circumstances. “Our team is proud to be involved in this kind of outreach to the healthcare community when we can," says Fernandes. "These moments are about helping others in challenging times, while demonstrating the high level of certification training of our own staff in core competencies in infection prevention and control and reinforcing the significance of their good work and its positive contribution to patient care.”

With information from Sunnybrook Archives
Colorectal Screening Awareness

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Colorectoscopy

With rectal bleeding for instance, a colonoscopy is advised. A colonoscopy is the careful examination of the lining of the rectum and colon, with a flexible tube with a light on the end. The actual same-day procedure only takes about 25 minutes. An individual planning to get a colonoscopy is given appropriate instructions on how to clear the bowels out the day before, and is given a mild sedative during the procedure.

Screening Before Symptoms

Men and women 50 years of age or older with no symptoms should be screened for colorectal cancer - it is a similar idea to women getting mammograms for screening for breast cancer. The fecal occult blood test (FOBT) can be done at home. The FOBT comes in a compact kit. Small scrapings from two parts of the stool on three separate days are collected and the kit is then sent to a laboratory. The laboratory tests the samples for microscopic blood which if found, indicates the individual will need to go for a colonoscopy to ensure there is no cancer causing the microscopic bleeding.

Familial Risk

Men and women at any age, with one or more close relatives - parent, brother, sister, child - with a history of colorectal cancer, are at increased risk and are advised to go directly for a colonoscopy.

Open Discussion is Key

"There remains a cultural discomfort to talk about the rectum, the colon, bowel movements, that we need to get past," says Dr. Rabeneck. "People can talk more openly about breast cancer and about prostate cancer but when it comes to colorectal cancer people still hesitate to talk about it and the need to go for screening." Because of this silence, where screening for breast cancer is about 60 to 70 per cent of women, screening for colorectal cancer is less than 20 per cent each for men and women.
Regional Anesthesia Model Delivers Benefits at the Holland Centre

BY MARIE SANDERSON

A shift to regional anaesthetic from general anaesthetic has transformed Sunnybrook’s Holland Orthopaedic & Arthritic Centre into a hub of increased OR efficiency and also resulted in increased patient satisfaction. Among the other positive results are decreased staff overtime, decreased surgery cancellations through increased efficiency and an increase in the volume of total joint replacements.

The ability to convert to the use of regional anaesthetic was made possible by a hospital proposal to the Ontario Ministry of Health and Long Term Care (MOMTC) in 2006. The Anaesthesia Team Care Model proposal was accepted and received over $1 million in funding. In essence, the proposal involved implementing four operating rooms dedicated to regional anaesthesia at the Holland Centre, four separate but adjacent areas to administer the regional anaesthetic and monitor patients, as well as two Registered Nurses and two Anesthesia Assistants.

"Regional anaesthesia is different from general anaesthetic because pain is blocked at the source," explains Dr. Sue Belo, site Chief of Anesthesia at Sunnybrook’s Holland Centre, who notes that typically some type of additional sedation is used during hip and knee replacements. "Physicians argue that the advantages of using regional anaesthetic include better postoperative pain relief, less narcotic use, faster recovery, less nausea, less blood loss and also a decreased risk of blood clots. There is no known increase in risk of morbidity or mortality with regional anaesthesia."

Heather Christensen can personally attest to the benefits of regional anaesthetic. “I was very worried about general anesthesia often causes patients to feel concern and apprehension. "I was very worried going into the operation and, therefore, to my recovery," says Heather.

"Because regional anesthesia can be induced prior to the arrival of the patient in the operating room, operating room efficiency can be increased with a consistent approach to regional anaesthesia," says Dr. Belo. "The numbers are impressive: the 18 per cent decrease in OR time with the anesthesia care team model, equaling approximately one additional case per day. In 2007, there were 2,100 total joint arthroplasties performed, with 85 per cent of patients receiving neuroaxial, or spinal, anesthesia.

The benefits extend beyond patient satisfaction. The Holland Centre has also increased its volume of cases and efficiency. Since implementing the strategy, there has been an 18 per cent decrease in OR time with the anesthesia care team model, equaling approximately one additional case per day. In 2007, there were 2,100 total joint arthroplasties performed, with 85 per cent of patients receiving neuroaxial, or spinal, anesthesia.

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"Regional anesthesia can be induced prior to the arrival of the patient in the operating room, operating room efficiency can be increased with a consistent approach to regional anesthesia," says Dr. Belo. "The numbers are impressive: the 18 per cent decrease in patient-in to patient-out time in the OR has facilitated the fast-tracking of surgical cases.”

The two Registered Nurses in the block area are dedicated to patients receiving regional anaesthetic and are responsible for monitoring patients and preparing equipment. The anesthesia assistants, on the other hand, monitor stable patients under regional anesthesia in the operating room while the anesthetist is able to establish regional block anesthesia in the next patient.

Dr. Belo does caution that there are still improvements to be made, especially in the area of the post-anaesthesia care unit. "She says that there is still a learning curve in this area in terms of spinal anesthesia but is confident that strides can be made in reducing the time and effort spent in the recovery room.

"This initiative demonstrates Sunnybrook’s commitment to working with the government of Ontario to reduce patient wait times and to improve OR efficiency," she says. "The government is looking to roll out the anesthesia team care model at other hospitals and also develop an evaluation tool for Anesthesia Care Teams."

Sunnybrook is pleased to announce the launch of a three-year partnership with the Schulich Executive Education Centre (SEE) to provide specialized leadership development to our senior leaders. We are also pleased that the Sunnybrook-Schulich Advanced Leadership Development Program Director will be Brenda Zimmerman, PhD. Dr. Zimmerman is the Director, Health Industry Management Program, and Associate Professor of Strategy/Policy at the Schulich School of Business. As Sunnybrook moves forward, effective leadership is critical. This new, innovative, state-of-the-art program will build on the previous Sunnybrook-Rotman-HPME Leadership Program and focus on personal leadership skills development.

Objectives of the Sunnybrook-Schulich Advanced Leadership Development Program include:

• To develop leadership mindsets that achieve results
• Focus development on a deeper personal awareness of leadership styles within the micro and macro contexts of both department and the total hospital environment
• Equips Sunnybrook’s leaders to propel the organization’s vision and strategic goals

Leadership Program and personal leadership greatly to my state of mind going into the operation and, therefore, to my recovery,” says Heather.

The Laboratory Services department produces lab reports and provides expert analysis that forms the critical basis for diagnosis, and for pre-clinical and clinical research. It is with a focus on total quality and the commitment of the excellent staff that the Laboratory Services department is able to meet the strict accreditation requirements and provide for the ever-growing needs for service.

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The Working Group for Patient Safety and Quality Improvement, consisting of clinicians and academic leaders in critical care around the world.

The William J. Sibbald Lectureship was established in 2007 to honour his memory and his legacy of excellence.