A new, correct version of Table 3 of the original publication, including the incidences of these metabolic acidosis outcomes, can therefore be found in the correction published on page 412.

We stress again that all comparative analyses, including the analyses on the effects of ST analysis on metabolic acidosis, were correctly performed in the imputed data sets separately, resulting in 10 RRs that were correctly averaged afterward using Rubin’s rule. Thus, the reported effects of ST analysis on metabolic acidosis are valid.

Nevertheless, for comparison purposes, we estimated the RR and 95% CI using the incorrect absolute numbers of events in Table 3 of the original paper, and found a similar, even slightly larger, effect of the index intervention (RR=0.61; 95% CI, 0.42–0.88). Hence, our analyses appeared to be robust regarding the problem induced by aggregation of the imputed data sets.

Finally, as discussed, this issue is highly relevant for future metaanalyses on this topic, in which researchers might want to use the original number of events per study group. Also, for future Individual Patient Data requests for metaanalyses, the 10 imputed MI data sets need to be used, or the MI needs to be repeated after merging the STAN trial data to other trials.

Financial Disclosure: Dr. Visser received travel and accommodation reimbursement from Neoventa for a presentation on patient safety in obstetrics in a sponsored satellite symposium, Congress controversies in OBG, Paris 2008, and the 9th World Conference on Perinatal Medicine, Berlin, 2009. The other authors did not report any potential conflicts of interest.

Michelle E.M.H. Westerhuis, MD, PhD
Gerard H.A. Visser, MD, PhD
Karel G.M. Moons, MD, PhD
Nicolaas P.A. Zuthoff, MSc
Ben Willem J. Mol, MD, PhD
Anneke Kwee, MD, PhD
University Medical Center Utrecht, Utrecht, the Netherlands; Amsterdam Medical Center, Amsterdam, the Netherlands; University Medical Center Utrecht, Utrecht, the Netherlands

REFERENCE

Generational Issues in the Ob–Gyn Workplace: “Marcus Welby, MD,” Versus “Scrubs”

To the Editor:

I would like to thank Dr. Sharon Phelan for her description of our medical “generations.” She elucidates, perhaps, why we each have our current work ethics and life goals. Yet Dr. Phelan offers no solutions to two perplexing shortages: female role models and female leaders in obstetrics and gynecology.

Women comprise approximately 50% of medical school classes, and over 75% of obstetrician–gynecologist residents. In academic medicine, the current Association of American Medical Colleges report indicates that 80% of full professors are men, as are the vast majority of division heads and department chairs. The current 2010 Executive Board of the American College of Obstetricians and Gynecologists (the College) and entire 2011 slate of College Board Candidates are men. Approximately 10% of the Committee on Nominations are women.

I offer suggestions to change these situations and increase the presence of women in academias, the College, and medical leadership positions:

1) Seek and encourage mid career or late-career women who may not have taught or served recently on medical committees to assume an obstetrics and gynecology committee, teaching, or leadership role, or a combination of these. Many women have exceptional qualifications, but have used them in nonmedical organizations or on governing boards.

2) Change requirements for “higher”-level positions to accommodate women (and men) who have spent (or are spending) time raising families.

3) Commit to having a young, diverse membership on the committees, and learn what it will take to keep them engaged.

4) Do exit interviews when men and women resign from committees or academic institutions.

I would like the College to represent “me.” I do not see the current leadership as representative of my peers, community, or needs. I hope to see changes in the near future so the next generations of obstetrician–gynecologists have appropriate representation.

Financial Disclosure: The author did not report any potential conflicts of interest.

Andrea Stein, MD
Clinical Professor, University of Southern California; Chairperson, Center for Research and Training in Humane and Ethical Medical Care (CHEC®) at Santa Monica Hospital-UCLA Orthopedic Hospital, Santa Monica, California

REFERENCES


In Reply:

My editorial looked at generational concerns as they affect current workplace issues. I feel it is important to analyze these issues from a generational viewpoint instead of a narrower, potentially less helpful, gender perspective. I do not have an answer for Dr. Stein regarding her concern about the number of women in leadership positions in obstetrics and gynecology. Her need for “female role models,” I feel, misses the point. Effective role models, male and female, from one generation or another are important and available.

I can provide my observations from over 25 years of advising women and men regarding career choice, including specialty and practice type:

1. For most of the 1980s and 1990s, I encouraged the “best and brightest” women to enter academic obstetrics and gynecology. I was repeatedly disappointed that many of these women did not want to go into academics due to low salaries, less control over hours, and demands to be a “triple threat.” For
over 25 years, over 50% of resident graduates have been women. The number of women entering academics has not approached those numbers.

2. Currently, more women are entering academics, but typically in nontenured clinical educator tracks. Many women work part-time jobs, which is problematic in the current system of promotion and advancement. Each individual needs to become actively involved in institutional activities, demonstrating interest and commitment, which will lead to committee appointments and more.

3. There are numerous programs for female physicians to attain leadership, skills such as the Association of American Medical Colleges’ Elam program. However, I repeatedly have seen individuals turn down these opportunities because of time and travel demands. This is a reason why the number of women leaders is not proportional to female graduation rates.

4. The American College of Obstetricians and Gynecologists has worked to increase the involvement of junior fellows in committees and other College activities. There are incredible opportunities here. It is up to the individual to get involved with section, district, and national activities.

5. I agree that a critical look at the lack of flexibility for part-time faculty to advance (albeit at a slower pace) is long overdue. Exit interviews from any position are always a good idea if an organization wants to improve institutional effectiveness.

The lack of more women in leadership positions is multifaceted, and involves the female graduates as well as institutional leadership. Blaming only current leadership for the lack of women leaders removes the responsibility from those who aspire to those positions.

Financial Disclosure: The author did not report any potential conflicts of interest.

Overlapping Compared With End-to-End Repair of Third- and Fourth-Degree Obstetric Anal Sphincter Tears: A Randomized Controlled Trial

To the Editor:

We would like to congratulate Farrell et al for their well-designed randomized controlled trial. However, we would like to highlight some inaccuracies and also make comments.

In his pilot study, Sultan2 concluded that “this study cannot conclusively prove that the overlap repair is superior to the end-to-end repair and a randomized controlled trial is needed.” Our Cochrane review3 conclusions state, “it would be inappropriate to recommend one type of repair in favor of another.” We were surprised that Farrell et al state in their introduction (and discussion), “because of this work, the investigators recommended the overlapping technique rather than the end-to-end surgical technique.”

Unfortunately, in the study by Farrell et al,1 twice as many surgeons performed overlap repair for the first time, and there was an inverse relationship between surgeon experience and flatus incontinence. The authors describe this as a “statistical anomaly.” However, surgeon experience and level of training do have clinical relevance, as there were more external anal sphincter defects and two rectovaginal fistulae in the overlap group, but no fistulae when performed by trained surgeons.

Internal anal sphincter injury is usually associated with passive soiling, flatus incontinence, and external anal sphincter injury with urgency and fecal incontinence, and therefore, this was our chosen primary outcome at 1 year.1 It is also interesting to note that in this randomized controlled trial there was 44% overlap compared with 27% end-to-end (P = 0.051) fourth-degree tears, and therefore, almost significantly more internal anal sphincter injuries that could account for the flatus incontinence. We also found more patients with flatus incontinence at 6 months, but at 12 months there was no difference. More importantly, we found that there was deterioration of defecatory symptoms in the end-to-end group at 12 months.4

We therefore wonder whether their 6-month findings may change, and look forward to a longer-term follow-up.

Financial Disclosure: The authors did not report any potential conflicts of interest.

Abdul Sultan, MD
Croydon University Hospital, Surrey, United Kingdom

Ruwant Fernando, MD
Imperial College Healthcare NHS Trust; St Mary’s Hospital; London, United Kingdom

REFERENCES

In Reply:
The authors would like to thank Drs. Sultan and Fernando for their letter concerning our recent publication.1 We would like to apologize to the authors, and acknowledge that our statement, “because of this work, the investigators recommended the overlapping technique rather than the end-to-end surgical technique…” may have been misleading to the reader. Perhaps we may be forgiven for the assumption that the authors favor overlapping repair, as we are not the only ones to reach that conclusion. In a study published in 2003 by Williams et al, the authors reported on their audit conducted in a Liverpool, United Kingdom, hospital of the effects of a Royal College of Obstetrics and Gynecology guideline,