Surgical Experience Disparity Between Male and Female Surgeons in Japan

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IMPORTANCE Women are vastly underrepresented in surgical leadership and management in Japan. The lack of equal opportunities for surgical training is speculated to be the main reason for this disparity; however, this hypothesis has not been investigated thus far.

OBJECTIVE To examine gender disparity in the number of surgical experiences among Japanese surgeons.

DESIGN, SETTING, AND PARTICIPANTS This retrospective, multicenter cross-sectional study used data from the National Clinical Database, which contains more than 95% of all surgical procedures in Japan. Participants included male and female gastroenterological surgeons who performed appendectomy, cholecystectomy, right hemicolectomy, distal gastrectomy, low anterior resection, and pancreaticoduodenectomy between January 1, 2013, and December 31, 2017.

EXPOSURES Differences in the number of surgical experiences between male and female surgeons.

MAIN OUTCOMES AND MEASURES The primary outcomes were the total number of operations and number of operations per surgeon by gender and years of experience. Data were analyzed from March 18 to August 31, 2021.

RESULTS Of 1,147,068 total operations, 83,354 (7.27%) were performed by female surgeons and 1,063,714 (92.73%) by male surgeons. Among the 6 operative procedures, the percentage of operations performed by female surgeons were the highest for appendectomy (n = 20,648 [9.83%]) and cholecystectomy (n = 41,271 [7.89%]) and lowest for low anterior resection (n = 4507 [4.57%]) and pancreaticoduodenectomy (n = 1329 [2.64%]). Regarding the number of operations per surgeon, female surgeons had fewer surgical experiences for all 6 types of operations in all years after registration, except for appendectomy and cholecystectomy in the first 2 years after medical registration. The largest gender disparity for each surgical procedure was 3.17 times more procedures for male vs female surgeons for appendectomy (at 15 years after medical registration), 4.93 times for cholecystectomy (at 30-39 years), 3.65 times for right hemicolectomy (at 30-39 years), 3.02 times for distal gastrectomy (at 27-29 years), 6.75 times for low anterior resection (at 27-29 years), and 22.2 times for pancreaticoduodenectomy (at 30-39 years).

CONCLUSIONS AND RELEVANCE This cross-sectional study found that female surgeons had less surgical experience than male surgeons in Japan, and this gap tended to widen with an increase in years of experience, especially for medium- and high-difficulty operations. Gender disparity in surgical experience needs to be eliminated, so that female surgeons can advance to leadership positions.

Published online July 27, 2022.
The “glass ceiling” refers to the invisible barrier that prevents women from advancing to managerial and executive positions in organizations, even when they succeed in fields that had traditionally been dominated by men.1 Globally, although the percentage of female surgeons has been increasing, gender disparity still exists in the field, with fewer women in leadership roles.2-5

According to the Statistics of Physicians, Dentists, and Pharmacists by the Ministry of Health, Labor, and Welfare, Japan had a total of 32,448 surgeons in 2006; however, this number dropped sharply to 13,751 in 2018, resulting in a serious shortage of surgeons in the country. Furthermore, the number of female surgeons decreased from 1,381 in 2006 to 853 in 2018, although they occupied a greater proportion of the workforce in 2018 (6.2% vs 4.2% in 2006). Moreover, in both years, the largest number of female surgeons were aged 30 to 34 years; this number gradually decreased as the age group increased, with very few women in leadership positions.6-9 Surgical training programs in Japan require graduates to complete a 2-year structured postgraduate general clinical training program. Thereafter, prospective surgeons are trained in a 3-year surgical residency and then take the Board of Surgery certification examination. During the 3-year surgical residency, the residents choose subspecialties, such as general and digestive surgery, cardiovascular surgery, pediatric surgery, and breast surgery.10 Although this choice is essentially made by the residents, supervisors have a strong influence, and the resident’s choice is sometimes not accepted. After passing the certification examination, surgeons work under the surgery director who allocates the surgeries.

In Japanese culture, a strong belief that women should play a central role in housework and childcare makes it difficult for women to build successful careers.11 Both female and male surgeons are expected to acquire a similar, certain level of surgical skill and play a leading role in surgical practice. However, to our knowledge, there has been no detailed study of surgical training for female surgeons in Japan. In other countries, there have been some reports on the disparity in surgical training between male and female surgeons, but it is still unclear whether they are sufficiently trained as surgeons for all years of experience. Because surgical experience has a significant impact on a surgeon’s career, identifying differences in surgical experience between male and female surgeons has important implications for examining the lack of female surgeons in leadership positions. The purpose of this study was to examine gender disparity in the surgical experience of surgeons in Japan, using the National Clinical Database (NCD) containing more than 95% of all operations performed in Japan,12,13 and to consider the implications of and countermeasures against this disparity.

Methods

This multicenter cross-sectional study was approved by the ethics committees of Gifu University and Osaka Medical and Pharmaceutical University. An email was sent to JSGS members once a month from November 2019 to May 2020 regarding the use of member information for NCD research and offering the opportunity to refuse participation. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

Among the operations performed by the members of The Japanese Society of Gastroenterological Surgery (JSGS) between January 1, 2013, and December 31, 2017, the following elective surgeries were selected for this cross-sectional study: appendectomy and cholecystectomy, defined as low-difficulty surgeries by the JSGS training curriculum for gastroenterological surgeons; right hemicolectomy and distal gastrectomy, defined as medium-difficulty surgeries; and low anterior resection and pancreaticoduodenectomy, defined as high-difficulty surgeries.

Data on the total number of operations performed, surgeon’s medical registration number, date of registration, and expected surgical mortality (defined by the NCD as inhospital deaths within 90 days after surgery or any death up to 30 days after surgery) were collected from the NCD. Cholecystectomy and appendectomy were excluded from the surgical outcome analysis because there were no data on the surgical mortality for these procedures. Surgeons’ years of experience was calculated as the number of years from the date of medical registration. Gender information was obtained by matching the medical registration number with the JSGS member records that contain gender information. The number of years from the date of registration was divided into 1-year increments up to 20 years after medical registration, 3-year increments for 20 to 29 years, 10-year increments for 30 to 29 years, and no increment after 40 years.

Statistical Analysis

The primary outcome was the number of operations performed per surgeon, categorized by gender and years after registration. The number of operations performed per female surgeon was calculated as follows:


where \( X \) (year) is the number of surgeries performed by female surgeons in their \( Z \)th year after registration in that year divided by the number of female surgeons in their \( Z \)th year after registration in that year. The number of surgeries per male surgeon was calculated in the same way.

The secondary outcome was the number and percentage of operations performed by male and female surgeons and the proportion of high-risk surgeries performed by the surgeons,
categorized by gender and years after registration. High-risk surgeries, as defined by the NCD risk estimation system, included those in the top 25% for predicted surgical mortality within 30 days. A risk calculator, built within the NCD, was used to calculate the predicted risk by entering the necessary preoperative information into the module on the website. \(^{14-17}\) Stata, version 16 (StataCorp LLC) and Excel (Office Professional Plus 2019; Microsoft) were used for data handling, analyses, and visualizations. Data analysis was conducted from March 18 to August 31, 2021.

Results

Number and Percentage of Operations by Male and Female Surgeons

Of 1,147,068 total operations, 83,354 (7.27%) were performed by female surgeons and 1,063,714 (92.73%) by male surgeons. The most frequent operation performed by both male and female gastroenterological surgeons was cholecystectomy (523,195 total operations), followed by appendectomy (210,089 operations) and distal gastrectomy (166,235 operations) (Table 1). The proportion of operations performed by female surgeons was 9.83% (n = 20,648) for appendectomy, 7.89% (n = 41,271) for cholecystectomy, 6.51% (n = 64,17) for right hemicolecction, 5.52% (n = 9,182) for distal gastrectomy, 4.57%...
times thereafter and more than doubled 24 years after registration.

The largest gender disparities were found at 30 to 39 years after registration, when male surgeons performed a right hemicolectomy 3.65 times more often than female surgeons; and at 27 to 29 years after registration, when male surgeons performed a distal gastrectomy 3.02 times more often than female surgeons.

**High-Difficulty Surgery: Low Anterior Resection and Pancreaticoduodenectomy**

For both low anterior resection and pancreaticoduodenectomy, male surgeons performed more procedures than female surgeons in all groups of years after registration. The difference between male and female surgeons for high-difficulty surgeries was larger than for low- and medium-difficulty surgeries and increased with years of experience. The number of male surgeons performing low anterior resection was 1.3 to 1.8 times that of female surgeons for the first 11 years after registration and more than 2 times thereafter. From 18 to 23 years after registration, male surgeons performed less than 2 times more than female surgeons, but after 24 years, they performed approximately 5 times the number of anterior resections. The number of pancreaticoduodenectomies performed by male surgeons was about 7 times that of female surgeons in the first 2 years after registration; thereafter, it was approximately 2 times for up to 10 years, 2.5 to 7.0 times for 11 to 29 years, and 22.2 times for 30 to 39 years after registration. The largest gender disparity was found at 27 to 29 years, with male surgeons performing low anterior resection 6.75 times more than female surgeons; and at 30 to 39 years, with male surgeons performing pancreaticoduodenectomy 22.2 times more than female surgeons.

**Proportion of High-risk Surgery**

The proportion of high-risk surgery performed by male and female surgeons, classified by years after registration, is shown in Figure 3. High-risk surgeries ranged between a proportion of 0.2 and 0.3 of the total surgeries performed by the surgeons in all groups of years after registration, except the first 2 years. There were no gender differences in the rate of high-risk surgeries; however, the numbers varied more among female surgeons, especially in the later years after registration, possibly owing to the small number of female surgeons in these year groups.
|                | 0-1 y | 2-3 y | 4 y  | 5 y  | 6 y  | 7 y  | 8 y  | 9 y  | 10 y | 11 y | 12 y | 13 y | 14 y | 15 y | 16 y | 17 y | 18 y | 19 y | 20 y | 21-23 y | 24-26 y | 27-29 y | 30-39 y | ≥40 y |
|----------------|-------|-------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|---------|---------|---------|---------|------|
| **Appendectomy** |       |       |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |         |         |         |         |      |
| Female          | 216   | 3314  | 3564 | 2578 | 2286 | 1087 | 1138 | 1111 | 1234 | 423  | 658  | 460  | 400  | 182  | 191  | 439  | 208  | 190  | 222     | 365     | 268     | 82     | 32    | 0      |
| Male            | 874   | 21329 | 16658| 18396| 14245| 10265| 8112 | 7251 | 5592 | 5328 | 5637 | 5785 | 5305 | 5374 | 5710 | 4635 | 4433 | 4893    | 4690    | 11706   | 8409   | 6804  | 7190   | 600    |
| **Cholecystectomy** |     |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |         |         |         |         |      |
| Female          | 367   | 5798  | 6132 | 4263 | 3790 | 2402 | 2368 | 2405 | 2496 | 941  | 1237 | 1193 | 1281 | 631  | 437  | 1010 | 537  | 403  | 503     | 685     | 2123    | 210    | 59    | 0      |
| Male            | 1540  | 36522 | 29763| 34477| 28474| 21915| 19784| 17994| 13636| 14536| 17094| 15967| 15987| 15144| 16977| 13346| 14753| 14752   | 13782   | 39855   | 29838  | 23182 | 30538  | 2068   |
| **Right hemicolectomy** |   |       |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |         |         |         |         |      |
| Female          | 17    | 736   | 827  | 668  | 532  | 436  | 412  | 374  | 327  | 263  | 237  | 225  | 227  | 194  | 164  | 147  | 117  | 104  | 88      | 199     | 72      | 36     | 15    | 0      |
| Male            | 197   | 4957  | 4925 | 4530 | 3594 | 3272 | 3178 | 3132 | 3069 | 3305 | 3529 | 3577 | 3475 | 3482 | 3558 | 3452 | 3524 | 3558    | 3142    | 8579    | 6956   | 4788  | 5752   | 557    |
| **Distal gastrectomy** |   |       |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |         |         |         |         |      |
| Female          | 89    | 748   | 982  | 823  | 630  | 588  | 539  | 518  | 519  | 504  | 405  | 501  | 465  | 319  | 269  | 279  | 188  | 143  | 114     | 304     | 139     | 70     | 46    | 0      |
| Male            | 459   | 5930  | 6910 | 6419 | 5256 | 5003 | 4948 | 4430 | 4979 | 5340 | 5801 | 5966 | 6251 | 6445 | 6388 | 6480 | 6272 | 6430    | 6252    | 16201   | 12948  | 9866  | 11232  | 847    |
| **Low anterior resection** |   |       |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |         |         |         |         |      |
| Female          | 13    | 250   | 341  | 376  | 350  | 302  | 282  | 270  | 265  | 250  | 183  | 193  | 223  | 203  | 167  | 150  | 158  | 143  | 83      | 220     | 52      | 20     | 13    | 0      |
| Male            | 113   | 2039  | 2709 | 2716 | 2501 | 2382 | 2482 | 2632 | 2799 | 3247 | 3624 | 3908 | 3851 | 4027 | 4190 | 4280 | 4347 | 4360    | 4146    | 10930   | 8844   | 6312  | 7176   | 546    |
| **Pancreaticoduodenectomy** |   |       |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |         |         |         |         |      |
| Female          | 1     | 32    | 65   | 75   | 69   | 75   | 94   | 109  | 110  | 96   | 72   | 71   | 58   | 38   | 46   | 70   | 53   | 26   | 61      | 68      | 28      | 10     | 2     | 0      |
| Male            | 66    | 291   | 648  | 916  | 902  | 1008 | 1155 | 1268 | 1390 | 1720 | 2017 | 2183 | 2206 | 2270 | 2371 | 2434 | 2279 | 2433    | 2236    | 6153    | 4559   | 3314  | 4656   | 552    |
Discussion

To our knowledge, this is the first study to classify the number of gastroenterological surgeries performed in Japan by the surgeons’ gender and years of experience. The findings revealed a marked disparity between female and male surgeons in terms of their surgical experiences. These results are important for identifying and alleviating discrimination against female surgeons during surgical training in Japan.

In Japan, junior residents do not choose a department for 2 years after registration and perform rotations through several designated departments. The large number of female junior residents observed in low- and medium-difficulty operations may be due to the recent increase in female surgeons among new members of the JSGS. It is possible that the attending surgeons actively recruited female junior residents for gastroenterological surgery by providing operative opportunities for them. On the other hand, in pancreaticoduodenectomy, male junior residents performed the surgery 7 times more than female junior residents, which may be due to gender bias of the attending surgeons who allocate surgical assignments. It is also possible that female junior residents are reluctant to undergo surgical training for high-difficulty procedures for a variety of reasons, including long working hours, difficulty in balancing work and family, and absence of role models.

After junior residency training, senior residents receive training in the specialty of their choice. In the Department of Surgery, senior residents rotate through several surgical specialties for 3 years, depending on their program. In the
Figure 3. Proportion of Operations in the Top 25% for Predicted Surgical Mortality by Total Number of Operations Performed by Surgeons Grouped by Gender and Years After Medical Registration

A Right hemicolectomy

B Distal gastrectomy

C Low anterior resection

D Pancreaticoduodenectomy
current study, it is noteworthy that male residents had more surgical experience than female residents for all 6 types of surgical procedures. Some studies have shown that female residents who perform fewer cases with meaningful autonomy are less satisfied with surgical training and are more likely to leave training compared with male residents. Furthermore, female residents are significantly underrepresented among award recipients in general surgery residency programs. In a study on gender disparity in robotic surgical experience in a colorectal surgery training program, female residents had lower rates of console participation and fewer opportunities to complete total mesorectal excision than male residents. Furthermore, female attending surgeons offered equal opportunities for surgical experience to male and female residents, but male attending surgeons offered fewer opportunities for surgical experience to male and female residents. A decline in the surgical experience of female surgeons may also occur because of pregnancy, childbirth, and childcare. Pregnancy during training not only leads to a reduction in the effort and period of training for female surgeons but also increases prejudice among male attending surgeons. Gastrointestinal surgery is one of the subspecialties with long working hours and many emergent surgeries. Therefore, it is possible that female residents informed their supervisors in advance that they would not choose gastrointestinal surgery, which may have affected the number of surgeries performed in this field.

After completing their senior residency training, surgeons are affiliated with the surgical department of their choice. This study’s finding that the number of operative procedures performed by both male and female surgeons decreased after senior residency may be attributed to the fact that a certain number of them went on to graduate school. Nevertheless, the fact that male surgeons had more experience than female surgeons for all 6 operative procedures, and that the more difficult the procedure, the greater the gender disparity, is important and cannot be ignored. However, it is noted that female surgeons performed surgeries for high-risk patients, as male surgeons did, in all the year groups, and there was no disparity in the postoperative mortality rate between the genders.

Pregnancy, childbirth, and childcare certainly have an impact on the surgical experience of female surgeons. The burden of childcare could be expected to decrease after several years, and the gender gap in surgical experience could become smaller; however, as observed in this study, this gap became larger with an increase in the number of years after registration. In particular, the disparity between male and female surgeons increased over the years for medium- and high-difficulty operations. In this case, the huge difference in the surgical experience of female and male surgeons cannot be explained by maternity leave alone. In Japan, after choosing a subspecialty, a surgeon’s place of work is often determined by the university medical office that they belong to. Professors of each department appoint medical staff, and currently, all but 1 of the professors in departments of gastrointestinal surgery across Japan are male. Thus, it is worth exploring whether a gender bias exists in the appointment of medical staff.

Based on the results of this study, our specific recommendations are as follows:

1. It is necessary for all surgeons to realize that there is a difference in surgical experience between male and female surgeons that cannot be explained by pregnancy and childbirth alone, and to discuss ways to improve this. The 2015 initiative of the Royal Australasian College of Surgeons may help consider future measures. The College has apologized for discrimination against female surgeons and has set a goal of 30% female representation in the current president’s leadership, and it is hoped that future action will be taken with a view to the future of digestive surgery.

2. It is important to motivate the administrators of medical colleges and the heads of surgical departments in all hospitals to eliminate discrimination in surgical training and place surgeons in training facilities without gender bias. In the future, hopefully, data from the NCD can be utilized to ensure the proper allocation and training of surgeons.

3. With regard to female surgeons with children, Brown et al stated that “it is possible to accommodate childcare during training if there is appropriate institutional support”; therefore, excessive restrictions should be avoided. Furthermore, it is essential to create a flexible and efficient program by holding discussions with female surgeons with children and paying attention to their needs.

4. It is necessary to actively promote female surgeons to positions of decision-making and authority in the JSGS. It is necessary to consider introducing a quota system to determine the number and ratio of leadership positions based on gender, and a goal and timetable system to set achievement targets and timeframes for specific numbers.

In recent years, the proportion of women in gastrointestinal surgery has been increasing, with approximately 20% of the field currently comprising women younger than 30 years. The Gender Equality Working Group was established within JSGS in September 2020. In 2021, the JSGS set the goal of appointing a fixed percentage of women as chairpersons and program committee members for its 77th General Meeting. In the future, a similar move is expected regarding council members. Thus, the JSGS is carrying out several reforms under the current president’s leadership, and it is hoped that further action will be taken with a view to the future of digestive surgery.

Limitations
This study has some limitations that should be noted. First, in calculating the number of operations per surgeon, the denominator was the number of JSGS members, which may not reflect the full population of gastroenterological surgeons in Japan, as some JSGS members were not participating in surgery during the study period. Second, information about the members’ marriage, pregnancy, and childbirth was not registered with the NCD or JSGS. Third, some residents were members of the JSGS but not necessarily aspiring gastroenterological surgeons, which may have affected their surgical experience.
Conclusions

This cross-sectional study found that female surgeons in Japan have less surgical experience than male surgeons. Furthermore, gender disparity in surgical experience tended to widen with years of experience for medium- and high-demand operations. These findings suggest that the overwhelming lack of women in surgical leadership and management positions was associated with the lack of equal opportunities for surgical training. It is necessary to build a system to eliminate gender disparity in surgical training and discrimination against female surgeons.

ARTICLE INFORMATION

Accepted for Publication: May 4, 2022.
Published Online: July 27, 2022. doi:10.1001/jamasurg.2022.2938
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Author Contributions: Drs Nomura and Miyata had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Concept and design: Kono, Isuzu, Nomura, Okoshi, Yamamoto, Yasufuku, Maeda, Sakamoto, Uchigama, Kakeji, Yoshida, Kitagawa. Acquisition, analysis, or interpretation of data: Kono, Isuzu, Nomura, Okoshi, Yamamoto, Miyata, Maeda. Drafting of the manuscript: Kono, Isuzu, Nomura, Uchigama, Kakeji, Yasuda, Kitagawa. Critical revision of the manuscript for important intellectual content: Kono, Nomura, Okoshi, Yamamoto, Yasufuku, Maeda, Sakamoto, Statisticians analysis: Isuzu, Yamamoto, Miyata, Uchigama. Obtained funding: Okoshi, Yoshida. Administrative, technical, or material support: Nomura, Yamamoto, Sakamoto, Yoshida. Supervision: Nomura, Okoshi, Yamamoto, Yasufuku, Maeda, Sakamoto, Kakeji, Yoshida. Conflict of Interest Disclosures: Dr Kono reported receiving personal fees from Olympus, Medtronic, Karl Storz, and Johnson & Johnson outside the submitted work. Dr Nomura reported receiving grants from JCR Pharmaceuticals and Nobelpharma outside the submitted work. Dr Okoshi reported receiving personal fees from Stryker Japan, CONMED Japan, Johnson & Johnson, Mellerue, AMC Incorporated, and Taiho Pharmaceutical outside the submitted work. Dr Yamamoto reported receiving grants from the National Clinical Database, Johnson & Johnson, and Nipro Co during the conduct of the study; consultation fees from Mitsubishi Tanabe Pharma Corporation, speaker fees from Chugai Pharmaceutical Co, Ltd and Ono Pharmaceutical Co, Ltd, and payment for a manuscript from Astellas Pharma Inc outside the submitted work. Dr Miyata reported receiving grants from the National Clinical Database and Johnson & Johnson outside the submitted work. Dr Maeda reported receiving personal fees from Merck Biopharma Co, Ltd and Tsumura & Co outside the submitted work. Dr Yoshida reported receiving personal fees from Taiho Pharmaceutical, Chugai Pharmaceutical Co, Ltd, Takeda, Eli Lilly, Daiichi Sankyo, Merck Serono, Johnson & Johnson, Nippon Covidien, Bayer Yakuhin, Olympus, Tsumura, Sanofi, Denka, Nippon Kayaku, Merck & Dohme, Yakult Honsha, Tsumura & Co, Pfizer, Intuitive Surgical, Ono Pharmaceutical Co, Ltd, and Asahi Kasei and grants from Sanofi, Yakult Honsha, Chugai Pharmaceutical Co, Ltd, Takeda, Eli Lilly, Taiho Pharmaceutical, Daiichi Sankyo, Johnson & Johnson, Nippon Covidien, Otsuka, Nippon Kayaku, Tsumura & Co, Eisai, Kyowa Hakko Kirin, Astellas Pharma Inc, Toyama Chemical, KCI Ltd, Abbott, Toray Medical, and Asahi Kasei outside the submitted work. Dr Kitagawa reported receiving grants from Chugai Pharmaceutical Co, Ltd, Taiho Pharmaceutical, Yakult Honsha, Asahi Kasei, Otsuka, Takeda, Ono Pharmaceutical Co, Ltd, Tsumura & Co, Kyowa Hakko Kirin, EA Pharma, Medicinon Inc, Kaken Pharmaceutical, Eisai, Otsuka, Teijin Pharma Limited, Nihon Pharmaceutical, and Nippon Covidien, and personal fees from Asahi Kasei, AstraZeneca, Ethicon Inc, Ono Pharmaceutical Co, Ltd, Otsuka, Olympus, Nippon Covidien, Shionogi & Co, Taiho Pharmaceutical, Chugai Pharmaceutical Co, Ltd, Bristol Myers Squibb, Merck Sharp & Dohme, Smith & Nephew, Kaken Pharmaceutical, and ASKA Pharmaceutical outside the submitted work. No other disclosures were reported.

Funding/Support: This study was supported by the project expenses of the Council of Societies Related to the Gastroenterological Database.

Role of the Funder/Sponsor: The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Additional Contributions: We sincerely appreciate all the data managers and hospitals participating in this National Clinical Database project for their continued efforts to enter data.

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