
Leadership conference focuses on quality, ethics, and future of surgery

by Diane S. Schneidman, Manager of Special Projects, Division of Integrated Communications

The American College of Surgeons presented the 2009 Leadership Conference for Young Surgeons and Chapter Leaders in conjunction with the Joint Surgical Advocacy Conference on March 22 in Washington, DC. The meeting comprised three shared sessions for young surgeons and chapter leaders as well as a block of breakout sessions.

Leadership for quality improvement

Opening the conference was a joint plenary session featuring Michael Glenn, MD, FACS, who was instrumental in developing and leading a quality improvement initiative at Virginia Mason Medical Center in Seattle, WA. He said the medical center got its “wake-up” call that it was time to take action when a postoperative patient was injected with a drug rather than saline solution and died. At least three similar adverse events had occurred previously in the state, “but no one ever really talked about it,” Dr. Glenn said. After that incident, Virginia Mason set one goal for 2004, which was to promote patient safety.

To effect and manage organizational change, Dr. Glenn said that leaders need to create a sense of urgency, build a guiding team, establish a clear vision, communicate effectively

so that the other people in the organization will “buy into” the change, and empower action. He also said that leaders should relentlessly promote the institution’s mission and the means of achieving it. They also must implement strategies to ensure that positive changes “stick.”

At Virginia Mason, the leadership created a mandate for change and implemented a joint accountability model with the goal of becoming the “quality leader” in the region, Dr. Glenn said. To achieve this objective, the institution’s culture had to change. Previously, the physicians and staff at Virginia Mason put the provider first, viewed waiting as inevitable, and expected errors to occur. The hospital also had a diffuse accountability structure and added resources regularly. The cultural mores now in place at the institution stress that the patient comes first, waiting is waste, and the goal is defect-free care, Dr. Glenn said. Virginia Mason also has adopted policies calling for rigorous accountability and a cap on new resources.

In addition, the medical center adopted the Lean systems-based model for quality improvement, which Toyota used in post-World War II Japan to become a bestselling, highly trusted automaker. Under this

system, an organization must identify value. Lean emphasizes the need to be responsive to the needs of the provider and other stakeholders—the patient, the payor, employers, and so on. “It’s really about having a better outcome for everyone,” Dr. Glenn said.

Ethics of leadership

LaSalle D. Leffall, Jr., MD, FACS, Charles R. Drew Professor of Surgery at Howard University College of Medicine, Washington, DC, emphasized the importance of ethical principles in leadership during a breakout session for young surgeon attendees.

Dr. Leffall said leaders define an organization’s mission, objectives, and priorities. He said an ethical leader must “always be willing to compromise on goals, but never compromise on principles.” An ethical leader also should be fair and be willing to cut his or her losses, but “demand the best of everyone.”

Effective leaders anticipate disappointments and are willing to listen, even to perspectives with which they may disagree, Dr. Leffall noted. He also emphasized a concept he learned from Charles R. Drew, MD, who said, “Excellence of performance will transcend artificial obstacles made by man.”

Leaders should be able to

maintain a level of “equanimity under duress” and “respect the dignity of the other person,” Dr. Leffall said. A key part of showing consideration for patients is telling them the truth about their medical condition and their treatment options. “Sometimes the truth hurts, but overall, when you really look at it [being honest] is the proper thing to do,” he added.

“The physician invites trust,” Dr. Leffall explained. Patients are vulnerable and sometimes frightened when they must consult with a surgeon. It is the surgeon’s job to demonstrate responsibility, capability, and a focus on the primacy of patient care.

Ethical surgeons also show restraint in using treatments that may not be of real benefit to the patient. “Provide access to therapies that will realistically improve the patient’s health and condition,” and be forthcoming with information about why certain treatments will provide little or no advantage, Dr. Leffall said.

The bottom line is “everything we do has to be based on what we can do for the patient,” Dr. Leffall added. “Isn’t that what life really is all about—seeing someone in need and giving aid? And when you do that, you have the satisfaction of knowing that you have done one of the best things that can be done.”

Outlook

Jon Chilingerman, PhD, associate professor of human services management at Brandeis University’s Heller School for

Social Policy and Management, Waltham, MA, discussed the hot issues in and outlook for surgical practice.

Trends he discussed included workforce shortages, payment issues, and the movement away from solo practice and toward large-group or hospital-based practice. Because these are uncertain times, the surgical profession “has a need for leadership and a need for a strategic vision,” Dr. Chilingerman said.

In the past, physicians have tended to worry about the wrong issues. For example, during the Medicare and Medicaid debates of the 1950s and 1960s, physicians argued that Medicare would result in the loss of physician autonomy and reduced income, “when in reality, by the 1970s, it made millionaires out of a lot of them,” he said. As it turns out, the real problem with Medicare was that it put unsustainable strains on the federal budget. “Now the ostensible problem is pay for performance,” but that may not prove to have been the real issue 10 years from now, Dr. Chilingerman said.

According to Dr. Chilingerman, young surgeons who are trying to decide where and how they will set up their practices need to analyze the pluses and minuses of each situation before defining their objectives and pinpointing their alternatives. More specifically, he suggested that young surgeons who are considering institution-based practice bear in mind that “hospitals are the most complex organizations on earth.” He also recommended

reviewing the financial statements of hospitals before making any commitments.

Before choosing a practice location, “identify your competitors—whether there are specialists or superspecialists in the area,” Dr. Chilingerman added. To remain competitive, any business must offer services either at a lower cost or provide extraordinary performance. “When you succeed, someone is going to come after you. So you’ve got to continually rethink your strategy and what you’re doing to differentiate yourself,” he noted.

As quality improvement demands increase, surgeons will want to make sure that their hospitals are involved in programs, such as the ACS National Surgical Quality Improvement Program, that measure outcomes throughout the institution and compare them to other facilities, Dr. Chilingerman said. When considering joining a practice, think about whether it’s a good cultural fit and “put financial considerations aside. Ask questions about the group and quality measures,” he advised.

Organized surgery

L.D. Britt, MD, FACS, Chair of the ACS Board of Regents, spoke about leadership and the role of organized surgery in an era in which “clinical practice is being overwhelmed.” Challenges surgeons are facing relate to workforce shortages, growing demands for the use of health information technology, cost controls, Medicare reimbursement, health care reform, and disparities in care.

“I think the College can take a stand, as one of the members of the ‘House of Surgery,’ to try and address many of the challenges that threaten the profession,” Dr. Britt said.

He noted that the College has been aggressive in its efforts to address surgical workforce issues, ensuring that the media informs the public about the shortages in general surgery. Furthermore, the analysts at the ACS Health Policy and Research Institute are conducting substantive research into this issue. Dr. Britt said that rural populations are feeling the most severe effects of the general surgeon shortage, noting that 80 percent of general surgeons live in or near metropolitan areas with populations of more than 50,000.

Dr. Britt also emphasized the need for surgeons to adopt electronic medical recordkeeping systems and for the College to assist in this endeavor. Electronic medical records (EMRs) are going to be an important component of quality measurement, yet only 17 percent of all physicians have installed and implemented EMR systems. Part of the problem is that adoption of the technology is cost-prohibitive for small practices, he explained. The ACS needs to think about what the organization can do to help physicians transition to EMR. “If this is not done correctly, I think it’s going to spell the death of [clinical] practice,” Dr. Britt said.

In addition, Dr. Britt spoke about the need to control costs, noting that the U.S. spent \$2.4 trillion on health care last year. He attributed the high

costs to waste, administrative burdens, the provision of inappropriate services, and other factors.

With respect to Medicare reimbursement, Dr. Britt said, “We cannot continue to take cuts.” To deflect the scheduled 21.5 percent payment reduction in 2010 and to prevent further cuts in the future, Dr. Britt noted that the College is asking Congress to repeal the use of the sustainable growth rate (SGR) in calculating reimbursement. The ACS also is recommending that Congress replace the existing formula with a system that would establish separate physician category targets or multiple conversion factors.

As for health care reform, “I believe it will happen,” Dr. Britt said, pointing to President Barack Obama’s commitment to overhauling the health care delivery system. He noted that the College has disseminated the ACS Statement on Health Care Reform to members of Congress and other stakeholders. The ACS also has been working with other physician groups to develop a unified message on health care reform.

Furthermore, Dr. Britt said, the geographic and ethnic disparities in health care represent “the civil rights issue of this century. [Americans] should never tolerate disparities in education, security, or health care.” All patients should have equal access to innovations in medicine. “What good is a scientific discovery if we can’t translate it to everyone?” he asked.

Sessions for chapter leaders

Concurrent to the sessions described previously, which were intended for the young surgeon representative participants, were programs designed for chapter leaders. This portion of the program included the following sessions and speakers:

- CME As a Bridge to Quality, presented by Murray Kopelow, MD, MS, FRCPC, chief executive of the Accreditation Council for Continuing Medical Education (ACCME)
- State Legislative Update, presented by Mindy Baker, State Affairs Associate, ACS Division of Advocacy and Health Policy
- Strategic Planning the Tennessee Way, presented by Gayle Minard, MD, FACS, President of the Tennessee Chapter of the ACS

The disruptive surgeon

During a joint plenary session for young surgeons and chapter leaders, T. Forcht Dagi, MD, FACS, Vice-Chair of the ACS Committee on Perioperative Care, spoke about disruptive behavior. Dr. Dagi explained how surgeons can take a leadership role in preventing and addressing this hindrance to providing quality care.

“This is a real problem,” Dr. Dagi said. “It’s our problem, and we have to deal with it.”

In the profession’s effort to address disruptive behavior, The Joint Commission issued a sentinel event alert on July 9, 2008, which is intended to stop hostile behaviors that undermine patient safety. The new Joint Commission stan-

dard of behavior took effect January 1, when all health care organizations were called upon to create a code of ethics, Dr. Dagi said. The commission's document also outlines methods of managing unacceptable conduct, including condescending language, verbal outbursts, threats, and physical intimidation.

The Joint Commission's directive is just the most recent example of the profession's efforts to control surgeons and other physicians who exhibit unprofessional behavior, Dr. Dagi noted. Another example is the ACS *Statements on Principles*, which indicate that Fellows should demonstrate effective communication skills, professionalism, and an awareness of the surgeon's role in the

larger context of patient care. The College's statement also addresses discrimination and harassment in the workplace.

Although the ACS and other physician groups have set standards of conduct, the surgical profession traditionally has tolerated the "l'enfant terrible MD"—the surgeon who is disruptive but somehow is excused from typical standards of behavior because of his or her technical and cognitive talent, Dr. Dagi said.

Many surgeons aren't aware of how their behavior affects the other members of the operative team and patient care. "People will tell you that very rarely do they intend to be objectionable. They will tell you that they just want to get things done," Dr. Dagi said.

Surgeons need to be reminded that "language and behavior are very powerful tools."

Dr. Dagi asserted that surgeons must be involved in addressing disruptive conduct and must discuss problems as they arise. "These concerns are not going to dissipate. They're only going to get worse [left unchecked]," he said.

Open forum

The conference concluded with an open forum in which the meeting participants were able to voice their concerns and to ask questions of Dr. Britt and Thomas R. Russell, MD, FACS, ACS Executive Director. Issues discussed included health care reform, reimbursement, and EMRs.
