Association of Surgeons of Great Britain and Ireland

A 'PULL-OUT' SUPPLEMENT ON

The 21st Century Surgeon
Challenges and Opportunities

How to recognise the opportunities and overcome the challenges of working as a surgeon in the changing health service of the 21st Century

A Consensus Conference

held on

Wednesday 12th December 2012

AN ASGBI CONSENSUS CONFERENCE

THE 21st CENTURY SURGEON: CHALLENGES AND OPPORTUNITIES

Jessica Pether
Communications Officer

Wednesday 12th December 2012 saw 60 delegates and speakers gather at the Royal College of Surgeons of England for a one-day ASGBI Consensus Conference, entitled ***The 21st Century Surgeon: Challenges and Opportunities****. As with previous Consensus Conferences, the aim of the day was to gather like-minded individuals together to address and discuss key issues currently prominent within health, relating to the day's topic. Usually, a Consensus Statement would be produced as a consequence of such a day but, due to the broadness of the topic, ASGBI have decided to produce this pull-out section in the* ***Journal****, including an overview and some of the day's talks in essay form.*

Professor Cliff Shearman, ASGBI's Director of Professional Practice, organised the Conference with the help of the Association's Development Officer, Sarah Walsh. The day began at 10.00am with an introduction from the President, Professor John MacFie, who reminded all attendees that the forthcoming discussions would be very revealing and important for all attending.

Session One was entitled 'What should patients expect from their surgeon?' John MacFie gave a introductory talk on **Surgery as a Profession** and urged those present to "not lose sight of the fact that we are all healers". This was followed by a talk from Mr David Mitchell, a consultant at Southmead Hospital in Bristol, who spoke about surgeons' results and league tables. He touched upon the very current topic of revalidation and concluded that surgeons have little to fear, and much to gain, from being open with their data. Mr Peter Lees, founding director of the ***Faculty of Medical Leadership and Management***, and journalist Christina Patterson rounded off the session with a talk on **Surgeons as Leaders**, and a personal account of an NHS experience respectively.

After a coffee break, Professor Shearman chaired Session Two entitled 'What does the NHS expect from surgeons?' He assured delegates that, although the start of the day had been full of stark and harsh messages, the afternoon sessions would be brighter, looking forward to solutions and the future.

Incoming ASGBI President, Professor John Primrose, opened Session Two with a talk on whether the NHS values research. Following this, the conference was privileged to receive a talk from Professor Sir John Temple, past President of the Royal College of Surgeons of Edinburgh. He asked delegates to question whose job it will be to train surgeons of the future. He emphasised that, when it comes to training, you must make every moment count and pointed out that the NHS has all the necessary building blocks in place.

To conclude the morning session, delegates heard presentations from Dr Mark Porter, the ***British Medical Association***'s Chair of Council, and Dr Jonathan Fielding, Medical Director of ***UCLH***. Both gave comprehensive talks which led the conference nicely into its first discussion session before lunch. The morning's speakers gathered at the front of the auditorium and were quizzed by those in the audience.

Chaired by John MacFie, session three followed lunch and asked 'What does the surgeon need from their employer?' Presentation topics ranged from **Who is my employer going to be?** to **The future of contracting and job-planning**. ASGBI's Vice President Elect, Mr John Moorehead, went through **The Bare Essentials**, raising the importance of a good secretary, a permanent office and the fact that surgeons must be given the complete set of tools necessary for undertaking their job. John MacFie concluded that the talks so far had been very instructive and full of clarity, and the day moved onto the final session.

Professor Norman Williams, President of the Royal College of Surgeons of England, was kind enough to chair the final session of the day, where he introduced the topic 'Why do things go wrong?' After he gave an overview of the category, Professor Martin Elliott, Co-Medical Director at Great Ormond Street Hospital, gave an enlightening talk on **How to Avoid Adverse Outcomes**. He linked surgery and the old adage of "prepare for the worse, it tends not to happen" with two other significant organisational structures; the constant rehearsal which Formula One teams undertake and the thorough debriefing the Red Arrows go through after every performance.

Dr Iain Simpson, a consultant cardiologist from University Hospital Southampton NHS Foundation Trust, gave a talk on **Coaching Consultants** and how this is beneficial, not only for the people involved, but also healthcare organisations. **Patient Safety** was touched upon by Mrs Joan Russell, Associate Director of Patient Safety at the NHS Commissioning Board Authority and Mr Colin Morgan finished the final session with a talk entitled **How Can Innovation and Technology Improve Surgical Services?** Mr Morgan is the Vice President of External Affairs at ***Johnson & Johnson*** and he concluded that everyone working within healthcare should take a personal responsibility to regain patients' trust.

As the Conference drew to a close, Cliff Shearman thanked all speakers and concluded that the day had been meaningful with positive outcomes and solutions. He urged those present to go forward and change the culture and ethos of what they do, as "only you hold the reigns".

After the success of this one-day conference, we are pleased to present three of the talks in this edition of the ASGBI ***Journal***, with introductions by Professor Cliff Shearman.

SURGEONS AS LEADERS

Peter Lees
Founding Director of Faculty of Medical Leadership and Management

Introduction by Professor Cliff Shearman

In his article and presentation on Surgeons as Leaders, Peter Lees, a neurosurgeon and founding director of the Faculty of Medical Leadership and Management, makes the very strong case that quality and outcomes are directly linked to good management and leadership. At a time when the problems with delivering healthcare have never been more exposed and raw, Peter argues that leadership is the solution to overcoming these problems. The logic and evidence from several examples is overwhelming and the opportunities to develop leadership skills widely available. The challenge is whether we can harness these skills to pull surgery through a very difficult time.

The big challenge facing western healthcare economies is the twin demand of overcoming the deep recession at the same time as improving quality to meet public, governmental and, indeed, professional demands. This is against the backdrop of low morale amongst many professionals, attributed variably to disempowerment, disengagement, failure to move with the times, lack of leadership, learned helplessness etc. (Depending on who one listens to!) The recently released Francis Report explores this in exhaustive depth [1].

Irrespective of the underlying reasons, it is reasonable to ask, where is the leadership? For it is a fundamental purpose of leadership 'to get results with, and through, people'. Widely attributed to Daniel Goleman, is the simple link:

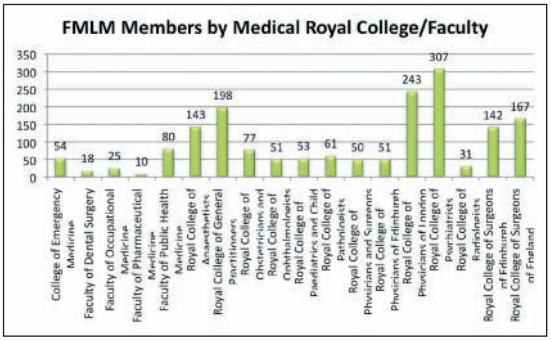
Leadership style - Climate - Results

To back this up, Harvard Business School, in a review of the turnaround of Sears, the North American department store, made the observation that growth, profitability and improved quality are the natural products of good leadership. Indeed, the inference is that sustained value (cost plus quality) for 'customers' is impossible without good leadership and good people management. The inference for the NHS in the current climate is obvious and the Faculty of Medical Leadership and Management (FMLM) has made the simple translation:

Hence, if we want to overcome the challenges of the recession and enhance quality as defined by '*Francis*', then logic would dictate that we need to address leadership within healthcare and look seriously at supporting and developing staff. Robert Francis' many recommendations about criminal prosecution hardly seem to fit this bill! None of this is new. Good human resource professionals have known this for ages; indeed, Dr Steven Boorman wrote a very impressive report for the Department of Health (England) entitled ***NHS Health and Well-being*** [2], which seems to have disappeared without trace. All that money, all that effort, all that common sense wasted!

On a positive note, in 2011, all of the UK medical Royal Colleges, faculties, and the Academy of Medical Royal Colleges made the collective decision to establish a Faculty of Medical Leadership and Management. This foresight is recognised positively in the Francis Report and strongly endorsed by the 2,000 doctors and students who joined in the first year. Furthermore, 730 delegates attended the first annual conference.

Many challenges remain but this is a most encouraging start. Equally encouraging are the breadth of specialty backgrounds and the range of career stages from student (10% of membership) and trainees (38%) through to the college presidents and chief medical officers. There is a deeply unhelpful, but widely held, misconception that leadership is something which older people with fancy titles do. Leadership exists and needs to exist at every level. The young surgeon first to attend a desperately sick patient at 3am has to lead; is that challenge, relative to experience, any less than the clinical director addressing a serious failure of clinical governance? Assuming the answer is no, why do we not routinely prepare our new recruits for such leadership challenges? Encouragingly, surgeons are very well represented in FMLM:



The numbers are an important start but the bigger prize is what those leaders do and there has never been a more important time to be 'doing' when it comes to leadership. The Faculty mission to improve the quality of patient care through better medical leadership is under-pinned by evidence. For example, we know that better teamwork lowers mortality [3]; we know that one standard deviation improvement in appraisal is associated with a reduction of 12.3% of the number of deaths after a hip fracture; we know that medical engagement correlates positively with quality in a hospital [4]. Now try to argue that such things are optional extras -

they are as optional as venous thromboembolism prophylaxis!

The Francis Report must draw a line in the sand. We must continue to resist the clamour for blame and knee-jerk reaction. The former poses the danger of the 'I'm alright Jack' mentality – it's just 'they' who have to change. The latter offers the dangerous illusion that something is being done. Although almost impossible to digest, such is its enormous length, *Francis* tells us, as any sane person knows, that there are deep and complex problems in the NHS which need to be overcome. He also tells us, as the Faculty of Medical Leadership and Management passionately believes, that leadership is vital. FMLM also shines a light on the evidence linking leadership and quality. FMLM is owned by all UK medical Royal Colleges and faculties, which offers a massive opportunity for medical leadership to be developed and for doctors to punch above their weight in the pursuit of leading the NHS out of the massive financial challenge, whilst simultaneously driving up quality. This is what we all joined the profession to do. It is time to deliver that potential and recognise this is a responsibility of the many, not the few.

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HOW TO AVOID ADVERSE OUTCOMES - MAKING IT PERSONAL: MY 10 COMMANDMENTS

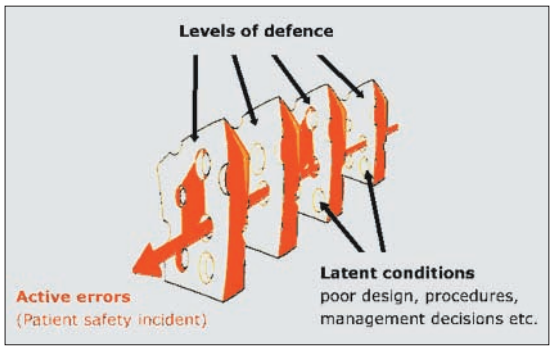
Martin Elliott
Co-Medical Director, Director of the National Service for Severe Tracheal Disease in Children, Great Ormond Street Hospital for Children NHS Foundation Trust

Introduction by Professor Cliff Shearman

It seems incredible that any surgeon is not concerned about safety and avoiding adverse incidents affecting patients they are treating. Perhaps, as Professor Elliot points out, it is not that we don't care, but that we don't often think about the problem and prepare for mistakes in a way that really engages the whole team. I would suggest anyone reading this incredibly insightful, yet simple, approach to reducing error would be hard pressed to disagree with any of the "10 Commandments". Perhaps, if we all adopted this approach to clinical practice, we would start to make a difference, not only to reducing avoidable errors but also in improving how our surgical teams work and function.

"First, do no harm" is at the core of medical practice, yet being a patient in hospital remains one of the most dangerous activities that humans undertake, on a par with mountain climbing. Over years of practice, and with a real interest in patient safety, I have identified a series of statements which help me in my attempts to avoid harm. I have grouped them together as **10 Commandments** and hope they will help readers keep patient safety at the top of their agenda, and act as a practical *aide memoire*.

I am a paediatric cardiothoracic surgeon. What I do is very complicated, not just because of the physiological and anatomical problems but because of interrelationships between people, and people and technology. The huge range of interactions produces an enormous potential for error. We are dependent on each other, the quality of our equipment and the processes we put in place to protect the patient. The hypothetical basis for the importance of processes in error protection is well exemplified in James Reason's Swiss Cheese Theory [1], which describes how processes without holes in them might protect against the concatenation of events leading to an accident.



As surgeons, we live in a world where human factors predominate. 60 to 70% of hospital budgets are spent on staff, reflecting the importance of relationships. If we consider ourselves to be 'liveware' with attitudes, stresses, cultural pressures, our own attitudes and knowledge, then we have to interact with others with the same personal factors, with various forms of hardware (monitoring etc), with the 'software' of policies, manuals and protocols and all in the context of external organisational or political pressures. These interactions make up the human factors with which we have to deal effectively to do our jobs well [2]. However, each of these interactions also has the potential to fail, resulting in poor quality care or a bad outcome.

One needs to bear the likelihood of such failure constantly in mind if one is to avoid it. I have found the following question (which I ask myself

every day and for every patient) to be culture changing and constantly challenging:

"Would this quality of care be acceptable to me or my family?"

If the answer is 'no', one should do something about it then and there, and not duck the issue. If you think from the "customer's" perspective, that is what you would expect. Run to the problem and solve it [3]. Against that background, it is always better to prevent than to treat, and so I begin my 10 commandments as follows:

1. **Adverse events are important**
   As a patient or parent, I would expect the medics to get my treatment right first time and without cock ups. As a surgeon, I need to respect that and remember the core values of providing safe care, with good outcomes, in the context of good experience for the patient. I must tell the *truth* to create *trust*, and each of these values underpin all that I do. Thus, giving weight to the existence of adverse outcomes and doing all that I can to prevent them is **core** to my work as a surgeon. By acknowledging that adverse events are important, you give them the mental space needed to avoid them.

2. **Human error is inevitable**
   No one gets up wanting to make a mistake, yet anyone working in accident investigation or organisational psychology will tell you that any human can make a mistake, even the most experienced and senior. Given that 60 to 70% of an NHS Trust's turnover is spent on staff, it is not surprising that human error is often at the root of adverse events. But we DO all make mistakes, and remembering the Swiss Cheese Theory makes us think about what we need to do to mitigate that risk.

3. **Anticipate adverse outcomes**
   There is an old adage: '*prepare for the worst: it tends not to happen*'. If you anticipate that adverse events are likely to occur, then you can do everything possible to mitigate that risk. By thinking ahead, even though you may not be able to prevent the event, you should have thought through what to do if it did happen; a get-out strategy. A clear example of this is seen week-by-week in the Formula One season. We can observe the consequences of good planning and a commitment to safety, overseen by the late, lamented Professor Sid Watkins, as drivers emerge unscathed from the most horrendous crashes. Much of that safety is due to a commitment to detail and genuine and repeated rehearsal. This manifests itself as **anticipation, preparation and practice**. All of these are so often lacking from day to day surgical practice, in which we rely largely on things going right, rather than preparing for the worst.

4. **Plan what you are going to do, with the whole team**
   You must involve them in what you are intending to do, and make sure they are up for it and have the right kit etc available for good and bad outcomes. Clearly, if you are involving them, this rule is all about *effective* communication, something which I notice, as I travel about, surgeons are not uniformly able to deliver without help. Briefings, checklists and discussion are critical to this as the WHO checklist programme has shown (and as everyone who flies recognises by their repeated survival). Medicine is changing. Our concept of professionalism used to be a doctor, with leather patches on his (and it was a he) elbows, who knew everything and was confident enough to say so. We know now that none of us can know everything, and in the digital age, especially in my field, patient and parents have grown up with smart phones and know just as well as I do how to access Google and PubMed. They *know* as much as we do, just not how to *interpret* it. We need to work with them as partners in a team, and we all need to recognise that we work in teams. Thus we must...

5. **Communicate. It is all about communication**
   Communication is not just telling; it is listening to the rest of the team and hearing what they have to say. If something or someone is missing or there is an equipment problem, don't press on regardless. Discuss with them what may happen, get their views and clearly record it was done.

6. **Respect the patient**
   I can almost hear the cries of "Duh, of course we respect the patient!". Actually, I have been horrified by how often that is clearly not the case. Someone has loaned to you their loved one for a period of time, for you to treat. They are not 'your' patient or a 'VSD'. They are a person, a child, someone's child, someone with a name, a personality and a life. Not an organ or a disease, but a person. After a terrible never event happened at the Beth Israel Hospital in the USA, despite a checklist, the CEO and CMO introduced something they termed 'the moment of reverence', a term which may not have much leverage in the secular UK, but which accurately reflects the principle. After briefing, checking and prepping, take a moment out, as a team, to remember who this person is on the table and how important they are to *others*, not to you. Such a moment's pause keeps it personal and gives the patient due respect. It aids concentration and reminds everyone of the potential and importance of avoiding error. If you want to hear how important respect and truth are listen to Clare Bowen speak at Risky Business GOSH annual conference to learn from other organisations [4]. Prepare to be moved.

7. **Check**
   It is, of course, vital to check that everything

is OK. We now know that the best way to do this is to use checklists. The WHO checklist project has worked, and lives have been saved, wrong procedures avoided and complications reduced [5]. There is **no excuse** for surgical teams not using a checklist, in the same way there would be no excuse for the airline pilot taking off without checking the situation and systems. Engage your team in checking; it is often useful to get the most junior person to read out the list to ensure it is all done. It engages them and influences the culture.

8. **Do it once and do it right**
   Don't take short cuts; think about what you are doing and check with your team, and by now you will have encouraged them to tell you if you are heading for an error. They are your friends and not your enemy. Let them protect you *and* the patient.

9. **Debrief and learn**
   This is probably the thing we do least well as surgeons. If we were the Red Arrows, we would debrief religiously, as a team, after each display and analyse minor errors in the pursuit of perfection. I have seen very few surgical teams do this after surgery, but there is so much to gain. Near misses can be identified, experiences shared and new processes and protections evolved. It induces respect amongst team members and fosters a spirit of continuous improvement; vital for a successful organisation. If we only had 'Black Boxes' in the operating room, including video and audio, we would be able even better to analyse our work.

10. **Measure, share and improve**
    Accurate data is the only way to effect rapid change and improvement. The plural of anecdote is not data, so we need to be sure that we put in place relevant quality control metrics to monitor, present and use as a basis for improvement. Good examples of such modes of presenting data are SPC (statistical process control) charts, and CUSUM charts, both of which are relatively easy to set up and can be used to monitor both success and failure of any event. Doctors and nurses are inherently competitive, so if you show them how they are performing in relation to their peers, even anonymously, they naturally try to improve, without 'management'.

I think Steve Hanson, the All Blacks coach, got it right in December 2012 when he said "Don't ask us how good we are. Just be aware that we are going to get better". We know the All Blacks are a great side, but they are never satisfied; continuous improvement is what they are about. That, too, is our responsibility as surgeons. Nobody jumps higher by lowering the bar.

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[2] http://www.safersurgery.co.uk/human-factors-in-healthcare.php#

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COACHING CONSULTANTS

Iain A Simpson
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Introduction by Professor Cliff Shearman

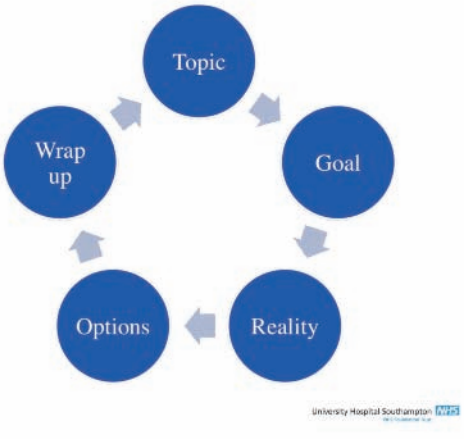
The life-time cost of employing a consultant surgeon by an institution is considerable and the performance of that surgeon is likely to have a direct effect on the success and reputation of the employing organisation. It is surprising then, at present, very little attention is paid to ways of helping and ensuring that consultant surgeons are performing at their optimum level. Likewise, most surgeons have trained and competed hard to become consultants but, having been appointed, few then plan their careers and life beyond that point. In his article on coaching consultants, Dr Iain Simpson outlines the role of coaching and how it can be used to help individuals working in organisations, such as the Health Service, to achieve success and be valuable assets to their employing organisations. Coaching is widely used in organisation around the world and hopefully its potential role for surgeons working in the NHS will be recognised.

Coaching means many different things to different people. From the sports coach to the life coach, there seems to be an increasing spectrum of coaches available to help us through many of the activities and challenges of modern life. The area of "executive coaching" has become widely established in business practice but less so in the healthcare environment, where it has largely been the domain of the manager rather than the clinician. This is changing, especially as clinical leaders discover opportunities for coaching and recognise its value to their personal development and ability to excel in their chosen field. But what is this executive coaching and how is it relevant to consultants?

Executive coaching for consultants, even if recognised, has generally been associated with failure not success, often recommended following the outcome of investigations into possible professional misconduct. Yet this could not be further from the truth. "Coaching for excellence" is about allowing individuals, already performing at a high level, to fully achieve their potential.

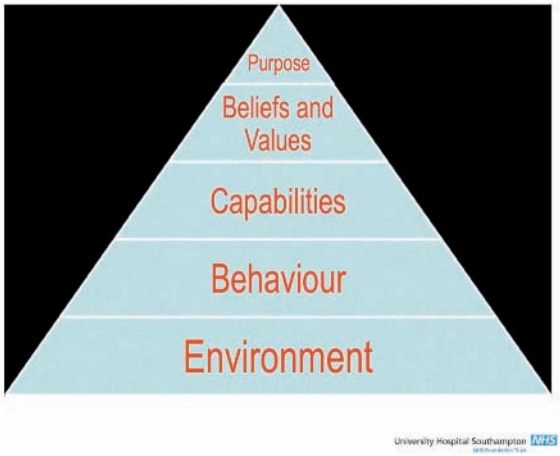
In essence, executive coaching takes the form of a structured, purposeful discussion, based around a specific topic chosen be the person being coached. This structured discussion allows the individual to fully explore the topic, define the goal or goals to be achieved and explore a range of possible options with agreed outcomes ***(Figure 1)***. Coaching is all about the person being coached, not the coach. As such, although it is important that the coach has knowledge of the healthcare industry and how an organisation and the teams within it function, it is equally important that they do not interfere with the discussion by having a close working relationship with the person being coached, where unwarranted assumptions may be made by the coach. Indeed, it is generally advised that, where possible, the coach and the person being coached have no personal knowledge of each other. In a Trust hospital, where an internal coaching programme has been established, this may not always be possible, so it is essential that the coach is aware of this potential interference and takes steps to avoid it.

Figure 1
"Grow" model of structured discussion



The coach will use a structured discussion model with tools to facilitate the discussion, exploring various levels of logical thought around the working environment, behaviours, capabilities, beliefs and values ***(Figure 2)***. The use of "clean" language, i.e. the language that the person being coached is using, is important. So, for example, if the person being coached indicates they are "upset", it is wrong for the coach to ask question about being "saddened", "angry" or "distressed", which may not be the exact meaning of "upset" to the person being coached. In this way, the discussion can progress using the language of the person being coached and the meanings attached to this, a fundamental aspect of a successful coaching session.

Figure 2
Dilts Logical Levels Model



It is important to recognise that coaching is not a form of psychotherapy or counselling, nor is it about performance management, but rather a mechanism for the person being coached to translate their own thoughts on a topic into outcomes and actions appropriate to them. Coaching differs from "mentoring" in a number of ways although there can be some degree of overlap. Unlike coaching, a mentor tends to be senior and experienced in the same field, more of a role model, with knowledge of the individual undergoing mentoring. A mentor tends to give advice and has a degree of influence on the person being mentored. It also tends to be a longer term relationship, sometimes spanning a whole career, rather than the shorter term, topic-based coaching environment. As such, whereas mentoring is often most valuable early on in a consultant's career, coaching tends to be valuable for more experienced consultants undertaking leadership roles.

The benefits of coaching for individuals in improving workplace related performance has obvious positives for the organisation, providing consistency of leadership behaviours and decisions as well as improved clinical outcomes resulting from functional teams. Consultants can benefit greatly from coaching, not only by undergoing coaching themselves but also by learning some of the skills of coaching which can prove invaluable in working with their clinical teams, assisting in education supervision, appraisal discussions and even with the difficult conversations everyone encounters from time to time with clinical colleagues and management.

This supplement is also available, as a separate off-print, at
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