Role of the Surgeon

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Introduction

In recent years, the role of the surgeon has come under much scrutiny as a consequence of investigations into professional practice. The Frances Report of 2013 identified problems in working culture as being responsible for "appalling care" and creating "a culture of fear in which staff did not feel able to report concerns; a culture of secrecy in which the trust board shut itself off from what was happening in its hospital and ignored its patients; and a culture of bullying, which prevented people from doing their jobs properly" [4].

A positive working environment has been shown to promote workers' motivation and happiness, increasing productivity and reporting of problems as a knock-on effect. This is affected by a wide range of factors, ranging from individual actions to group-work and institutional regulation on a larger scale, as demonstrated in "To Err is Human", a publication by the Institute of Medicine [3]. This chapter will examine the role of the surgeon in different settings, considering interactions with the workforce and subsequent effects on patient care.

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Leadership

Surgeons frequently have a role leading a multidisciplinary team. Defining "leadership" as a concept is difficult and many have attempted to summarise the role of a leader in one sentence. The role of a "leader" has undergone much change over time; in 1954, esteemed surgeon Sir Heneage Ogilvie, lectured on surgical leadership, stating:

> "The effectiveness of the treatment depends on the services of one man – the surgeon – on his correct assessment, his timely decision, his skilful manipulation, and his unremitting care" [6]

Meanwhile, in the twenty-first century, attitudes have evolved and the Royal College of Surgeons directly contradict Ogilvie's attitude:

> "Consultant surgeons should develop a partnership with management to focus on team working and its positive effect on patient safety. Trust management must be involved in team development."

Common to modern descriptions of leadership is the importance of effective leadership and the benefits that this brings. In the surgical setting, tangible advantages are gained by patients, staff, the surgical team and the healthcare service as a whole (Fig. 4.1). As well as a myriad of definitions, various theories exist regarding how best to lead (Fig. 4.2) and the qualities of a good leader (Fig. 4.3) [7].

Transactional and transformational leadership theories are among the leadership models

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Fig. 4.1 Benefits of effective leadership

most commonly compared. Whereas transactional leadership is based on the premise that followers will only respond with the desired behaviour when motivated by the promise of receiving something in return, transformational leadership aims to alter the beliefs and actions of followers so that they match those of the leader and the team advances together [1]. The latter is important within the surgical team as it reduces any hierarchy, promoting unity and increasing the efficiency with which aims and objectives are met.

The Surgical Team

The multi-disciplinary team is fundamental to medical practice in the twenty-first century and consists of leaders and followers. The setting of patient care dictates what professionals are involved and what their role entails. Different clinical teams, consisting of a variety of individuals, are involved in patient care at different stages of the patient journey (Fig. 4.4) [8].

Within the surgical team, doctors and surgeons with different levels of experience work in a multidisciplinary team with nurses, physiotherapists, dieticians and an array of allied health professionals. Though led by a consultant surgeon, they themselves will not necessarily operate on every patient, for example when supervising the training of others in their given specialty. Nevertheless, the consultant takes responsibility for patient care and maintenance of good standards within the surgical team at all times. Other members of the surgical team may include:

- Associate specialist surgeons
- Specialty/staff grade surgeons
- Specialty surgical registrar (StR) (Previously known as Specialist surgical registrar (SpR))
- Core training doctors (CT1, CT2)
- Foundation doctors (F1, F2)
- Anaesthetists
- Theatre nurses
- Operating department practitioner
- Surgical assistants

Effective leadership and communication are integral to the function of any team and provide substantial additional benefits. Functional teams have demonstrated a reduced rate of error, which corresponds with a fall in hospital-associated mortality, reducing costs and time saving. As well as being beneficial to patient safety and wellbeing, efficient teamwork confers advantages to staff, creating a supportive environment which is enjoyable to work in, and has been shown to reduce sickness absence.

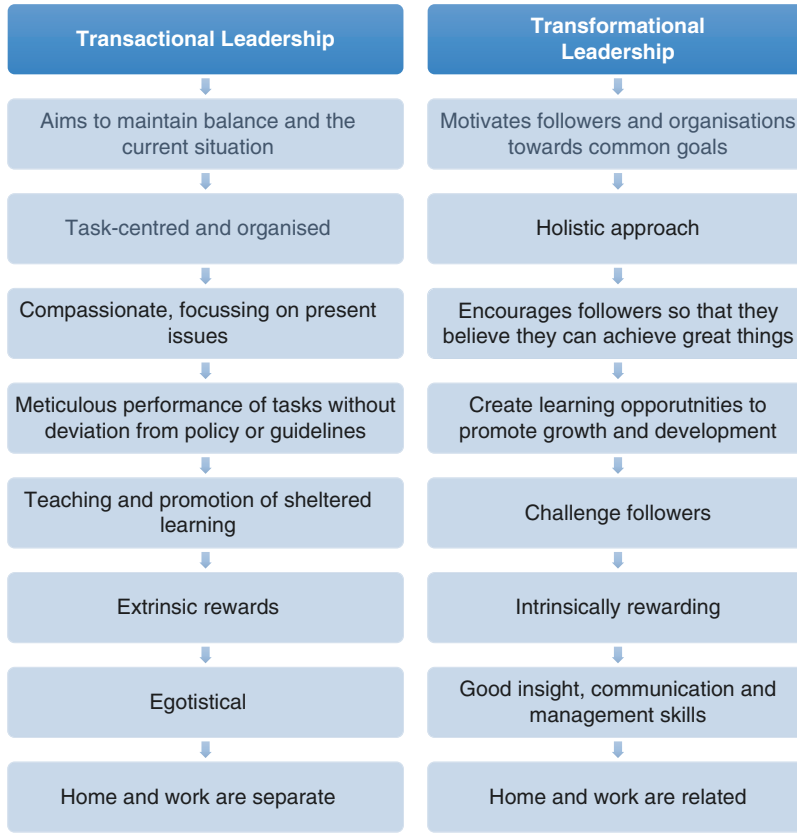

Fig. 4.2 Transactional vs. transformational leadership

Attributes of a Good Surgeon

Realising the benefits that good leadership and teamwork can deliver requires commitment from all those involved in patient care. From the surgeon's viewpoint there are numerous desirable attributes which are developed through medical school education, foundation training, core training and into professional practice [9]. These are outlined below [10]:

1. ***Clinical Care***
   An obvious consideration of what makes a "good surgeon" is the care provided to patients throughout the patient journey. This includes technical ability in the operating theatre and non-technical skills.
2. ***Maintenance and Improvement***
   Remaining up-to-date with innovations in surgical practice and patient care is an important attribute of a good surgeon. In doing so, one is able to inform patients and explain the reasons for and against procedures, allowing them to make an informed decision. Willingness to learn from others and improve from others by reviewing personal practice forms part of Continuing Professional Development; this is a requirement in a portfolio to meet revalidation and recertification criteria.
3. ***Teaching, Training and Supervision***
   Educating others forms part of professional development and surgeons frequently oversee projects for medical students or trainees. This requires knowledge of the objectives of the

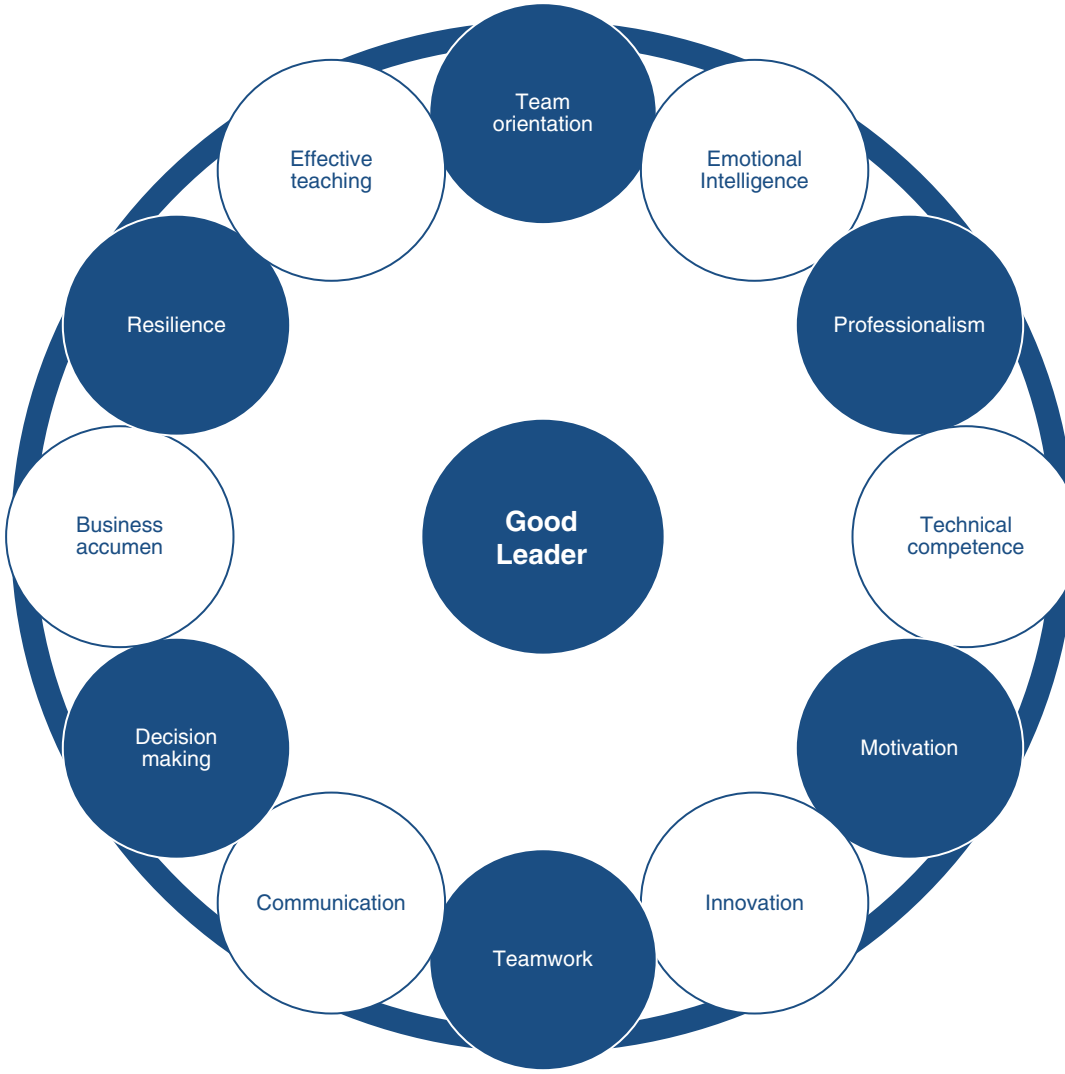

Fig. 4.3 Qualities of a good leader

tasks undertaken, knowledge of what technical and non-technical skills should be improved and knowledge of how to encourage the development of these skills. The mentor-mentee relationship should work both ways, such that the mentee is able to approach their supervisor for assistance and is accepting of any constructive criticism delivered.

4. ***Relationships with Patients***
   Relationships with patients are fundamentally based on trust; the patient trusts that the surgeon will do all in their power to help them and their surgical journey. Obtaining informed consent prior to clinical care is based on trust and allows patient autonomy to be upheld. Developing relationships with patients begins from the first consultation and is continued after the day of an operation being undertaken. Acknowledging the needs of the individual and employing effective communication helps in developing an open relationship. In this way patients disclose their medical history and admit underlying fears, allowing better patient care to be delivered.
5. ***Relationships with Colleagues***
   Partnership with all members of the multidisciplinary clinical team, management, technicians and support staff fosters healthy working relationships. Consequently, patient

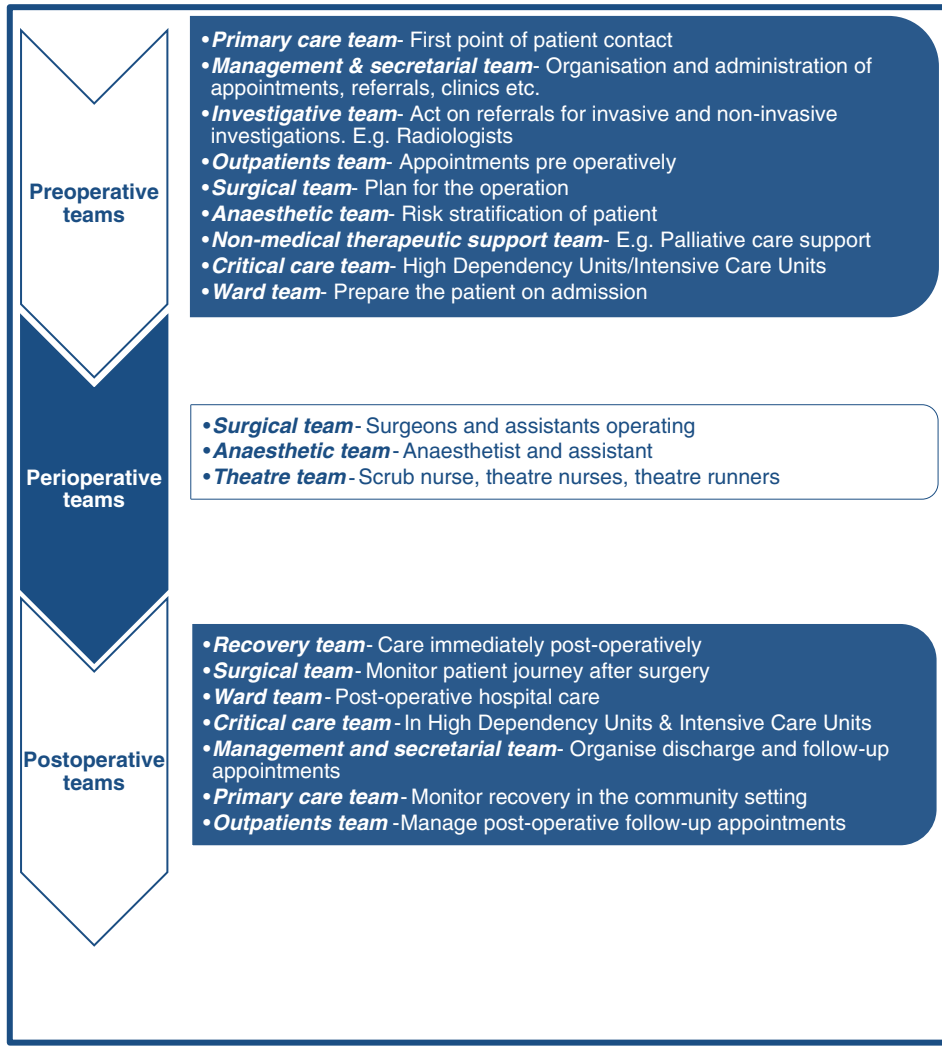

Fig. 4.4 Examples of clinical teams throughout the patient journey

care is enhanced through communication, enhanced productivity and an improved team dynamic. Understanding how a colleague works and taking action to facilitate a positive working environment is beneficial to all. Emotional intelligence forms an important component of working relationships, through the ability "to understand and recognise emotional states and to use that understanding to manage one's self and other individuals or teams" [2].

6. ***Health***

Maintenance of good personal health and knowing when you must stop working is important in the protection of patient safety. The relevant senior staff must be informed of communicable disease or blood-borne disease transmission. In addition, being vigilant of the health of colleagues forms part of protecting patient safety, for example, failure to report suspicion that the consultant consistently operates after several glasses of wine or that the CT2 has been seen smoking drugs can facilitate the propagation of errors in the workplace. Finally, surgeons are renowned for working at all hours, however acknowledgement that we all need rest is crucial in good patient care.

Communication: The SBAR Tool

Effective communication between individuals within a team and between teams can enhance the benefits gained from teamwork including efficiency and patient safety. A specific framework has been designed to help clinicians share information about a patient's status and requirements. Adopting a structured approach to communicating patient information ensures that important details are not overlooked and that action can be taken promptly to meet the needs of patients. The SBAR mechanism includes details that are essential when discussing any case (Fig. 4.5) [5]. It is important to practice your ability to communicate a patient's information using the SBAR tool as it is frequently examined in OSCEs.

Situation

Primarily, one must set the scene for the individual receiving information. Ensure that they are not distracted by others but are listening and are ready to take notes if necessary. In many cases, communication between wards over the phone will require you to explain who you are, what your role is and from where you are calling. A brief overview of the relevant patient and why you have made contact should be given. For example:

> "Hello, it's Catherine Lovegrove speaking, I'm one of the CT2 doctors in ward 10. I am calling regarding Mr. Cooke in bay 5 who underwent a total hip arthroplasty two days ago. We have just reviewed him and are satisfied with how his wound is healing, his vital signs are all within normal range and he is looking well. I wonder can we arrange for a physiotherapist to come up to the ward and initiate rehabilitative exercises?"

Background

After setting the scene, more details about the case at hand can be explained. This includes information regarding the patient, their reason for

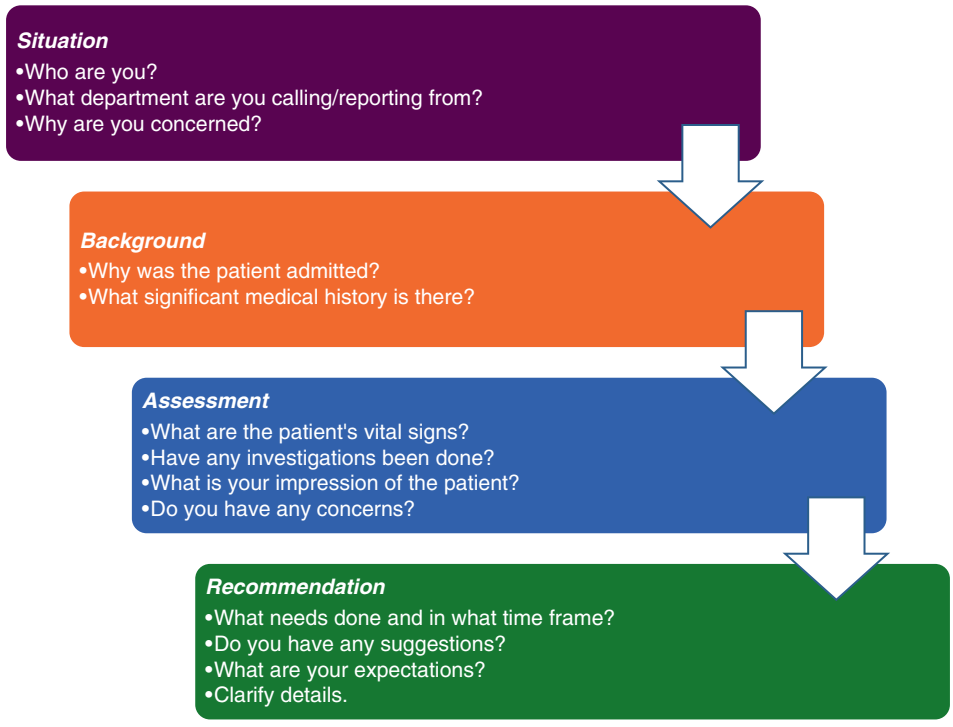

Fig. 4.5 SBAR framework for communication

admission and any relevant past medical history before elaborating in more depth on the patient's case. In describing the background, details regarding their condition, admission history and investigations should be communicated. For example:

> "Mr. Cooke is a healthy 70 year old man who came in two days ago with an intracapsular fracture to the femoral neck after slipping and falling on ice on the paving stones in his garden. After reviewing his x-ray results, he underwent total hip arthroplasty on the same day, which proceeded without complication. He suffers from type 1 diabetes, which is well controlled with insulin. We are monitoring the wound for infection, thus far all is well; urine output is good, oxygenation is satisfactory and his blood pressure was 134/73 mmHg on last measurement. Mr. Cooke lives independently at home with his wife and is a keen golfer in the summer."

Assessment

When describing your assessment of the patient's condition, use objective information such as results from investigations. In addition, it can be useful to call on information from other sources, such as nursing staff that have been regularly monitoring the patient. For example:

> "Given the fact that his progress is satisfactory I feel that he is ready to meet with a physiotherapist to discuss future rehabilitation. The nursing staff have said that he has been alert, but he has expressed concern that his quality of life will be limited if he does not resume activity soon. I think it would be beneficial and reassuring to him to initiate contact with the occupational therapy and physiotherapy departments so that he can be prepared when the time for his discharge comes."

Recommendation

Finally, conclude the conversation by explaining what you feel should be done, indicating when, by whom and how. As with any communication, make sure that your colleague has understood what you have told them and what you need to happen. This avoids unnecessary confusion that is inefficient and delays patient care. For example:

> "Can we arrange for a physiotherapist to come to the ward tomorrow morning and meet Mr. Cooke and explain how his rehabilitation will be structured and what he can expect in the coming days and weeks? I would also appreciate if an occupational therapist could consult Mr. Cooke about what adaptations he may need at the time of discharge so that he can continue to live as independently as possible. Does that make sense? Do you think someone will be able to come then?"

Using SBAR in an OSCE Setting

It is common in some medical school rotations to be asked to perform an SBAR to the examiner at the end of an OSCE station. In our experience, this is often after emergency/resuscitation stations, where you are expected to synthesise your findings into a succinct format to allow help to come as quickly as possible. In this case, your SBAR may be expected to be much shorter than the example above:

"*Situation:* Hello I'm Annabel Darling, one of the FY1 doctors in A&E. A 20 year old girl, Miss Charlotte Mason came in 30 min ago with a severe asthma attack which came on 2 h ago. Despite salbutamol nebulisers and high flow oxygen, her CO_2 is now rising and is currently 7.1 kPa. She is looking increasingly tired and her respiratory rate is now just 14 breaths per minute.

Background: She has been to ITU 3 times before with severe attacks, and is well known to the department. She has no other medical conditions.

Assessment: I am very worried about Charlotte, and her worsening type 2 respiratory failure needs to be acted upon immediately as I suspect she is getting tired and could become very unwell very quickly.

Recommendation: If you agree, I think we should get a bed in ITU for Miss Mason for intubation and mechanical ventilation. Would you be able to help me with this? How long will it take to secure this? Is there anything you would like me to do in the meantime?"

Student tip: "It is helpful to ask "Is there anything you would like me to do in the meantime?" after you do an SBAR. As well as being

useful in reality, if you use it in an exam it may make you appear more on top of things and seem more competent than other students!" Rebecca Fisher, Medical Student, Edinburgh University.

Conclusion

The role of the surgeon within the surgical team and the multi-disciplinary environment has effects on patient care through various pathways. Healthcare efficiency, team dynamics and the patient experience are all heavily influenced by how a surgeon interacts with their colleagues and patients. Maintaining a careful balance in leadership style, and encouraging the use of effective communication are important considerations when thinking about the role of the modern surgeon. The diverse range of skills required should be continuously reviewed and assessed to ensure good practice.

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