VIEWPOINT

The Importance of Increasing Surgeon Participation in Hospital Leadership

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Research indicates that there is an association between physician leadership and hospital performance.[1] Hospitals led by physicians have higher US News and World Report (USNWR) quality scores, reduced complication rates, better bed-usage rates, higher physician-satisfaction scores, and financial performance scores that equal those of nonphysician managers.[2-4] These findings in the health care sector are in line with new management thinking that organizations led by core-business experts (ie, participants or practitioners in their respective fields) tend to demonstrate better performance.[5] A recent article[6] suggests that management-led organizations may be lagging because they have not embraced physician input and leadership, thus resulting in resistance to change.

Becker's Healthcare listed the chief executive officer (CEOs) of 183 nonprofit hospital and health systems in 2017,[7] and of these, only 46 were led by individuals with MDs. Among the 115 largest hospitals in the United States, 34 are physician led, and that ratio is approximately the same in the USNWR rankings of US hospitals.[3] The small numbers of physicians in CEO positions in the United States makes impossible a formal statistical assessment of the prevalence of any specialty; however, a cursory glance at the data reveals the relative absence of surgeons. Of the 46 physician-leaders in the nonprofit hospitals identified by Becker's Healthcare,[7] only 4 were surgeons. In the 2009 study[1] examining physician leadership and hospital performance across 3 specialties, 3 of the CEOs were surgeons.[1] These numbers appear low when considering that surgeons make up 19% of US physicians.

To determine whether there has been any recent increase in surgical hospital leadership, we analyzed the 2017-2018 USNWR Rankings of Hospitals (ranking data available on request). We combined the list of honor roll hospitals with hospitals in the top 20 in 3 ranked areas (oncology; cardiology and cardiovascular surgery; and gastroenterology and gastrointestinal surgery). We chose these ranked areas because surgeons provide care for a high percentage of patients in these categories. Hospitals that appear on multiple lists were counted once, resulting in a cohort of 32 unique institutions. Information on the hospital CEOs was obtained from a review of hospital websites. Our simple analysis revealed that of the 32 high-performing institutions, 19 were led by physician executives; however, only 1 was led by a surgeon—Toby Cosgrove, MD, of Cleveland Clinic. Dr Cosgrove joined Cleveland Clinic in 1975 as a research-active surgeon. He led the $8 billion health care system between 2004 and 2017, when he relinquished the position.

Why are so few surgeons in organizational leadership positions such as CEO and chief operating officer? Herein, we consider 3 possible explanations.

First, an economist might suggest the gap exists because the relative pay of surgeons exceeds that of most other specialties. Therefore, there is less incentive to accept the challenges presented by leadership roles. Second, surgeons have been stereotypically perceived to exhibit arrogance, a characteristic that others may not warm to. An interesting study[6] that revisited a cohort of Cleveland Clinic physicians 10 years after participating in a leadership development course sheds some light on this. The Cleveland Clinic training focused heavily on emotional intelligence, including assessing participant emotional intelligence competencies through 360° feedback. The study[6] examined the association between previously measured emotional intelligence competencies and physicians' subsequent promotion to a leadership position. Sixty-nine member of the cohort (25%) were surgeons, no difference in emotional intelligence was found between surgeons and nonsurgical physicians; however, surgeons demonstrated lower scores in 3 competencies—conflict management, change catalyst, and emotional self-awareness. The perception of an expert surgeon is that they are trained to perform operations independently, reacting to unexpected surgical emergencies, making timely decisions with his or her own judgements, and being responsible for the consequences. Surgeons may, therefore, need specialized leadership training to broaden their perspective and awareness.

Finally, the craftsmanship nature of the surgical specialty discourages development of other career interests at a trainee level. With the introduction of the European Working Time Directive in the United Kingdom, the legal maximum working time is, on average, 48 hours a week. In contrast, the Association for Surgeons in Training stated that to ensure optimal training with adequate time for surgical exposure and patient care, it is necessary to return to a working week of 65 hours. The physical demands of meeting training requirements and operating volume means that there is less available time for management training or undertaking leadership responsibilities. Nonsurgical specialties, such as anesthesia, encourage trainees to explore other areas and participate in out-of-program fellowships in medical leadership and management. The hands-on nature of surgery—the required dexterity and intense focus—may also work against the requirement in leadership to draw back the perceptual lens and observe an organization as a whole.

The omission of surgeons as leaders seems inappropriate given the sizable portion of cost and revenue

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directly attributable to surgical care. There is evidence to suggest that surgeon-leaders within hospitals and health care systems are capable of generating the necessary changes to improve quality and reduce costs.[6] Quality improvement efforts led by surgeons including the Veterans Affairs Surgical Quality Improvement Program, American College of Surgeons National Surgical Quality Improvement Program, Society of Thoracic Surgeons, Enhanced Recovery After Surgery Society, and State Surgical Collaboratives, have led to dramatic decreases in surgical mortality and morbidity. Recent surgeon-led efforts to reduce the cost of surgical supplies and implements, standardize care pathways, and improve efficiency have seen dramatic reductions in the cost of care.[6]

We propose 3 potential solutions to increase the number of surgeons in hospital leadership positions. First, considering the contribution of surgery to health care value, it is critical to nurture future surgical leaders through exposure to management training. This education should be integrated into the surgical resident training curriculum. This need was recognized in 2014 when the The Royal College of Surgeons published a guide[8] intended to provide standards and recommendations to inform training, development, and the assessment of surgical leadership. Their key recommendations include: (1) minimize status and power differences between surgeons and other specialties; (2) ensure surgeons are accessible, self-aware, and mindful of their actions, professional and otherwise, on others; (3) ensure surgeons recognize their own response to stress; (4) ensure surgeons demonstrate openness to being challenged and receiving feedback; and (5) allow flexible working for surgeons in manager positions to ensure that clinical practice is maintained while entering a leadership track. In the United States, the American College of Surgeons, Society of University Surgeons, and Harvard Medical School have all developed surgeon-specific leadership and management training similar to these recommendations.

Second, current hospital leadership could recognize the important contribution that surgeons make to health care quality, patient safety, operational efficiency, and cost efficiency. It may be necessary to invest in tailored leadership development programs that focus on the particular weaknesses of surgeons, while also offering incentives to encourage surgeons to invest time in service of the hospital and away from clinical practice.

Finally, academic departments of surgery and medical schools could recognize administrative and quality-improvement efforts as important aspects of the overall academic mission. Allowance needs to be made for lost work relative-value units. Additionally, credit for promotion should be given for major accomplishments in the area of health care delivery and administration.

A successful future for the US Health Care System will undoubtedly require the engagement of outstanding physicians in leadership positions. Surgeons may first need to recognize the importance of their influence in health care strategy and delivery. A leadership pathway should be integrated into the training program of surgery.

ARTICLE INFORMATION

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