Perioperative leadership

Models for governance of the OR

What is the key to a successful leadership model in perioperative services? Is the model different for academic and community hospitals? Does the structure differ in organizations with an integrated physician model versus a private practice model?

If we are not achieving our goals as hospital and physician leaders, it may be because of the leadership structure. Although we often blame each other or outside forces—reimbursement, staffing shortages, patient volumes and acuity, rising costs of technology—leadership is what drives the organization to success or failure.

*OR Manager* asked hospitals and consultants about perioperative leadership structures and what makes them successful. Regardless of size or affiliation, some common themes emerged (sidebar).

**Large academic facility**

William Mazzei, MD, medical director for perioperative services at the University of California, San Diego (UCSD), an academic medical center, believes authority should be centralized in a collaborative physician-led directorship model. He thinks this model is successful because “major issues, many of which are emotional, are physician issues and require physician-to-physician communication.”

UCSD’s Surgical Services Executive Committee consists of Dr Mazzei as the paid medical director, active surgeons, OR nursing leaders, and a hospital administrator. Strong physician leadership, not necessarily titled physician leaders, is an essential element for this committee, Dr Mazzei says. The committee operates by consensus building, aiming for solutions all parties can live with. The nursing director for perioperative services hires, fires, and provides oversight for the OR nursing staff.

Collaboration between the nursing director and the medical director is important for physician and hospital staff, Dr Mazzei believes. Having the hospital administration at the table gives the committee the authority to make decisions and authorize expenditures. It is crucial to have open communication about finances and management decisions to facilitate trust and teamwork, he adds.

Asked how an anesthesiologist can be successful as medical director for a large, academic surgical department, Dr Mazzei listed these prerequisites:
1. Anesthesia providers and surgeons have to be at the same table.
2. A good anesthesia department must agree to do what it takes to make the department function successfully—and needs to be supported by the hospital.
3. The administration and the Surgical Services Executive Committee must welcome surgeons as customers so they know they are wanted.

**Striving for open communication**

At Shands Hospital at the University of Florida, Gainesville, also an academic medical center, the aim is to “create a culture and environment where issues are brought out instead of pushed under the rug,” says Gail Avigne, RN, BSN, CNOR, director of operating room services. The OR Committee is chaired by the medical director, David Paulus, MD, an anesthesiologist, in a paid position. Other members are surgeon representatives from every service (not necessarily the chairs of the services), staff members, and surgical services management.

The leaders strive to keep lines of communication open, build consensus, and
empower the staff through team leaders to encourage strong relations with physicians. Leaders also teach and encourage use of communication skills based on the book, *Crucial Conversations*, by Kerry Patterson and others (McGraw Hill, 2002). The book offers skills for mastering conversations, “where stakes are high, opinions vary, and emotions run strong,” according to the authors.

The groundwork for a positive work environment is laid during prospective employee interviews, Avigne notes. Shands has an established process for managing disruptive behavior that coworkers, physicians, and managers can use to address interpersonal conflicts. One measure of their success is that there have been no RN openings in the OR for several years. (An article about the disruptive behavior policy is in the March 2005 *OR Manager*, pp 24 and 27.)

**Large community hospital**

At St John’s Regional Health Center in Springfield, Mo, a large community hospital with 34 ORs in 2 locations, leadership is provided by the Perioperative Services Guidance Team (PSGT). The team is led by Fred McQueary, MD, chair of the Department of Surgery, who reports to the chief of staff, and Ted Shockley, RN, CNRN, director of perioperative services. Dr McQueary is paid for his role as the department chair but is not the OR medical director.

The PSGT includes active surgeons in resource-intensive, high-volume services; anesthesia representatives; nurse managers; and materials management. The group meets twice a month with 100% attendance. Dr McQueary says the group is successful because all members have a voice.

Oversight of the PSGT is provided by the Surgical Department Executive Committee, which addresses major physician issues, while the PSGT deals with the nuts-and-bolts issues. Dr McQueary and the hospital leadership determine what issues each group evaluates. The PSGT is mature, having met for several years, and can make rapid progress on even the most difficult issues. “People must command respect and want to participate—not just do their time on the committee.” Dr McQueary says.

St John’s is an integrated organization with the hospital and physicians under the umbrella of the St John’s Health System. This integrated model allows physicians to have a voice in management. A separate governance structure for the health system provides for negotiation, conflict resolution, and a partnership in which physicians and hospital want each other to succeed. Physicians are expected to be fiscally responsible and outcomes driven, resisting technological advances that appear to have advantages but in reality only add cost. The hospital, on the other hand, must have a commitment to maintain quality and technology. Financial information and status of vendor negotiations are shared with the physicians regularly, with feedback and solutions provided to the administrator on the team.

Medical directors, in Dr McQueary’s view, must have a good clinical record, maintain an active clinical practice, be good listeners, and be able to deliver unpopular information and decisions to their peers. Hospital leaders must be committed to the community and quality of care, be dedicated to quality over financial issues, and be open minded.

**Medium-sized hospital system**

Scottsdale Healthcare in Scottsdale, Ariz, consists of 2 not-for-profit community hospitals: Osborn, a Level 1 trauma center with 9 operating rooms, and Shea, with 15 operating rooms.

At Osborn, the chief of surgery is the chair of the Perioperative Guidance Team (PGT). All of the highest-volume specialty physicians are invited to participate, along with the administrator, director of organizational development, director of perioperative services, OR manager, postanesthesia manager, and quality manager, who assists with data collection and analysis. The group strives to improve OR efficiency, working on late starts, turnover times, block scheduling issues, and OR capacity. All members of the committee have an equal vote.

Shea has a PGT cochaired by an anesthesiologist and surgeon. There are more
service-line and hospital managers on the Shea team. The group reports directly to the hospital executive committee. Though only the physicians have a vote on the PGT, the group strives for consensus. Physicians on the PGT volunteer their time. Only the trauma medical director is a paid position. The group meets twice monthly and has a stable membership.

The motto is MSA—move, second, and approve, which encourages “getting things done,” says the Shea’s PGT chair, William Leighten, MD. MSA enables decisions to be implemented immediately. For example, when considering a new piece of OR equipment, the team researches the issue, comes to a consensus, and “MSA”—the decision is implemented immediately. Groundwork is laid before decisions are made, and the COO is kept informed.

The director of organizational development, Sylvia Bushell, CPHQ, serves as liaison between the PGT and the administration, holding members accountable, facilitating meetings, and acting as a bridge to the administration. Because she is not a clinician, she says she does not have a vested interest in decisions and can ask questions that need to be addressed. Scottsdale adopted this structure based on the St John’s experience and finds it has worked well, she notes.

**Small county hospital**

At Contra Costa Regional Medical Center, a county hospital in Martinez, Calif, leadership is provided by the Perioperative Care Committee (PCC), which reports to the administration and CEO. The facility is largely staffed by family practice physicians, rather than specialty physicians, notes Carolyn Billings, RN, CNOR, nursing program manager for the OR, PACU, and sterile processing department.

The PCC is a multidisciplinary committee that includes the ICU medical director; the department heads of anesthesia, obstetrics/gynecology, and surgery; nurse managers, OR staff, outpatient nurse educators, and physician chairs of the preoperative and postoperative care workgroups. The model is “successful because of the commitment from the workgroup, dedication, and permission from administration,” comments the chief of surgery, Ramon Berguer, MD, who is a paid department head in addition to his role on the PCC.

According to Billings and Berguer, the administration was “invited to leave the committee. The CEO had been on the committee, and it tended to limit discussion to a yes or no process rather than an exploratory and open one.”

While the administration makes the final financial decisions and sets broad quality goals, the PCC runs surgical services within the broad parameters set by the administration. Because of this relationship with the administration, Dr Berguer says many PCC members have a good grasp of strategic goals, financial constraints, and general hospital operations, and the group is empowered to make decisions that are supported by administration.

“Slowly, over time, people have come to see that the group functions, and they can’t get around it,” he says. Among changes the PCC has made are to improve surgical outcomes, reduce delays and cancellations, and decrease conflicts and cost.

—Christy Dempsey, RN, BSN, MBA, CNOR
Vice President
St John’s Regional Health Center
Springfield, Mo
**Success factors for OR governance**

Factors identified by Sullivan Healthcare Consulting, Ann Arbor, Mich, which specializes in OR and surgical services consulting.

**A strong executive committee**

The most effective leadership structure is a small surgical executive committee—the so-called “gang of 4”—with representatives from the hospital’s senior leadership (a vice president) plus anesthesia, surgery, and nursing, says Mark Ayer, consulting manager. That advice applies regardless of the size of the department.

“Organizations I’ve consulted with that have this type of structure tend to make strides in changing the culture and operating as a business unit,” Ayer says.

More common—but less effective—is the traditional OR committee with the OR director and chiefs of services.

“Without senior leadership at the table or anyone with authority to make binding decisions, the structure is fraught with individual chiefs’ political agendas,” says Tammy Tenerowicz, RN, BSN, MPA, CNOR, senior management consultant.

Much less common in surgical services is a service-line structure used for other services, such as cardiovascular care. A true service line operates as a business unit with leaders accountable for market strategy, financial performance, and supporting functions such as human resources and materials management. That is difficult in surgery because it services so many specialties.

A pitfall of a surgical service line is that if the structure and reporting relationships are not clearly defined, the OR director may have to negotiate for support from other functions essential to the unit’s performance, such as the finance office or materials management, Tenerowicz observes.

**Accountability**

The OR leadership group needs to be held accountable for the department’s performance, which is easier with a small executive committee, notes Randy Heiser, MA, Sullivan’s senior vice president.

“From the board and CEO on down, it should be known that when you have a problem in surgery, this is the group you go to,” he says.

Representation from the hospital’s senior leadership is crucial. Otherwise, when a surgeon goes to the CEO, “it’s easy for the CEO to put on his sales hat and give the physician whatever he wants,” says Heiser. If there is a strong surgical exec committee, the CEO can say, “Doctor, you need to go to the surgical executive committee, and they will address the issue.”

**Clear policies and guidelines**

“Clearly define your policies and guidelines,” says Nancy Macleod, RN, MBA, a Sullivan vice president. Sullivan advises clients to make a clear distinction between a policy, which must be followed 100% of the time, and a guideline, which is more flexible.

An example:

**Policy:** “We will conduct a time-out before every surgical case.” This is a requirement. Cases will not go forward unless the policy is followed.

**Guideline:** “The history and physical and other documentation will be in the patient’s chart 24 hours before surgery.” This is strongly recommended, but the process doesn’t stop if the paperwork isn’t complete 24 hours before surgery.

**Data-driven decisions**

Decisions are based on the hospital’s mission and data rather than on perceptions or politics, says Ayer. An example is reallocation of surgeons’ block time.

Consider a senior surgeon who has contributed a great deal to the organization but is starting to do less surgery.

“You look at his data, then you meet with him and say, 'You’re not using the time you used to. We need to reallocate that,’” Ayer says. That expectation is applied consistently to all surgeons, regardless of rank or seniority.
**Good communication**

“You need a communication system that gets information out to everyone. You can’t share information too much,” Tenerowicz suggests. “Use newsletters, post information, send letters, put notices in the physicians’ lounge.” That’s more effective than relying solely on chiefs of service to communicate with their members.

**Stipend for physician leader**

If physician leaders are paid, you can hold them accountable more easily. “I’ve yet to find a strong physician leader who didn’t receive a stipend,” says Heiser. Typically, the position is 10% to 40% of an FTE.

“I’ve never found that a rotating or elected chair was effective,” he adds. “There is no incentive for them to be a leader because in 2 years, they will be back on the regular staff, and someone else will be in charge. Plus, they may depend on the other physicians for referrals.”

**Medical director more common**

The position of OR medical director is becoming more common in all sizes of facilities, the consultants say. The position may be full time or part time, depending on the size of the institution.

“The programs we think work best have 2 medical directors, for anesthesiology and surgery, because they have different issues,” Heiser says. Both serve on the surgical services executive committee.

In most cases, nursing does not report to the medical director. “I’m not a fan of having nursing report to anesthesia,” Heiser says. That removes 1 member from the surgical executive committee, which makes it less effective.

More information about Sullivan Healthcare Consulting is at www.sullivanhc.net.