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Who's really in charge in the operating theatre?

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The Opportunities in Surgery committee of the RCS provides advice and guidance to surgeons and aspiring surgeons. For the 2012 annual medical student prize, entrants were required to submit a 500-word abstract in response to the question 'Who is in charge in the operating theatre?' A wide range of suggestions, parallels, anecdotes and, clearly, some traumatic memories were recollected. But are we any closer to answering the question?

Simplistically, only 47% of the entrants managed to identify an individual: the patient (18%), the surgeon (15%), theatre nursing staff (11%), the anaesthetist (1%), the operating department practitioner (1%) and the GP(!) (1%). The remainder concluded that anybody (13%), everybody (13%) or nobody (7%) was in charge, with 20% failing to draw any conclusion at all. Does this mean our medical students find it difficult to formulate an opinion and express it using reasoned logic or are we playing to one of the finest fallacies created by the human mind, namely that there is a simple explanation to what is actually a complex set of circumstances?

Fortunately, the traditional 'performing' of operations in a 'theatre' has long since passed but these words originated when the surgeon was the centre of the show. Even as recently as 1949, the Pennsylvania Supreme Court ruled the surgeon to be responsible for an error of commission by his intern, citing him to be the 'captain of the ship' and therefore responsible for its crew.[1]

There is also a perception in law, ethics, the media, soap operas and among patients that the surgeon leads the operating team. (These are the same patients whose anatomy, physiology and pathology ultimately dictate the course of events.) Patients put their trust in us and only come to meet other members of the theatre team briefly either pre or post-operatively. This complex relationship is burdened with responsibility: ethical, legal and moral. Indeed, the greater an individual's authority and expertise in any given task, the greater that individual's legal responsibility becomes.

In general terms, the *Medical Leadership Competency Framework* states that leadership can come from any level of staff when there is a shared responsibility for the outcome.[2] In actuality, the operating theatre should always have a leader: the operating surgeon. This should be evident to any observer by expression of several key traits including directing and enabling, decision making and communicating as well as coordinating and managing resources.[3] The latter includes but is not limited to the social inferences of controlling the music system!

There may be difficulty if the surgeon is not from a 'typical' mould or if he or she is not perceived as a natural dominant leader. If surgeons fail to fulfil this role, however, the mantle of leadership is surrendered to any individual willing and competent to adopt it. This is seen commonly in the day-case environment, where surgeons are increasingly becoming guests. If this were true, as guests we have both rights and responsibilities. Surgeons have the right to access a team of trained, competent staff with appropriate facilities, equipment and resources. Our responsibility is to communicate well with and respect the team as well as to provide a high quality of care. When either side fails to deliver, discord may occur.

The true test of who is really in charge, however, is demonstrated when the calm serenity of a case is interjected with difficulty. Being decisive in the presence of uncertainty and leading those individuals who lose control when the

unexpected arises is surely a job for the surgeon. But can a surgeon who is fixated on arresting venous haemorrhage in the pelvis really maintain adequate situational awareness to lead a team? Probably not.

In this situation we would rely on our colleagues to recognise the gravity of the situation and rise seamlessly to the challenge. It may well be, for example, that the individual with the greatest ability to help the patient is the one bringing blood products back from the blood bank. We are dependent on our team just as the patient is dependent on us and we are only really in charge if we have empowered our team to perform.

Being in charge incorporates both control of and responsibility for any given situation. The danger of fulfilling this role by adopting a steep hierarchy, however, is the perceived barriers that it creates. No individual should possess unequivocal authority or control as this would predispose us to errors. It is important to remember that each team member brings to the table his or her own knowledge base and expertise. Yes, at an individual level these contributions may be unequal but collectively they provide the strength, efficacy and safety to guide the process.

A flatter hierarchy allows patient safety and surgical outcomes to be optimised with inputs from different members of the multidisciplinary team.[4] That said, the nature and complexity of the work we undertake in the operating theatre does require effective leadership. Establishing this leadership position while creating an environment of humility requires an understanding of emotional intelligence[5] as well as a battery of non-technical skills spanning interpersonal, cognitive and personal resource.[6] Ultimately, human nature dictates that inherent differences need to be managed actively by a single driving force to achieve a singular purpose. Managing actively means using influence. A key strategy is behaviour mirroring, in which, consciously or unconsciously, we manipulate people to behave as we do. We must therefore set the standards of professionalism, care and behaviour that we expect others to follow.

So how is this influence achieved? The armed forces use a highly structured briefing tool that incorporates details of command structures, logistical arrangements and actions to be taken upon unexpected or adverse events. The briefing serves as a method not only of disseminating important information but also of establishing command and control of the situation. The World Health Organization surgical checklist can be used in a similar manner as there is good evidence to suggest greater impact when the process is led by the surgeon.[7] Leadership is defined in many ways, including 'a process of facilitating individual and collective efforts to accomplish shared objectives'.[8] Eisenhower once famously stated: '*Leadership is the art of getting someone else to do something that you want done because he wants to do it*.' These briefings are important in aligning the agendas of all team members and motivating them to achieve a common goal.

There is a clear need for an overt surgical leadership presence in the operating theatre. Combining this with a degree of humility and low authority gradient is likely to engender a positive working environment that generates the best outcomes. This is no easy skill set to develop but directed surgical specific leadership training in parallel to the traditional skills based courses, when combined with personal development plans, mentoring and regular peer review, is likely to create a surgeon with the ability to deploy his or her skills with maximum effect.[9]

As with any apprenticeship, early assumption of responsibility leads to increased competence.[10] This concept extends not only to inpatient and outpatient management or to operative skill but also to the non-technical skills required to lead a team in a complex and rapidly changing environment such as the operating theatre. It is important to remember that by developing good leadership in the surgical team, our patients are ultimately the biggest winners.

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