Presidential Address

Decisions Are More Important Than Incisions!

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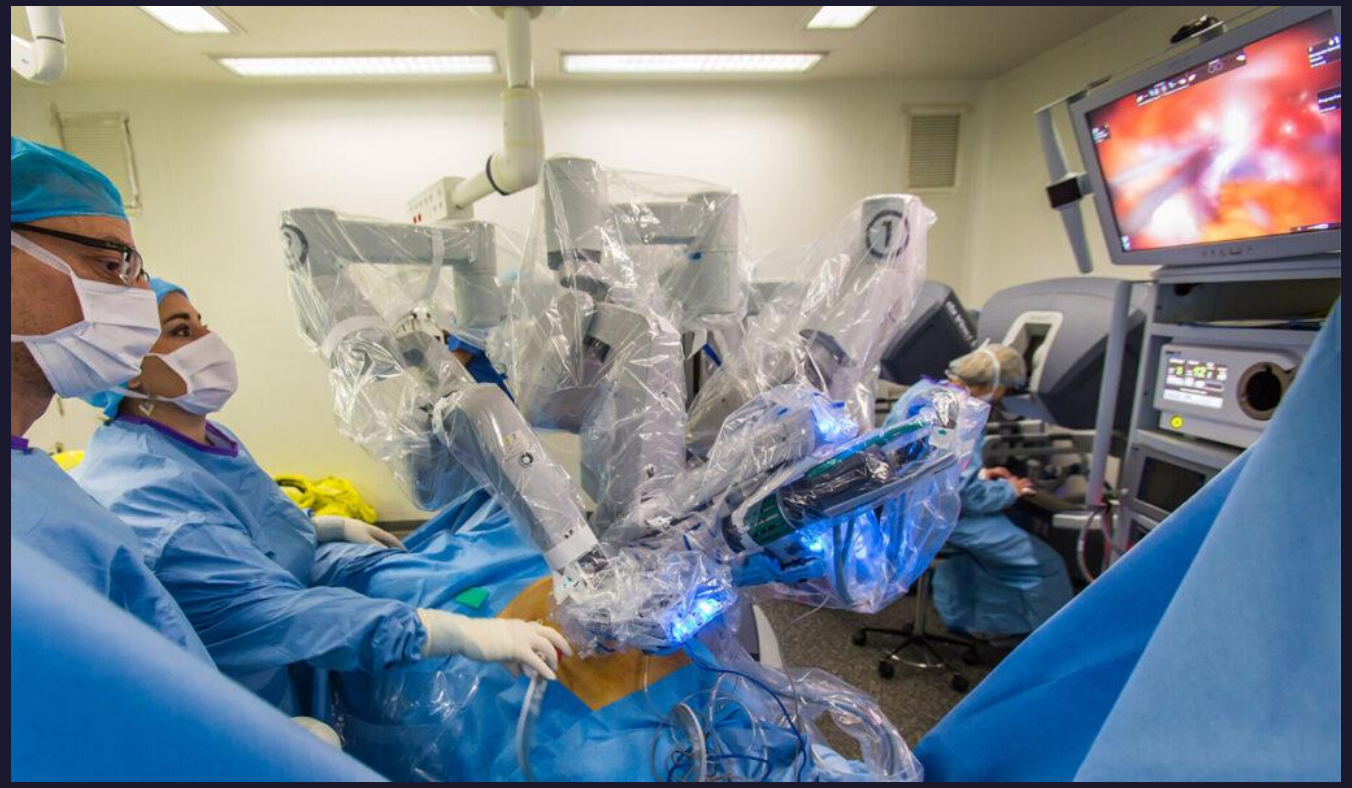
Disclosures

- Speaker and trainer for Medtronic

- Consultant for Touch Stone

From 1960 to 2024



How Did We Manage The Change in colorectal practice?

- From hemmorhoidectomy to Lazer ablation and PPH
- From proctectomy to TME
- From 100% fistulotomy to selective use of LIFT and Mucosal advancement flap
- From standard postoperative to ERAS
- From postoperative CXRT to total neoadjuvant CXRT
- From standard guidelines (one size fits all) to precise medicine!!
- From open surgery to laparoscopic and then Robotic

Role of Mentors

- Mentors have been instrumental in any development, opportunities, the provision of second chances, decision making, education, and success
- I owe more thanks than it is possible to many mentors who guided me all my life , but I do want to address a few people

I have been so humbled by their character, their strength in the face of adversity, and their diligence. I especially appreciate their patience and tolerance of me during my training and their role in leading a lot of new technologies in Colorectal specialty

“

Decisions are more important than incisions

ROBERT BRUCE SALTER

#WHEN NOT TO OPERATE

Dr. Akhilesh Thota

Role of Mentors

- You are all in leadership positions or will be soon and are tasked with the responsibility to address challenges which is immediately linked to decision-maker, facilitator, negotiator, fixer, and healer…

- It is tough to imagine being successful in any of these responsibilities without the ability to communicate well and have some difficult conversations and Decisions

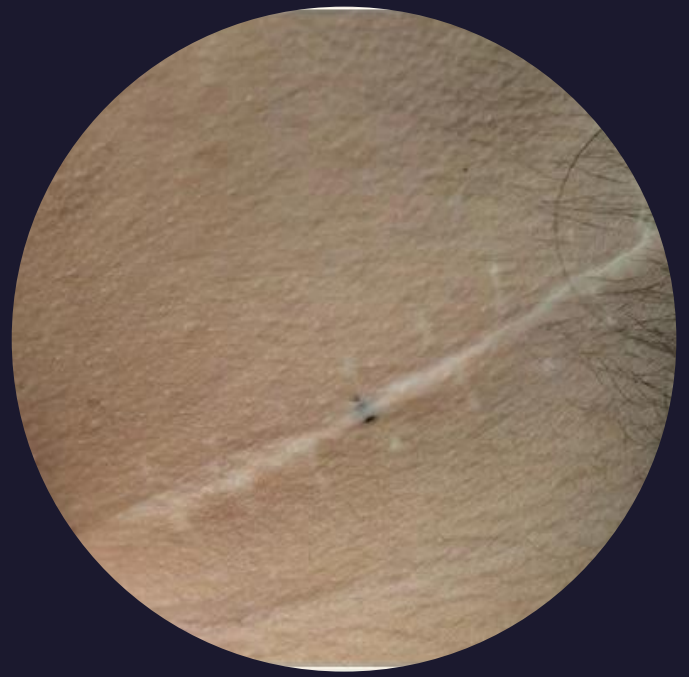
Difficult conversations

- My primary objective simple but more complex to implement
- I want to encourage you to have difficult conversations about problems that we see and ignore in our hospitals and I think difficult conversations are necessary for resolution
- Will challenge you with some current issues we all need to face boldly and hope that I can stimulate some enthusiasm to press on

Challenges

- ▪ Resident struggling with any competency
  - ▪ Moral injury/resiliency
  - ▪ Personal challenges
  - ▪ Conflicts with ancillary/nursing teams
  - ▪ Faculty not completing evaluations
  - ▪ Resident not meeting expectations for promotion

Mentorship



- As a mentor , you have to be ready to mitigate conflicts, uncover skeletons, uncover scars, expose problems we are not aware of…

"Take on the difficult trail straight on to avoid erosion"

- This model is simplistic but it is inherent to what we do

"If you walk past something you know is wrong, and you keep walking, you have just lowered your standards" Ed Steiner

- Don't wait till you feel that you could have done bet[illegible]r could have salvaged a problem before it gets out of hand

Mentorship

- There are clearly more complicated scenarios that we must mitigate. While you may need some support from your department chair, your CMO, or your human resource department
  - Your anger
- - Dishonesty
  - Substance abuse
  - Faculty does not trust a resident
  - Faculty/patient verbally abusive to resident
  - Resident fear a faculty
  - Resident/faculty failure to integrate
  - Mental health

Why a surgeon got angery?

- Governmental regulation
- Administrative redundancy/ reluctancy
- Clinical evolution/ complications
- Workforce issues

What is your recation?

BLOW UP

ACT OUT

Reflex response

- Restrain
- Reassess
- Respond

First Conversation
Resident mistreatment

The NEW ENGLAND JOURNAL of MEDICINE

SPECIALTIES TOPICS MULTIMEDIA CURRENT ISSUE LEARNING/CME AUTHOR CENTER PUBLICATIONS

SPECIAL ARTICLE

Discrimination, Abuse, Harassment, and Burnout in Surgical Residency Training

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Published October 28, 2019 | N Engl J Med 2019;381:1741-1752 | DOI: 10.1056/NEJMsa1903759 | VOL. 381 NO. 18

- We know that mistreatment is prevalent against our trainees
- Noted high % of self-reported gender discrimination, physical and verbal abuse, and sexual harassment
- Patients were the most commonly reported source of gender discrimination with attendings being a close second
- Attendings lead the sources studied for verbal and physical abuse, sexual harassment, and pregnancy/childcare discrimination

First Conversation Resident mistreatment

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- Confronting those who cross these lines is imperative. Holding faculty accountable is a brutal challenge and is probably the most important
- Having the difficult conversation openly with patients who frankly may have never considered the impact or hurt of words, expressions, and actions is crucial
- Institutional vision needs to include educational patient seminars, probably taking advantage of online educational resources
- Awareness is a necessary first step to develop action plans for success and to address resident mistreatment

Second Conversation

Be Nice To Others

Consider	how many speak about, perhaps, regional surgeons who send us patients with complications - conversations without them being present to explain what happened
Consider	how we assess our colleagues from other departments in our own institutions!!
Consider	perception of rural surgeons in university settings and vice versa!!

Second Conversation

Be Nice To Others

Consider	how osteopathic medical students and physicians are viewed - a misunderstanding of their training and skill acquisition - a negativity that needs correction with education
Consider	We are all human, have mistakes and complications

Third Conversation

Eliminating Barriers/ get out of puddle

- Clearly, we have failed at addressing diversity in both undergraduate and graduate medical education programs
- We have been measuring inequities for decades with little improvement
- Well-developed action plans become popular and then fades gradually
- That puddle I talked about has become an ocean, and there are no easy answers

Third Conversation

Eliminating Barriers

- I cannot believe the passion of those before us was any less enthusiastic than that of ours today
- We have to ask ourselves, "what happened to defeat prior efforts?" so that we do not fail this time
- We need to continue the ongoing conversations regarding inequity and proactively work to eliminate barriers

Fourth Conversation

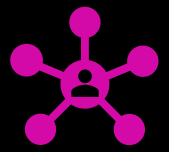
Resident Autonomy – Perceptions And Need

Many local surveys reporting that some attendants never allow a resident to perform any part of an operation

Patients who were less than 50, males, patients in public hospitals, and workers in health care were more likely to believe that resident involvement increases complications

Questions for us?

Are we as mentors/ directors advocating for our residents to accomplish what they are capable of doing?



Are we having the difficult conversations with our faculty and our patients stressing the need for resident autonomy?

Are we educating and informing our patients of resident and attending roles in the operating room and on the wards?

Fourth Conversation

Resident Autonomy – Perceptions And Need

Resident autonomy must happen, and patients must understand these roles

We must be strong in our support for trainees as the fabric of what we accomplish for our patients each day

We should not require them to manage a post-operative patient for us if we cannot permit progressive autonomy during an operation

We must incorporate formal and dedicated autonomous experiences for our senior residents. The safest environment for residents to gain confidence and demonstrate competency is during training

Fifth Conversation

Competency Matters

The gold mine we all seek is that of competency-based assessment tools that could accurately attest to medical student and surgery resident abilities. **we are not there yet!!**

Objective assessment measures lacking, our ability to gauge resident ability to be successful in graduate medical education is far

Fifth Conversation

Competency Matters

We must have standardized assessment tools and measures to help us formulate the process and make difficult decisions

We must not graduate residents who have clinical and technical concerns – we must address challenges during residency and be the true gatekeepers when individuals fail

We need not be a profession that passes everyone through to be potentially harmfull to our patients and the dissatisfaction of a career that individuals may not be capable of accomplishing

Sixth Conversation

Duty Hour Reform

I was not an early adopter – "If you are not in the hospital - you're not learning"

"Why surgeons struggle with work hour reforms." ?

- 2 major reasons for unlimited working hours. Patient ownership and patient safety concerns with increased transitions in care
- I do believe that many of the personal tragedies, substance use issues, and lack of any personal time that was inherent to pre-reform days were in a part related to unlimited duty hours

Sixth Conversation

Duty Hour Reform

- The challenge we still seem to have is how to train residents adequately with limited hours?
- Remember : We are training some of the brightest, well-connected, and well-resourced young adult learners with amazing potential
  - Set expectations
  - hold them accountable
  - Have the difficult conversations to keep them on task and address deficiencies
  - Recognize success and build them up for the next phases of this career

Last word

- As I conclude - I hope I have encouraged you to engage in any of these difficult conversations I have challenged you with today
- I encourage you all to generate a list and consider approaching scenarios that you may not feel comfortable with, those you have avoided, and those that you know in your heart need to be managed


THANK YOU!