Letters to the Editor

Strategic planning and the changing nature of effective surgical leadership

To the Editor: Academic surgery in South Africa is in a state of crisis. The academic sector and a powerful private sector coexist with a vast under-serviced and disadvantaged population with limited access to sophisticated services.1,2 There are several threats to the future of academic surgery, including reduced funding for research, diversion of funds to primary health care, and continuing personnel losses to the private sector and overseas. Coinciding with the decline in funding has been the widespread adoption by the public service of management theory emphasising accountability, strategic planning and accreditation.3 These plans are often generated by a hospital management who appear to have little formal training in management and without due involvement of clinical staff. Academic surgeons who have tended to remain outside these processes have no ability to implement change and so compound their already declining power. In order to reassert ourselves we must understand strategic planning and thinking.

Strategic planning is a methodology to make sense out of a continuously changing environment; strategic thinking is not a process but rather a state of mind.1 The planning process first looks outwards and identifies environmental threats and opportunities before turning its attention inwards and identifying organisational strengths and weaknesses. The process generates a plan that responds to each of the identified threats or opportunities. A good plan exploits organisational strengths and resources while addressing weaknesses. However, strategic planning and thinking remains a foreign concept to many academic surgeons. The old style of surgical leadership is exemplified in a description of de Bakey: ‘It is said that he rarely sleeps, requiring only one to four hours a night. His management style is unique and demanding. He is able to concentrate on a patient, an upcoming operation, an incoming phone call from the president, the budget of the medical school, the recruitment of a new faculty member and an upcoming presentation to the detriment of none.’4 Other great surgical pioneers had a similar style.5 There was much that was good and is still of relevance in this. These leaders led from the front. They established surgery in their centres, leaving a legacy of vibrant departments and famous trainees. They were driven by a vision and passion that took surgery to new frontiers and made the world sit up and take notice of South African academic surgery. We must rekindle this fire in a new generation of academic surgeons, while recognising that the arena is not the familiar one of the past. Although vision and passion will show us our destination, it is strategic thinking and ongoing engagement with stakeholders that will help us to find the way. We need a strategy and we need effective leadership. If these are lacking we are rather like Cowan’s model (Fig. 1) is a useful checklist that highlights the differences between the old leadership and the new.6 Further, the political process behind health policy is not linear and does not involve a rational choice of the best options available to improve the health of society.7 Rather, it involves a complex, messy interplay between a variety of forces and pressure groups. We cannot remain outside this process. We need to set our agenda and to place it in the domain of public debate. We must engage, or risk becoming sidelined. Management is as much our responsibility as teaching, research and clinical practice.

The challenge is to devise a model that continues to provide a supervised specialist surgical service while producing trainees and research of world standard firmly rooted in South Africa with its unique challenges and opportunities. Modern surgical leadership involves the art of the possible, but passion and vision remain vital ingredients. When Chris Barnard returned from America he carried a primitive heart-lung machine in his luggage.8 Open-heart surgery in Cape Town was in its infancy. Yet Barnard had a vision and a passion that took cardiac surgery to new frontiers and made the world sit up and take notice of South African academic surgery. We must rekindle this fire in a new generation of academic surgeons, while recognising that the arena is not the familiar one of the past. Although vision and passion will show us our destination, it is strategic thinking and ongoing engagement with stakeholders that will help us to find the way. We need a strategy and we need effective leadership. If these are lacking we are rather like

1. ‘Think before you shoot.’
2. ‘Pick your battles.’ Don’t waste effort on fights you can’t win; save it for when you really need to fight.
3. ‘Bend the rules, don’t break them.’ Bending the rules in order to resolve a complicated situation requires imagination, discipline, restraint, flexibility, and entrepreneurship.
4. ‘Find a compromise.’ Successful leaders do not see situations as polarised tests of ethical principles. They strive to craft compromises that are responsible and workable enough to satisfy all stakeholders.

This quest for consensus requires emotional intelligence and the ability to sacrifice personal ambition and short-term satisfaction for a greater goal. Mintzberg describes this modern approach as covert leadership, managing with a sense of nuances, constraints, and limitations. A modern leader must lead without seeming to, without his people being fully aware of all that he is doing. That is because in a world of professionals a leader, although not completely powerless, does not have absolute control over others. The most useful metaphor is the conductor of an orchestra, who has to get talented musicians to play together such that the combined result is greater than the sum of their individual efforts. Professionals don’t need to be empowered, as they are already secure in their own domain; however they do need to be infused with enthusiasm for the task at hand. The covert leader must act quietly and unobtrusively, not seeking obedience but inspired performance. Souba’s model (Fig. 1) is a useful checklist that highlights the differences between the old leadership and the new. The political process behind health policy is not linear and does not involve a rational choice of the best options available to improve the health of society. Rather, it involves a complex, messy interplay between a variety of forces and pressure groups. We cannot remain outside this process. We need to set our agenda and to place it in the domain of public debate. We must engage, or risk becoming sidelined. Management is as much our responsibility as teaching, research and clinical practice.

The challenge is to devise a model that continues to provide a supervised specialist surgical service while producing trainees and research of world standard firmly rooted in South Africa with its unique challenges and opportunities. Modern surgical leadership involves the art of the possible, but passion and vision remain vital ingredients. When Chris Barnard returned from America he carried a primitive heart-lung machine in his luggage. Open-heart surgery in Cape Town was in its infancy. Yet Barnard had a vision and a passion that took cardiac surgery to new frontiers and made the world sit up and take notice of South African academic surgery. We must rekindle this fire in a new generation of academic surgeons, while recognising that the arena is not the familiar one of the past. Although vision and passion will show us our destination, it is strategic thinking and ongoing engagement with stakeholders that will help us to find the way. We need a strategy and we need effective leadership. If these are lacking we are rather like
Alice asking the Cheshire cat for directions: ‘Would you tell me please, which way I ought to go from here?’ ‘That depends a good deal on where you want to get to,’ said the cat. ‘I don’t much care where,’ said Alice. ‘Then it doesn’t matter which way you go,’ said the cat.

D. L. Clarke
S. R. Thomson
Department of Surgery
Nelson R. Mandela School of Health Sciences
University of KwaZulu-Natal
Durban

REFERENCES

Acknowledgements: M Dinanath, research assistant.

Blunt abdominal trauma in Zaria, Nigeria

To the Editor: Trauma to the abdomen results from road traffic injuries, violence and armed robbery attacks, among others. Late presentation to hospital, absent diagnostic facilities and late surgical intervention militate against appropriate management. As infection is controlled in Africa, and the economic power of the populace improved, trauma is becoming more prominent. This is a report of recent experience with blunt abdominal trauma in Zaria, Northern Nigeria.

Between 1988 and 2002, 60 patients were managed operatively for blunt abdominal trauma in our centre (Table I). There were 52 males and 8 females. Their mean age was 36.4 years (range 15 - 60 years). Fifty-three (88.3%) were aged less than 40 years. The mean time of presentation to hospital was 22 hours after injury (range 12 - 96 hours), the mean time from presentation to operation was 20 hours (range 18 - 38 hours) and the duration of hospital stay ranged from 10 to 31 days (mean 13 days). Road traffic accidents were responsible for the injuries in 41 patients (68.3%), assault in 10 (16.7%), civil strife in 5 (8.3%), falls in 3 (5%), and a collapsed building in 1 (1.7%).