**2023 Presidential Address Transcript**

*Conor Delaney:*

I can't thank everybody and the Society enough for their privilege and opportunity to have had this year, and now to give this talk. And I was trying to think of, you know, how to follow talks that so many people here in the room past presidents have given these talks of what, what I would talk about. And I thought I would talk about something that I think has been important to me and has certainly been a factor in the evolution of my career, and I think is really important for all of us. And I keep getting asked, you know, why have I, you see, I mean, it's so true. I love operating. There's nothing more than, than getting into the operating room and always going for that perfect operation, right? And so why am I not doing that anymore? And it's in ways sometimes hard to explain, but in ways, I think sometimes easy to explain. So I'm going to talk a little bit about that. And I know there are a number of people in the audience who have jobs just like mine.

And I also know that all of you in the audience lead your own teams and are leaders. But these are some of my reflections around it. Also, I think it is important to bring up the fact. And, and I hear often that, you know, while administration does this to me, administration did that to me. And just as a reflection that the administrative side of the hospitals that we all work in and the care sites we all work in, they are certainly not the enemy. And our opportunity is to provide more clinical perspective and experience to them to help them or join in and do it ourselves. Uh, shape healthcare, which is something that is complicated and moving fast, and then maybe to the younger members in the audience to, to show you that it's not just a triple threat of clinical care, research and education. But the operational side of things is really an important fourth arm, to our leadership.

So, as Brad said, had the journey started in Ireland, obviously, and I was very lucky in Ireland, we rotate around different hospitals. And I, I got to work with a number of, incredibly excellent surgeons and incredibly good technical surgeons. One here today, Ronan O'Connell. I had the privilege of working with Ronan for a year. And one of the things I, I learned early on was the importance of focusing on technique. And we were lucky in the training system that we had that we got to do a lot of surgery. Having said that, as Brad said, the most important rotation I did during my clinical training was six months cardiac surgery in the matter hospital in Dublin, where I met Claire. And, so we've been on this journey for quite a long time.

I did go to Pittsburgh again. You know, so much of what I've done has been because of the mentors that I've had and also the role models that I've been lucky enough to be exposed to. I talked about Ronan, but went to Pittsburgh thinking I wanted to do transplant surgery, and got to work with John Funk, who at the time was running transplant. And Dr. Starzl was in an emeritus role and transplant in Pittsburgh at the time was down to doing about 450 liver transplants a year from their peak of close to 700. It was an amazing unit, an amazing place. And John Fong and Jake Demetris were amazing and being exposed to, and spending time and traveling a little bit, luckily enough. But Dr. Starzl was just incredibly formative. But obviously then after going back to Ireland for a while, we came back to Cleveland. And I've been lucky to have a couple of careers in Cleveland, initially coming over as Brad said, to, to work with Dr. Fazio and in his unit. And then also, having this wonderful experience where I got to experience the leadership of Jeff Pons. And a number of you in the audience would certainly know Jeff Pons, but Jeff is an amazing innovator, invented the peg, real forefather of endoscopy leader, president of many societies. But more important is the absolute passion that Jeff has for his people and his team, and the people who've trained with him. And it was, it was an incredible opportunity to learn from him. And now, obviously getting to learn at a a different level, as Brad mentioned, you know, we have a, a Florida executive team for the five hospitals in Florida, but also part of the enterprise executive team.

And you met Jim Marino yesterday, in his talk on patient experience. And it's just been another level of learning for me and getting exposed to the amazing people that we all have working in healthcare in our organizations. Well, probably I didn't realize well enough when I got to Cleveland that I, I wasn't just working with, Dr. Starzl and there was a whole team there, a little different to the way it is now, but there were six surgeons when I got there, and we get to spend two months with each of them. So it was very easy. And the office is moving down the hallway where, Dr. Fazi, of course, and then Ian Lavery and James Church, and Scott Strong, and Tracy Hull and Tony Senegor. Uh, and Tracy and Scott are here today.

And, you know, again, I owe them a debt of gratitude for the training they gave me and the mentorship they gave me, and the coaching. And again, the importance of technical surgery. And I think at the clinic, really the importance of getting exposed to high volume, complicated surgery. And it was just such an experience there. You know, everything from reoperation pels to Crohn's, to cancers, to leaks to whatever. And to be in that environment with six such talented and experienced surgeons, it was o obviously hugely formative. And you know what, it's, it's laid the seeds, having learned about technical excellence, now seeing technical excellence at another level and volume at another level, about the importance of this.

But Tony Senegor had just joined the clinic probably about a year before I got there. And Tony was the only person doing laparoscopy. And it's funny, I was chatting to somebody last night, but we'd come to meetings like this and, you know, a lot of people thought laparoscopy was heresy, you know, there were people doing it, a number of people in the audience here today, early, early pioneers in laparoscopy. But there wasn't much of it around back then, and it was quite controversial. So we had that opportunity as a number of other leaders did to, start developing the, the teaching mechanisms, you know and how do we standardize these operations, just like open operations have been standardized to make them reproducible and safe and to make them teachable to others. And so I was, I was very privileged and fortunate to be around at that time. And Tony and I got to do a lot of studies and a lot of randomized controlled trials. And ended up publishing a series of a thousand laparoscopic colectomies in the few years that we worked together there. Also learning and evolving the simple things like port position. You know, if you get port positions right, maybe you don't need other advanced technologies, things like that. It helps your ergonomics hugely. Things we're talking about now, more informatively. But again, if you have the right techniques, you can do it more easily. Somebody who wasn't on the faculty at the clinic though, was Henrik Kala, and Henrik came to give grand rounds in February, I think it was in 2000. And he had just published this paper with Linda Bassa, who was the first author. And Henrik is a general surgeon in Denmark who had been working on improving care for hernia surgery and minimizing pain and accelerating recovery. And he'd just published this paper of Fast Track colectomy, and he came and gave us grand rounds, and it was really, really impactful. He had 60 colectomy patients. They were all first-time colectomies. He developed a multimodal pathway with a transverse and oblique incisions, which, you know, we had various feelings about with stomas, maybe that is or isn't the right thing with an epidural, a preemptive thoracic epidural. And he'd use a cathartic and a prokinetic cide, which then went off the market. But he developed this very effective, multimodal pathway, and published this series of 60 colectomy patients with a median stay of two days in hospital. Wow. And that was back in 2000. Now, he did cheat a little bit. There was no mean in the paper, but if you calculate the mean from the error bars, it was 4.1 days, which is still really impressive 23 years ago, and they'd readmission rate. And, this was really, you know, wow, how can we do things differently? Laparoscopy's evolving, how might this work with it? So I was a fellow at the time and just about to go onto Vic's service and, probably intimidated by the census on the service and thought, Hey, if we can do this, maybe I don't have to round on as many patients. And Vic was fantastic. And he said, absolutely, let's do it. Let's try it. So we did. So these were the, the 60 cases over a couple of months, that were open colon and rectal cases, a lot of pelvic surgery, a little different to Henrik's crew of patients. A lot of patients had previous laparotomy, like this patient. And we did pretty well. We did a mean hospital stay pretty close to that 4.1 and a decent readmission rate. And this suddenly looked like, wow, this might make sense. Obviously, we hadn't got to the terminology of enhanced recovery. We still used his term of fast-track care at the time. But it was certainly different. So over a larger period of time, we looked and compared, the numbers of patients who were having this fast track care pathway, as we called it, versus traditional care. And you can see the numbers were increasing, and the length of stay differences. And these are meaningful and got to the concept of thinking of resource utilization. How do we manage them? What does it even mean? And it can mean a lot when you think about it from a resource utilization perspective. We're saving pretty close to 40% of the hospital beds. So you know, that's an extra larger floor, fewer nurses, more efficient care. We don't have enough beds anyway, this really may mean something. And then when we added laparoscopy in 60% reduction in length of day, so that really can impact hospital operations and resource utilization.

So we did further studies on it and, and it started to look pretty robust actually. This is a paper we published a couple of years later, and a very careful case match, not propensity match, but very carefully, case match, no prior laparotomies, in either group, things like that. And, and by diagnosis, et cetera. And you can see how these numbers started to pan through about half the length of stay. As Brad mentioned, a reduction in cost, although I guess he was talking about a slightly different topic. This series didn't reach statistical significance in complications. As we all know, the anastomosis is the same or should be, but the wound complications, as we all know, are very different and pain and things like that. But this was early data and the readmission scores were pretty similar. And that was an important thing to track because the worry and the pushback against fast track, and obviously there was a significant amount of pushback back then was that patients are just going to get readmitted. You're sending them home too early. But we were lucky, and we were able to evolve the story a little bit further. This was the first series of patients I did, after I got to Case and, before Brad had started, and we looked at a little over a hundred patients, and it had evolved. So the overall mean length of stay was about three and a half days. The readmission rate was still decent, but started sending patients home at 24 to 48 hours after resection. And what we learned as we started doing this, was that as long as you pick the right patients, so it's not the 99-year-old or the BMI of 50 who's in a wheelchair, but as long as you pick the right patients, this works very well.

And it become highly effective, very robust. And you can see, and I pulled the P values off this slide, but they're significant. Those who were discharged within 48 hours, and about half of those were at 24 hours, which was a, a decent amount, you know, 15, 16 years ago. The readmission rate for those patients is about 5%.

And even with all the predictors we had and all the care, the patients who stayed four days or more, we still weren't as good at predicting, and 13% of them came back in. But overall, the concept worked and the pathway worked. So the next step after that is high reliability. This is starting to become highly reliable. We're getting patients home reproducibly safely in a very short time to home doing well. Jim Marino yesterday, who just gave an amazing talk, and I thought it might compliment this, the, the patient experience side of it with the, the value and operation side of it. But Jim obviously brought up the concept of high reliability and how important that is for patients, and, our patients' outcomes. And this is a paper that Mark Chasin and Gerald Loeb wrote in 2013, high reliability healthcare, getting there from here. You know, we're starting to learn these muscles, use these muscles, talk about it in 2013. But you know, if you think of the car industry, they've been doing it for 50 years now since the seventies. And Toyota classically, in Japan, you know, this model of Lean six Sigma and operational excellence, and, you know, meaning that, you know, everything within six standard deviations of the mean is an acceptable product in healthcare. We're probably at about half sigma, certainly for major abdominal surgery. So, you know, how do we drive that better and how do we make it better? And it's by two things. It's by reducing variation, getting towards that narrower sigma and shifting the mean. So up maybe for discharge home and down for length of stay, you pick your metric that you're focusing on, but shifting the mean in the direction that you intend.

As Brad mentioned, I went back to the clinic a a few years later and we started using these pathways again, and you can see that this, this is observed to expect at length of stay. We were able to reduce length of stay, but more importantly, able to start to expand it to other specialties, GYN and neurology, and bring down their length of stay. And often in patients who you could argue were aren't always as complicated, although these guys have pretty complex disease, profiles at main campus. This was all at main campus in Ohio, but we're still able to make a difference and move that needle a little bit.

So this concept of value and doing this across an organization is very important. So we hear a lot about the value proposition for reimbursement in healthcare, and that that train is moving pretty slowly. That's probably a good thing for many of us in hospitals because it would fix reimbursement or limit reimbursement. And the, you know, the volume related reimbursement that we still all get to an, a certain amount is helpful for most places, although I'll talk a little bit more about that too. But this value equation, the most important part of it is, you know, how do we provide value? And it's by driving an outcome and by reducing a cost, there has to be some improvement. Uh, either an improvement above the line or a reduction below the line. And if we're keeping an outcome the same, and you can argue about the outcome you pick, and you get your cost down, that'll help if you improve your outcome, and the cost stays stable, that'll help. If you don't improve your outcome and you increase your cost structure, that doesn't help. That reduces the value equation.

And the way healthcare is moving at the moment, we all have to come together to think about the value that we're providing to the health system in general, and how, how do we improve how we do that.

So why is value so important? Brad's disposable ports, no, I'm teasing. Or a TME or an open exam APR for recurrent cancer. You know, cases that we all love to do, they're great, they're fun. We help patients, we cure patients, they do well, generally. You know, so why even think about value? And maybe we should just keep our heads down and keep doing the surgery that we're doing. Well, maybe not. Healthcare's in a really complicated space.

I was actually preparing for this, and I found this slide in an old talk that I gave in 2003 actually, and talked about reductions in resources, fewer beds, decreased staffing, sound familiar, financial pressures, reductions in reimbursement, cost structure, increasing modifications in reimbursement codes. A guy that story keeps continuing, they just get worse and worse, right? And, and pick this picture again, back in 2003 of, you know, healthcare sailing towards this complicated storm or where in 2023, this is the hurricane in Florida last year. And we are right there now, right? We are, we are living the dream of complicated healthcare. And yet, 2023 is even more different to 2003. It's not just costs and people. We came off last year, the worst operating income year ever in the history of, in the measured history of healthcare. That's not a good thing.

A lot of it driven by the increase in our labor expenses. You can see the adjusted increase in labor expenses, per adjusted discharge. You know, most healthcare organizations are in the 50 to 60% of their cost structure is labor. So if you put the labor costs up by this much, then you're in a 3% business. It's a challenge, right? This is a great statement, and the first person I can track it to is Justin Trudeau.

But the pace of change has never been this fast, yet, it will never be this slow again. Uh, again, I just look at ai, it's going to drive things really, we thought it was fast last year and just wait. It's going to get faster and faster and faster. It's so true. And yet there is profit in healthcare, but where is that profit? So the profit at the moment, and this is part of the complexity, is not with providers. The profit is profit is with biotech and pharma, around 10% margins. Uh, the profit is with payers around a 9% margin. So I think CVS Aetna, that fusion of a pharmaceutical group and an insurance group that now has revenues in the multiple hundreds, of billions of dollars and margins of 10% of hundreds of billions of dollars, think of United Health also, hundreds of billions of dollars, tens of billions of dollars profit. And actually 60,000 physicians employed by United at the moment, pretty incredible, largely in primary care. So they can control where patients go, so they can manage the overall margin and mission, and they're covering a lot of Medicare, dollars, and they, they keep their margin from it. This is part of the complexity of healthcare and why it's so difficult to fix.

But the other side of it, of course, is where we all are. And this is not just individual providers. This is hospitals. You know, hospitals are running at a, about a minus 1% operating income, which is a whole lot better than last year, but it's still a bit of a challenge, right? So this is the national Flash report from Kaufman Hall, earlier this year. And I know it's far too small to read from even the front row, but those are negative margins. And as you go to the right of that bar graph, you're coming up to about minus 1%. So that's, it was a whole upmost last year, but it's still not great now. And really, when you put a societal hat on, this is really complicated. We're already starting to see hospitals close. We already have challenges with access to healthcare.

How are we going to do it differently? And it wasn't really covid, COVID was complicated, but it wasn't really complex. It was a new disease. We had to manage it. The real complexity came when we lost workers. We lost workforce. We can't cover floors, we can't cover clinics. I'm sure you're all living it to very real extents, where you are. And so it becomes hard to manage and hard to resolve. I'm not sure any country has healthcare, right? Maybe Norway, smaller population, incredibly well funded Germany, great system, starting to go into funding challenges. Ireland, certainly not going doing great. Huge waiting list issues. And we have our, our major challenges over here, although we're structured very differently, they pull in different directions. Patients, they want quality at low cost,

ideally no cost or paid for by their employers, I think. So they're not really thinking cost, and that's part of the problem. Patients in the US don't really think cost and probably not anywhere else either. But at least, within this room and, and within this, country, it's, this is the issue. Access. They want information and unbiased guidance providers, well put the hospital hat on, or even the individual hat on. We need sustainable reimbursement that's changing fast. We still want to be able to pursue our mission, whether it's clinical care or academics or research or whatever. Part of mission that is, is your practice, and you want to have the right environment of care, and it's getting harder and harder, right? And of course, the payers and policymakers pulling in a totally different direction. They want measured effectiveness. The things they measure largely don't relate to our clinical practices. You know, they're thinking, deep tissue injuries and other things, but largely don't relate directly to ours, at the lowest cost, meaning they want to keep, I showed you the margin as much as possible and selectively release it to employees. But this is complicated. Everyone's pulling in a different direction. And this is actually a great read by McKinsey. A recent book they put out, on the gathering storm, the uncertain future of US healthcare and the themes they come up with, which are things we've been working through at the clinic, actually as, as we work on an operating model to be even higher quality, even more efficient, et cetera. But redesign for speed. Most healthcare organizations are not really good in the speed and agility space. Optimizing workforce productivity. That doesn't mean working harder, that means putting resources in the right place. And it's kind of echoed in the last point on this slide, reshaping portfolios.

We see it all the time with hospitals, particularly maybe on the for-profit side, their services they just don't want to offer. But we'll see it more and more on the not-for-profit side, because hospitals are trying to stay open to serve their communities. And that's a complex societal issue. And then diversify and build your business models, start to do some pharmaceuticals, drugs, other things. Think of other models that you can have. And not many healthcare organizations have capacity in that space. So there are potential solutions that are not all easy to implement. So we all went into a healthcare thinking of this, triple mission of research and education, and of course, clinical care. I think now for leaders, operational management has become the primary responsibility of clinical leaders. Leaders in space and leaders running large clinical operation groups have to manage that first, because if we don't manage that, nobody else is going to be able to do the research and the education and all the things that we know are so valuable to redefine care moving into the future and to teach future generations of surgeons. So I think this is increasingly, the single most important responsibility for clinical and administrative leaders is managing the operations. So it's optimizing patient outcomes. It's supporting and mentoring your team. It's thinking constantly how you can improve operational efficiency. It's optimizing length of stay and documentation. Yeah, it can be a nuisance. Try and figure out a system that you can do it better. It'll help. It's actively reducing operational costs. You know, people say, well, does it really matter? I'm just one surgeon. Well, just think if you spend, say, 2000 extra dollars on a case that you do once a week For a year, that's a hundred thousand, which could be an extra nurse in your clinic. So it actually does matter focusing on operational costs, and that's why that value equation is so important. And then, of course, increasing patient volume for so many reasons. One for your practice, one for your healthcare system, one for quality, right? The more you do, the better you'll be at whatever you do.

So it's funny, when I was interviewing to,

to go down to Florida after I was asked to go down there and going through the process, you know, I said, it comes down to four things. Its quality, it's team, it's operations, and it's growth. And physician leadership really is a requirement for all of these. Actually, there's a couple of papers, if you look up the literature showing how physician led organizations tend to do better for quality. And one could argue, it's not a surprise, but we have that understanding of quality and clinical care directly at the bedside in the operating room. So we can help optimize quality. We function as teams, whether it's in clinic, whether it's with residents, or whether it's in an operating room. We run and lead teams all the time, and so have, have background in that.

We increasingly need to focus on operations. Many of you do already thinking of those resources and those costs that you have to manage. And we increasingly need to focus on growth, building the business to provide the sustainability for the, for the institutions and enterprises that we're in. And as I said, I think as surgeons particularly, but physicians really pick up a lot of these leadership skills on the way. You know, you're in an operating room, complicated case, something bad happens, you're getting paid from the floor, somebody gets called to another room.

We're all trained to remain calm under duress. We're all trained to make decisions with limited information and multitask, particularly, I guess if you think cancer. But we have to have some patients and take the long view on how our patients are doing. We're trained to communicate well.

It's a core part of our practices. We're trained to take responsibility for what we do. And particularly if you're working well. And again, Jim Marlina did such a good job, teaching and, and discussing this yesterday. It's a key role of providing patient care, is providing that empathy and compassion to our patients.

Actually, just to leave you with this, there's a great paper, by the society Surgical Chairs, which actually talks about a lot of these themes very nicely. And it comes up with many of the important things leading a department or surgical group, being around collaboration and communication, humanizing relationships and mentoring teams, and operational efficiency. They have it in there, recruiting, mentoring, protecting, and of course picking the right team. This is another good read, particularly when you think of change management and how do you implement change. This is, general Stanley McChrystal, who wrote this book, team of Teams. And he was sent, to the Middle East when there were a lot of challenges, in Iraq when they were getting bombed by small groups that were so small, they couldn't monitor them. And his teams on frontline forces would be asked to respond, but they'd have to ask the next layer, ask the next layer, ask the next layer sometime after the phone to the us. Yes, you can do the mission, the message would go down. And of course, the bad guys were gone. So he had to come up with a different model of, of teaching. And he, it's a super book. He talks about the difference between complicated and complexity. Car engines are complicated, lots of moving parts, but they're pretty predictable. Complexity is when you have complicated and unpredictability. It fits for healthcare at the moment. So it's a good read. And he talks about the agility that you need in responding to situations. The adaptability that you need in responding to situations have to how you have to empower your teams and how you have to teach resilience. Sounds pretty familiar, doesn't it?

So that engagement of teams is critical.

I think one other thing that we probably need to do better as a group of physicians and surgeons is think more broadly of what our team is. We often think of the people in our department or something like that. Well, none of us could do our jobs without our nurses, administration techs, HR teams, finance, analytics, and the environment. People who clean the rooms and clean the floors, and the security who keep us safe in the emergency room. So healthcare is a team of teams, and you have to manage your team and include your team, and you'll be richly rewarded, as you do it, as I'm sure you all know. So what's it about at the end of the day? Well, it's about quality and accountability. So patients experiences, their experiences, clinical outcomes, it's about people and teams, managing your team, picking the right team, communicating with them, and empathetically, collaborating with them, mentoring and teaching them. But it's also about managing clinical operations.

Healthcare needs more than ever before your engagement as leaders, you or we are all the leaders that we've been asking about and waiting for, and we'll have to step up and help, because if we all don't, it's going to be even more complicated for healthcare.

So I want to end by saying thank you to so many people, to my colleagues, at the clinic, both in Ohio and Florida, and of course at Case, to the council of ASCRS, friends and colleagues. We've done so much together and people have passed off. Council. People who are coming in the society is a very, very special society. It truly is to the administrative team of the society, who've done yet again, I I hope you agree, amazing work in how they've helped us structure this meeting. Just what a, what a job they do. And to so many of you in the audience, it's been a privilege working with you for so many years, meeting you for so many years, and different countries are here. The colorectal family is strong, and it's wonderful to see all of you here. And then of course, my family to Claire, who's been on this journey, didn't think I'd get upset for 30 years with me next week. So, and my kids and Matthew and Adrian who couldn't be here. This has been the privilege of my career. Thank you all.

Thank you.