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LEADERSHIP IN SURGERY SYMPOSIUM

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TRANSFORMING SURGERY OF KOSOVA IN THE ERA OF UNCERTAINTY: WHAT IT WILL TAKE?



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Abstract:

- Background:** Surgery is the cornerstone of the healthcare industrial complex and the foundation of every hospital, every healthcare system, and every Academic Medical Center (AMC) or Academic Health System (AHS). This advancement of surgery has to follow the model of advancing premedical studies, the medical school curriculum, surgery residency programs, academic and clinical growth of an individual surgeon, the individual department, as these are all essential ingredients and at the same time, the very byproduct of the healthcare system.
- Objective:** To review the initiative of the establishment of the Kosova College of Surgeons as a platform for the transformation of, and other factors that affect the very creation, the development of a successful department of surgery and a surgery transformation overall.
- Results:** On December 3rd, 2018, the representatives of 14 Surgical Societies representing more than 800 practicing surgeons of Kosova agreed to establish the *Kosova College of Surgeons (KCS)* as a scientific and advocacy body of all surgeons that will lead the advancement of surgery in all surgical disciplines in the future. The advancement of surgery, however, is intertwined with multiple factors and is overall a result of the healthcare system, political, societal, and scientific state of the country. Subsequently, the individual surgeon is a result of the academic health system that consists of a medical school, residency training program, and department of surgery faculty membership, thus making the individual surgeon an overall byproduct of the healthcare system.
- Conclusion:** The creation of the KCS represents an important historical moment of surgery in Kosova. The College will need to work on standardizing the care, practice, and protocols of surgical care and work in advancing the clinical, scientific, and research agendas of surgery in Kosova.

Keywords: *Surgery, transformation, Kosova College of Surgeons, American College of Surgeons, Kosova.*

“Transform we must, if we are to provide the best possible care to our patients; transform we must, if we are to recruit the best minds in surgery, so we can not only compete and be ready to deal with unpredictable market forces around us, but lead the process of further advancing surgical modernization; transform we must so we can make sure that we innovate, and adopt new technologies; transform we must, in order to initiate new work processes, work and collaborate with partners across all surgical disciplines, basic science, surgical industry, and government agencies, for the good of our patients, our institutions and the future of surgery and surgical science of Kosova. We should always keep in mind that the surgery itself is and should be the easiest part of what we surgeons do.”

Rifat Latifi

SURGERY AS CORNER STONE OF HOSPITAL AND ACADEMIC HEALTH SYSTEM

Academic medical centers (AMC) or academic health systems (AHS) have become major and complex healthcare business enterprises around the world. Their mission is to provide complex but evidence-based clinical and high quality care, advanced teaching and education, and innovative research. To ensure completion of this mission, each AHS should combine its teaching hospital(s) with teaching and

research programs affiliated with medical schools and other colleges/universities, clinical faculty and in some cases affiliated community physicians, or the AHS may own community physician group practices.¹ In the past, AHS functioned within a fragmented governance, financial, and clinical practices accounted for the majority of costs. Clinical care structures were set-up and performed in silos with hospitals in most cases completely separate from the medical schools and universities. Such practices are still present in few countries, and Kosova is one of them. In these cases, the governance of the hospital(s) from the medical schools and universities are unaligned, and lead to duplicative clinical practices – hence, reimbursements are based on clinical productivity. In addition, in these cases, the clinical care objectives may be in conflict with the teaching and research objectives.

How does a hospital look today? It is supposed to be

modern, state of the art, with all of its beauty, complexities, developments, and its flaws. After all, a hospital is a place that people go when they are sick, to undergo major surgeries and other procedures, get well, but often they do not get well and die there. I always wondered what the walls of the waiting rooms near the ICU or operating room hear. They hear good news, they hear joy, but often they hear caution for optimism and uncertainty, and they frequently hear bad news. Hospitals rightly have their triumphs, but historically hospitals have had their bad days also, just like they are experiencing them nowadays as COVID-19 sprawls around the world. We the surgeons, have been fortunate to be a part of these triumphs, but have had the honor to be humiliated by the setbacks as well. Yet, we have seen how science has made unimaginable progress and the hospitals have both pushed that progress forward and reaped the rewards of it.²

On the other hand, The hospital as we know it today, is part of the most complex industry referred to as the healthcare industry. At the same time, hospitals have developed and grown into patient-centered, research-oriented, technology-driven, disease and financial performance based, clinically functional, complex architectural design, ergonomically friendly, and patient driven view point.³

Surgery is the corner stone of this mega industrial complex and the foundation of every hospital, every healthcare system, and every Academic Medical Center(AMC) also known as Academic Health System (AHS). There cannot be a modern hospital without modern surgery; there cannot be a modern healthcare system without modern and advanced surgery. There cannot be a modern department without individual surgeons vested in the modernization of this process, that eventually creates the system. Finally, there is no patient safety and high quality surgical clinical services without a modern department of surgery

and a modern hospital. As part of the AHS, surgery has become major part of complex healthcare and business enterprises around the world. As such, it is expected that the department of surgery at any hospital provides the most complex, evidence-based high-quality surgical care, advances surgical education, and leads innovative research of any hospital. Despite the considerable progress that has been made, the medical world is still divided into those who have everything and those who barely get by, everybody else is in between. In other words, there has never been wider differences between hospitals in wealthy and impoverished countries in providing care for their populations, despite many processes, guidelines, and other progress made worldwide. Yet, “few institutions have undergone as radical metamorphosis as have hospitals in their modern history” writes Paul Star in his classic and must-read book for anyone who works in medicine, *The Social Transformation of American Medicine*.⁴ He continues to say that “in developing from places of dreaded impurity and exiled human wreckage into awesome new moral identity” hospitals have simply undergone an amazing transformation. The metamorphosis of hospitals is a direct result of changes in the medical field overall, but surgery has led many of these processes.

This process is not an easy one, though. Locally, as part of the

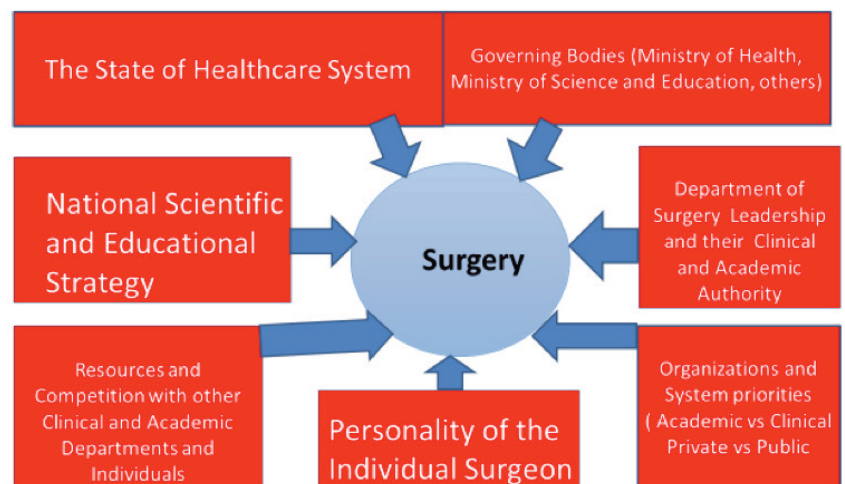


Figure 1: The Factors Influencing the Department of Surgery

medical enterprise, surgery has to compete with the rest of the medical fields for resources to advance itself into new, modern surgery that can adopt and innovate itself on a regular basis in order to survive (Figure 1).

This advancement of surgery has to follow the model of advancing premedical studies, the medical school, surgery

residency program, individual surgeon, the individual department, and finally all become ingredients and byproduct of the healthcare system. Any break in this chain may have serious consequences and negative effects. The individual surgeon is a

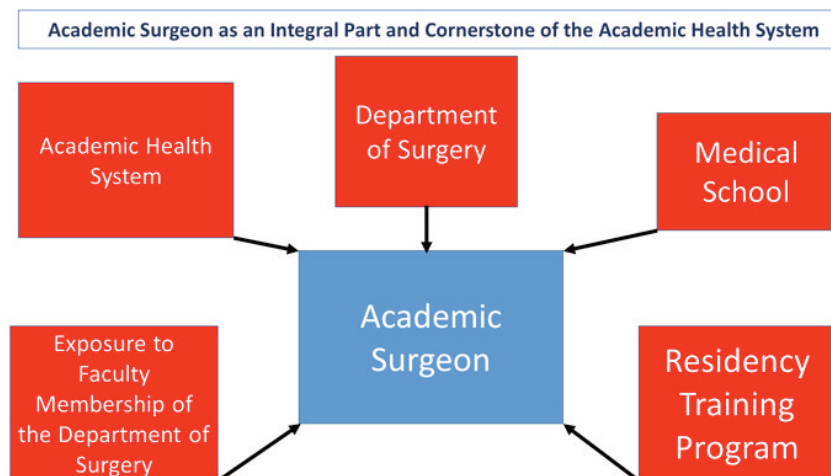


Figure 2: Academic Surgeon as an Integral Part and Cornerstone of the Academic Health System

result of the academic health system that consists of a medical school (Medical Faculty), residency training program, and department of surgery faculty membership, thus making the individual surgeon an overall product of the healthcare system (Figure 2).

An individual surgeon can become a true academic surgeon, that comes from a system that does support such growth and development, but have found themselves working and practicing surgery outside the country in an environment that supports greatness (mostly in the Western world), where they have achieved great scientific milestones. Therefore, greatness in surgery is not only genetic make-up, it is a product of the complex scientific and political environment.

CYCLE OF SUCCESS:

**QUALITY,
VOLUME,
REVENUE,
QUALITY**

In order to succeed in a world of highly competitive, large networks of hospitals, physician groups, vast ambulatory and outpatient feeder systems, along with post-acute services, rehabilitation centers and nursing and assisted living facilities, one has to address three basic elements. These three elements are complex, but the process doesn't have to be complicated.

1. There must be a political will and vision to invest your resources in the quality of clinical services and education of

human capacities and infrastructure; 2. This will attract a volume of patients and a high volume of patient services will generate high revenue; and 3. High revenue clinical services will enable you to reinvest resources back into quality and



Figure 3: The cycle of success

Israel M, Brudnicki G. Foreword. In: Latifi R, ed. *The Modern Hospital: Patients Centered, Disease Based, Research Oriented, Technology Driven*. Springer; 2019:xi-xiii.

sustainability of services and retaining advanced expertise. In other words, the cycle of success of three elements is crucial to the success of a modern hospital that current and future healthcare leaders should focus on: quality, volume, and revenue.⁵

Kosova has to enter this cycle in order to succeed. But the order is a bit taller than it appears. In order to have high quality clinical services (here is it assumed in terms of both human and infrastructure capacities), we must have a much better medical school and training (Figure 2). This will increase surgical volume in the country and improve revenues, which could be invested in research and other

resources, which would then be translated into further volume. The math is very simple, even this author understand that.

To this end, the surgery of Kosova as major part of the ailing and forever “healthcare system in transition” must model itself based on all these elements, on scientific clinical developments, market forces, new innovative technologies, reformed regulatory policies, and last but not least, patient demands. Furthermore, it should be patient centered, technology driven, and evidence based.²

EVOLUTION OF SURGICAL LEADERSHIP AND SURGERY TRANSFORMATION

In the past, the Department of Surgery, as the cornerstone of the hospital and the surgery discipline unit itself, operated with independent governance, independent financial, and independent academic and clinical practices. The Chairs often had large packages which allowed for the recruiting and retaining the best faculties, and the development of new services and clinical research. It was up to the Chairman to govern the Department of Surgery as he/she saw fit. In the past, hospitals used to fund educational surgical programs through traditional revenue streams, and research was funded through federal or non-profit grants and traditional revenue streams. Today, granting agencies have become few and far between, and basic science research for surgery has just about become a thing of the past. In Kosova this is even worse. The days of Drs. Billroth, Kocher, Halsted, Roads, Sabiston, Dudrick, Cameron, and other famous chairmen of surgery departments, that were seen as larger than life, are now long gone.

As Director of a large Department of Surgery in the a major tertiary / quaternary hospital (Westchester Medical Center Health Network, a network of 10 hospitals, in Valhalla and Hudson Valley, NY), and

Chairman of one of the oldest Medical Schools in the USA (The New York Medical College, School of Medicine, Valhalla, NY), I work with a centralized budget, and budget season is always an interesting exercise and great time to be away. However, that does not mean that I cannot rebuild the department, individual sections or divisions, develop new innovative clinical services, advance quality indicators and revamp surgical education of students, residents, fellows, health care allied personnel, and advance research productivity. With or without a major budget package, you are still a leader and need to find a way to lead and align your mission and vision with the academic and clinical mission and vision of the institution.

Although I did not have a set “chairman’s package” when I joined my current position, I was able to hire nearly 40 surgeons over the past 5 years and rebuild the department of surgery into a truly modern clinical department, with a world renowned caliber faculty that is diverse and highly clinically specialized. Moreover, while providing high quality advanced surgical care, we were able to advance academically a great number of faculty through the academic ranks of assistant professors, associate professors of surgery, professors, and professors emeritus. In addition, we instituted the concept of advancing Chief Resident Instructor of Surgery.

Personally, I believe every leader of surgery has to understand that the governance of the new Department of Surgery in a new healthcare system is not the model that was utilized by the previous Chairman. Now, it is more complex, interdependent, multidisciplinary, collaborative, and it is based on the Mission, Vision and Alignment (MVA) model of the hospital, medical school, or healthcare system, and eventually with Ministry of Health or the governing body of the healthcare system (Figure 1). The times have surely changed, and we have to adopt to these changes and the new evolution of leadership in surgery.

THE NEED FOR TRANSFORMATION AS A COMPLEX BUT ACHIEVABLE PROCESS

In order to succeed in the transformation of the Department into a modern clinical entity, we need to embrace and lead the rebuilding process, reengineer the vision, perfect the sustainable strategy, and ensure that human capacities, quality indicators, and all intricacies are in place and functional. Moreover, to achieve excellence in healthcare, we must deal with all constant distractions that come from regulatory governmental agencies, the insurance industry, and market forces. Balancing all this with the need for academic and clinical individual and departmental transformation, including teaching medical students, surgical residencies, and fellowships, in era of limited hours of

education, adds a whole other dimension of complexities in what often can be seen as chaotic transformation, but it should not be chaotic.

Therefore, the question remains: how will the full transformation of surgery look, and what does that mean, particularly for Kosova? What will surgery look like in 50, or 100 years from now? While it is difficult to predict for certain the upcoming changes, I do know that this transformation process should be constant, proactive, fully transparent, multidimensional, and too dependent on technological advances. Chances are it will be much better than today.

As I completed a robotically assisted cholecystectomy the other day, I sat 5-6 meters from the operating table and used the most advanced images to identify the common and cystic duct, with a flip of finger (there is no need for cumbersome and painful cholangiograms anymore), which displayed a view that is out of this world. I could not help but think that perhaps I entered the world of surgery about 20 years earlier. Inguinal hernia, colon and gastric resection, hepatobiliary and pancreatic surgery, lung resection, even thyroid resection are being done robotically assisted. The prime winner of these technologies are the patients. To this end, I can safely predict that at least in the western world, particularly in the USA, most operating rooms will have a robot that can be used both for elective and emergency cases. Laparoscopic surgery will be a thing of the past. This transformation of surgery is and will continue to be led by both the industry and surgeons who have accepted the challenge.

THE CORE OF VALUE TRANSFORMATION

At the core of the value transformation is changing the way clinicians are organized to deliver care and build the scientific future.⁶⁻⁷ The end results include: faster treatment, better outcomes, lower costs, and improved market share of the condition. The key to the measurement process is to focus on the functional parameters that matter to the patient. Innovative technologies such as tablet computers, web portals, and telephonic interactive systems for collecting outcomes data from patients allows providers to track progress as they interact with patients.⁷

To determine value, providers must measure costs at the medical condition level by tracking expenses involved in treating the condition over the full cycle of care that requires understanding the resources used in a patient's care, including personnel, equipment, and facilities; the capacity costs of supplying each resource; and the support costs associated with care, such as information technology and administration. By understanding true costs, clinicians are able to work with

administrators to improve the value of care with better outcomes. Global capitation provides a single payment to cover all the patient's needs. It rewards providers for spending less but not specifically for improving outcomes or value. Fee-for-service couples payment to something providers can control, the variety of services such as MRI scans they provide, but not the overall cost and outcomes.

In recent years, hospitals and health systems have significantly expanded providers' ability to share and receive patient information from a variety of care sources, both inside their own hospital/health system and with unaffiliated hospitals, health systems, or other settings. However, barriers such as a lack of interoperability, continue to prevent universal sharing and effective use of information. Interoperability refers to the ability of electronic systems to efficiently and correctly transmit and receive information without the need for manual entry or other intervention by an individual. Interoperability is critical to effective use of shared information for core hospital activities such as care coordination, patient engagement, quality improvement and ensuring patient safety.⁸

BIOMEDICAL RESEARCH STATE IN KOSOVA

During this vicious cycle, young surgeons, other physicians, nurses, even medical students have moved out of the country; sadly, they have left Kosova even more so now after 20 years since the war ended. In fact, as of late, this has taken epidemic proportion. Subsequently, for the last two decades, the state of medicine and surgery has not change much, and most importantly, the government did not take even minimal measures to improve the work conditions, to improve the future of the best and the brightest surgeons and

surgery students, and moreover to prevent corruption and mismanagement. Kosovar surgeons have not been present in significant surgical organizations, congresses, or literature.

In a recent study, we analyzed biomedical research productivity (published in this issue) defined by the number and quality of publications in PubMed, between January 1998 and July 15, 2019 as an indicator of the research capacities in Kosova.⁹ Of 1334 papers published biomedical on PubMed (which was the lowest number of produced papers within the Western Balkan countries), 39% of articles were published in journals without an impact factor, 45% had impact factor <1, and 7% had impact factor >5. Only in 46% of papers featured a Kosovar author as the first author listed, and in 46% of papers the first author was non-Kosovar. In 8% of papers on Kosova, no Kosovar author was listed among the authors. Their corresponding journals' mean impact factors were 1.02, 3.14 and 6.87, respectively, which differed significantly ($p=0.0001$). A Kosovar first author in meta-analysis, systematic review, experimental studies, and cohort studies was in only 2.9% of all papers altogether. Furthermore, the mean journals' impact factor of these high-quality Kosovar first author articles was significantly lower than the journals' impact

factor of non-Kosovar first author articles. The scientific ranking by Nature Index which assessed growth in the scientific contribution of all countries around the world puts Kosova at bottom 10 countries of the world in terms of science productivity.¹⁰⁻¹⁴

FINALLY: KOSOVA COLLEGE OF SURGEONS AS A PLATFORM OF TRANSFORMATION OF SURGERY

The surgical science and practice in Kosova is experiencing crucial times and it is at a major crossroads, similar to American Surgery during the years when ACS was created. Drs. David Nahrwold and Peter Kernahan, in a proclaimed book *A Century of Surgeons and Surgery: The American College of Surgeons 1913-2012* published by ACS in 2012, wrote in the first chapter of the book "the American College of Surgeons (ACS) grew out of unstable medical environment and a crisis in surgical care. Three factors—scientific, regulatory, and economic—combined to produce this crisis."¹⁵ This describes verbatim the state of surgery in Kosova, although some may not agree with this author.

Consequently, as surgical science and practice in Kosova is experiences crucial times, we have a lot of catching up to do in for surgical science and surgical research to advance optimally. It almost seems as though we got stuck in time, but now we need to travel the new horizons of the world of surgery. At the same time, Kosovar surgeons have become leaders of surgical departments, surgical division, and are renowned surgeons in many western countries. All Kosovar leaders of surgery in the world have longed to help Kosova. For years, myself and others have offered and suggested to each Dean of the Faculty of Medicine of Prishtina, to engage Kosovar professors around



From left to right: Dr. Fatmir Hajdar; Dr. Ismet Lecaj; Dr. Xhevdet Quni; Dr. Saudin Maliqi; Dr. Violeta Zatriqi; Dr. Gani Çeku; Dr. Vjollca Binçe; Dr. Rifat Latifi (present virtually through telemedicine of Kosova); Dr. Dafina Mahmutaj; Dr. Skender Zatriqi; Dr. Belinda Pustina; Dr. Bedri Braha; Dr. Sinan Rusinovci; Dr. Ylber Zejnullahu.

the world. Other Kosovar experts have done the same.

The combination of brain drain and political apathy has had alarming consequences for Kosova. Academically, we have fallen way behind, and clinically, Kosova was exploited by our “friends” in the region by depriving Kosova of every penny by taking every complex patient for themselves. They ensured that the country falls into surgical/medical chaos, which it has.

On December 3rd, 2018, the representatives of 14 Kosova Surgical Societies representing more than 800 practicing surgeons of Kosova established the *Kosova College of Surgeons* (KCS), as a scientific and advocacy body of all surgeons that will lead the advancement of surgery in all surgical disciplines in the future.

The KCS will be modeled based on the American College of Surgeons (ACS) which was created in 1913. The American College of Surgeons (ACS) was established in Chicago, IL, at the initiative of Franklin Martin, MD, FACS. The College is a surgical society dedicated to promoting the highest standards of surgical care through the education of, and advocacy for, its Fellows and their patients, and to safeguarding the standards of care in an optimal and ethical practice environment.¹⁵ Since then, the ACS has led national and international initiatives to improve quality of hospital services in the fields of trauma, cancer, bariatric surgery, geriatric surgery, and surgical quality initiative. These initiatives have measurably improved the quality of care, prevented complications, reduced costs, saved lives, and have become the new surgical standards across the globe.



The Kosova College of Surgeons, a scientific and educational association of surgeons, was created to improve the quality of care for the surgical patient by setting the highest standards for surgical education and practice. The KCS is modeled based on the American College of Surgeons (ACS).

The mission and vision of the KCS is illustrated by it charter below:

1. Establish sustainable leadership infrastructure, professional administrative support and technological and administrative environment adequate to run the KCS.

2. Build a Clinical Research Center in Kosova with research and academic human capacities across the surgical disciplines and beyond.

3. Creation of Research Peer Review Process and editorial capacities through structured educational programs.

4. Publish the Kosova Journal of Surgery as the official journal of Kosova College of Surgeons, a peer review journal with the goal that in 5-7 years it will be cited in PubMed and other research engines.

5. Initiate accreditation program for various surgical disciplines such as trauma, cancer, vascular surgery and other programs for the Ministry of Health.

6. Establish the advocacy programs and capacities to represent the KCS in governmental agencies, and in international collaboration.

7. Create educational programs to support patients and families with surgical diseases.

8. Advanced Quality and Patients Safety Programs in all surgical disciplines in order to improve the quality of care, based on the American College of Surgeons quality, and improve programs and patient's safety.

9. Execute the work of the College through around 13 committees:

1. Committee for Quality and Patient Safety
2. Committee for Trauma
3. Committee for Emergency Surgery
4. Committee for Geriatric Surgery
5. Committee for Cancer
6. Committee on Advanced Technologies and Information Technology.
7. Committee on Surgical Research

8. Committee for Continuous Education and Membership
9. Committee for Diversity
10. Committee for Ethics and Disciplinary issues
11. Committee for Medical Students in Surgery
12. Committee for Residency and Fellowships, and
13. Committee for Health Policies and Advocacy

Other working groups and committees will be added as needed, and as the College increases its activity and content.

The creation of the College is a result of the need to advance surgical clinical care, and to advance surgical research, which is either lacking or completely missing in Kosovo. KCS will be a home to all surgeons in the region and of course, to Kosovar surgeons around the world. The College is dedicated to improving the care of the surgical patient and to advancing the ethical practice of surgery. The College's achievements will significantly influence the course of scientific surgery in Kosovo, and the region and will become an important advocate for all surgical patients. The creation of the Kosova College of Surgeons will clearly represent one of the most important historical moments of surgery in Kosovo. The College will need to work on standardizing the care, practice, and protocols of surgical care and work to advance the clinical, scientific, and research agendas of surgery in Kosovo. Additionally, the College should become the voice of Kosovo in all surgical congresses in the world, especially at the American College of Surgeons.

One of the most important objectives of creating the KCS was to afford opportunities for leadership of human capacities in surgical disciplines. The inclusion of all Kosovar surgeons around the world in all activities, leadership, and governance of the College will be of particular importance for the KCS.

Finally, the Kosova College of Surgeons, as the youngest college of surgeons in the world, will lead the transformation of

surgery and medicine in Kosovo, a transformation that we must undergo and must fully achieve. The reasons for such transformation are many, but transform we must, if we are to provide the best possible care to our patients; transform we must, if we are to recruit the best minds in surgery so we can not only compete with unpredictable market forces around us, but also lead the process of further surgical modernization; and transform we must, so that we can make sure that we innovate, adopt new technologies and new work processes, work and collaborate together with partners across all surgical disciplines, basic science, and surgical industry disciplines as real partners for the good of our patients, our institutions and the future of surgery. We must be led by and governed by metrics, data, and quality indicators. We must do this by involving new minds, new revolutionaries of medical science and administrative processes who simply will not continue with the status quo of surgery, but instead will ask the most fundamental question: can we do better than this? Let us remember all those who changed medicine and surgery before us.

LESSONS FROM WORLD CLINICAL LEADERS: THEY DID NOT AGREE WITH THE STATUS QUO OF THEIR TIMES

Dr. Thomas Starzl, true liver transplant hero of the world, in his paper in 1968 in the *Annals of Surgery* started the report by stating "there had been nine reported attempts at orthotopic liver transplantation; seven in Denver and one each in Boston and Paris. Two of these patients had succumbed within a few hours after operation, and none had lived for longer than 23 days."¹⁶ But, he goes on to say "this dismal picture has changed within the last 9 months, in as much as seven consecutive patients treated with orthotopic liver transplantation from July 23, 1967 to March 17, 1968 all passed through this previously lethal operative and postoperative period. Three of the recipients are still alive after 9, 2, and 1 months; the others died after 2, 3^{1/2}, 4^{1/3}, and 6 months."

One can only imagine what was going on in the operating room, in the lab, and in the minds of the surgical teams led by Dr. Starzl's.¹⁷ Dr. Starzl was fired from University of Colorado, but instead of giving up, he moved to the University of Pittsburgh and established world's most prestigious liver transplant center, and trained thousands of surgeons from around the world. To date, this center has performed thousands of liver transplants, and liver transplant is the standard of care for liver failure and many other indications. In addition, heart, lung, pancreas, and small bowel transplants are

also the standard of care with excellent long-term outcomes and survival rates. This was made possible only by scientific and personal persistence, personal sacrifice, and the willingness to learn from mistakes and from one another.

The list of surgeons who changed the field of surgery forever is long. Successful practical development of total parenteral nutrition (TPN) in the 1960s led by Dr. Dudrick has changed the medical world forever.¹⁸ Since 1968, TPN has become the standard of care for all patients who cannot, or should not, be able to maintain their nutritional status by oral or enteral means. When Dr. "Barney" Crile Jr. of the Cleveland Clinic suggested that, "we do not need to perform radical Halstedian mastectomy," he was expelled from the Cleveland Academy of Surgeons. Now, radical mastectomy is never performed and has not been performed for decades. Dr. Bernadine Healy, director of the National Institutes of Health, referred to Dr. Crile as an "unsung hero" who had been the object of "ridicule and scorn" by his peers and had touched millions of American women in an "extraordinarily positive way." Now, an Accepted Wisdom.¹⁹

Professor Dr. Med Erich Mühe of Böblingen, Germany performed the first laparoscopic cholecystectomy (LC) on September 12, 1985. He was not the only ridiculed by his peers for innovative thinking, but after he reported this accomplishment in 1986 to the German Surgical Society, he was rejected from the group. Yet, in 1992, he received their highest award, the German Surgical Society Anniversary Award, and in 1999, he was recognized by SAGES for having performed the first laparoscopic cholecystectomy. Now LC is a standard of care throughout the world.²⁰

In 1990 Juan C. Parodi performed the first endovascular abdominal aortic aneurysm (AAA) repair in Buenos Aires. Today endovascular surgery is a standard of care and is sought after both by patients and

vascular surgeons worldwide.²¹ The list of surgeons, leaders, and innovators who have changed the status quo of their times for the better of human kind is very long.

LEADING THE TRANSFORMATION PROCESS THROUGH SURGICAL TEAM BUILDING

The transformation of surgery is possible only by scientific developments and innovative approaches to clinical practice; a team-based approach has become the new model for delivering hospital care. To this end, there should be a shift in the focus as to how we surgeons lead and work as a team, communicate, collaboratively make decisions, and how we manage tasks. While the surgeon has always worked with a team, the need for communication and group decision-making has taken center stage. However, working as a team is not an easy task. Every surgeon is required to master the competency to work in a team. All members of the surgical team are required to focus on working together toward achieving better proficiency and higher quality outcomes. It is not all about the surgeon and his or her kingdom. Rather, it is about the patient, the team, the quality, the outcomes, and seeking new ways of providing the best possible care.²² We surgeons have to realize that we are just one part of this incredible team. As I have said many times, the surgery itself is, and should be, the easiest part of what we surgeons do. Before the patient is on the operating table, she/he has passed through the emergency department or the trauma room and may have gone to intensive care units, undergone radiology studies, used pharmaceutical and nutritional services, and utilized public relations services.³ All of these individuals and disciplines make it possible for us surgeons to perform the necessary procedure. Let us look around us in the operating room: there are at least 7-8 other members of the team in the room helping us, and they are equally important if not more important than us surgeons. The anesthesia team, nursing team, scrub team, and the residents, and students (medical, and other students), all contribute in their own way. It takes an entire village of highly trained professionals for a successful surgery. There is also the "invisible team": blood bank service personnel, biochemistry, microbiology, pharmacy, all other support services, security, and cleaning services that we don't even come into contact with, but their help is necessary and critical to our mission.

Subsequently, the transformation of surgery and of surgeons alone cannot move the needle further, instead we need to transform the entire system. The entire system needs to be transformed. We, the surgeons, should lead this transformation and be directly responsible for the transformation of surgery in to patient centered, disease and disorder based, technology

driven, and a research oriented modern department.

SUMMARY

Surgery is the corner stone of the Modern Hospital and Modern Academic Health System, and must transform itself and the surgical practice continuously. Moreover, it has to grow, expand, and perform based on, and synchronized with, the Mission, Vision, and Alignment (MVA) model within the hospital, healthcare system, or Academic Center. The transformation should not be a passive and wait and see approach, or based on the previously prepared scripts not re-evaluated for decades, but it should be based on an active building and re-evaluating process, new scientific and technological advances, and clearly defined metrics and analysis of clinical data and indicators. This transformation should come from within, led by the members of the department, and be based on a strategy of increased growth, increased quality and patient's safety, increased recruitment of and retaining highly qualified clinical surgeons and research faculty to advance the clinical and academic mission of the department.

The Kosova College of Surgeons' mission, vision and alignment (MVA) model to improve surgical standards and transform surgery in Kosova will not happen overnight, and not in many years, but eventually it will occur. Conversely, in order to achieve this goal, each of us as individual surgeons need to change with time and evolve. Moreover, we should be able to predict, adopt, and evolve with these changes ahead of the time, and remain ahead of the process continuously. We the members of Kosova College of Surgeons need to make the College the perfect platform to launch and implement this transformation for the sake of future of surgery. After all we should lead and govern our own destiny.

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