
ADVANCE READING EXCERPT

Surgical Services by Design

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You know the problem. Can you get the decision?

A director brings the analysis. The executive still asks what needs to be decided. Follow the complete chapter, then compare three staffing, capital and flow requests before and after they become clear decisions.

Turn a department concern into a specific, accountable request.

Make the cost, credible alternatives and remaining uncertainty visible.

Leave the meeting with an owner, conditions and a review date.

Scenarios, prices and local authority assignments are fictional teaching assumptions. This is leadership education, not clinical direction or permission to change an operating standard.

Full book coming later. Preview only.

18. Executives Need a Decision, Not a Download

Executive communication is not the ability to make a complex department sound simple. It is the discipline of making the decision visible without hiding the clinical, workforce, operational, financial, or risk conditions that make the decision responsible.

What you will prepare: Deliver a one-page or five-minute brief that allows the correct authority to understand the situation, test the recommendation, make or route the decision, and confirm what happens next.

Working method: Executive Decision Brief

The meeting that ended with the question

In this fictional executive meeting, a director brings twenty-two slides on overtime, vacancies, temporary staffing, room closures, recruitment, and moved cases. The analysis is substantial, but the requested decision is not stated.

Twelve minutes into the presentation, the chief operating officer asks, "What are you asking us to decide today?"

The director answers with more context. The department is working hard. The schedule is unpredictable. Open positions are difficult to fill. Surgeons are frustrated. The team has tried different assignments. Finance already knows about premium labor. The executive asks again: "What decision do you need, from whom, and by when?"

The preparation needs a clearer opening. State the decision, its urgency, and the recommendation, then show the evidence that could change that recommendation. Keep the detail available for scrutiny.

An executive brief does something different. It carries the thinking far enough that the decision-maker can challenge the right assumptions, compare credible choices, understand the tradeoffs, and authorize or route a clear next step. The supporting analysis still exists. It no longer competes with the decision for attention.

Concision is compression without distortion

Perioperative work is genuinely complex. A short brief cannot turn an interdependent staffing, capacity, equipment, physician, financial, or safety problem into a slogan. When brevity removes a material dependency, uncertainty, protected concern, or balancing risk, it becomes distortion.

Keep the information that can change the decision in the main brief. A short page may be backed by a staffing model, financial workbook, risk review, implementation

plan, and source records. Readers should be able to trace material claims to that support.

An executive audience usually needs five kinds of truth at the same time:

clinical and quality truth - what condition affects patients, clinical capability, quality, or required safeguards;

workforce truth - what staffing, competency, workload, labor-market, fatigue, or adoption condition affects feasibility;

operating truth - what demand, capacity, flow, resource, technology, or handoff mechanism creates the current result;

financial truth - what cost, avoided cost, investment, contribution, forecast, or resource tradeoff belongs to the choice; and

risk and governance truth - what uncertainty, authority, compliance, privacy, contractual, implementation, or residual-risk condition must remain visible.

Not every brief needs equal space for all five. Every material brief should test whether one has been omitted because it is inconvenient. A staffing request that ignores operating redesign is incomplete. A capital request that ignores implementation capability is incomplete. A flow recommendation that ignores clinical safeguards or downstream capacity is incomplete. A safety concern that implies a financial return without controlled analysis is incomplete.

The United States Government Accountability Office's cost guide is written for a different setting, but its discipline transfers: define purpose and scope, document assumptions, analyze alternatives and uncertainty, present results, and update estimates with actuals. Federal plain-language guidance adds a communication principle: write for the intended audience, state the purpose and bottom line early, organize the information, and test whether the message is understood. Neither source validates the chapter method. Together they reinforce why responsible compression requires complete thinking before concise writing.

Start with the decision sentence

Before building a deck, write one sentence:

By [date], [authorized role or group] is asked to [approve, select, authorize, defer, stop, escalate, or route] [specific action or resource], within [scope or limit], so that [material result] can be achieved while [non-negotiable guardrails] remain protected.

If the final investment decision is not ready, specify the next decision that is: immediate protection, an interim resource, an interpretation, or authority to complete the analysis. Missing evidence is not a reason to withhold an urgent concern or wait for a polished presentation.

Some communications do not request an immediate decision. A leader may be providing early notice, reporting required performance, escalating unresolved risk,

seeking direction on scope, or confirming that a prior commitment was completed. Name that purpose. "For awareness" should not be used when the receiver is expected to act, and "I need support" should not replace the exact authority, resource, introduction, removal of a barrier, or decision being requested.

Authority also matters. The person hearing the brief may not own the decision. Name the decision owner, required consults, escalation route, and deadline. In a hospital, operational, capital, clinical, medical-staff, finance, privacy, HR, compliance, and governing-body authority may sit in different places. In an ASC, fewer people may hold several roles, but concentrated roles do not erase governance boundaries.

The Executive Decision Brief

Use this review to organize a material issue for the correct decision maker and record the resulting commitment. It is a communication aid, not a clinical handoff, board rule, disclosure process, or grant of authority.

Prepare and close an executive decision

Step	Question	Output
Frame	What decision or early notice is needed, by whom and when?	Purpose and authority
Explain impact	Why does this matter now?	Bounded issue and consequences
Show evidence	What is known, estimated, or uncertain?	Traceable facts and limitations
Compare	What credible alternatives and tradeoffs remain?	Comparable choices
Recommend	What do you recommend, subject to which conditions?	Recommendation and readiness requirements
Confirm	What was decided and who returns with evidence?	Actions, owners, and review date

Stage 1 - Frame the decision and authority

State the communication purpose, decision, decision owner, required consults, deadline, scope, and conditions that cannot be traded away. Identify what happens if the decision is delayed and whether a temporary control is already in place. If an immediate patient-safety or emergency condition exists, activate the authorized clinical and emergency route before preparing an ordinary executive brief.

Write for the actual audience. The chief financial officer, chief nursing officer, chief operating officer, medical executive committee, ASC governing body, and capital committee may require different emphasis while receiving the same controlled facts. Translation changes the order and explanation, not the truth.

Stage 2 - Establish the material issue and impact

Describe the current condition in one or two sentences: what is happening, where, for whom, over what period, and why it requires attention now. Then show the material effect across the relevant clinical, workforce, operational, financial, access, quality, partner, strategy, and risk domains.

Treat staff reports of exhaustion or distress as evidence requiring a response, not as noise to remove from the brief. Describe the reported experience accurately and pair it with available workload, relief, call, or capacity information. Escalate immediate concerns even when numerical evidence is incomplete. For a planned resource decision, distinguish the reported experience, corroborated facts, and questions still to be answered.

Stage 3 - Control the evidence and uncertainty

Present the smallest body of evidence sufficient to establish the pattern, materiality, and decision consequence. Show definitions, counts and denominators, trend, comparison period, source, validation status, assumptions, and important limitations where relevant. Distinguish verified fact, estimate, assumption, hypothesis, and unknown.

Do not imply causation because two measures moved together. Do not present a favorable benchmark without testing comparability. Do not improvise a number when challenged. If a missing fact could change the recommendation, name the owner and due date for validation. If the decision can safely wait, wait. If immediate containment cannot wait, separate the interim action from the permanent decision.

Stage 4 - Compare options and tradeoffs

Include credible alternatives, including the current-state or defer option when it is genuinely available. Compare each option on the same dimensions: patient and quality effect, workforce feasibility, operating capability, access, full cost, timing, implementation burden, risk, reversibility, and strategic fit.

Do not create a false choice between the preferred answer and an obviously irresponsible alternative. If only one safe or compliant option remains, say why and identify the authority that made that determination. If more than one acceptable option exists, show what the organization gains, gives up, delays, or risks with each.

Stage 5 - Recommend with conditions

State the preferred option and the reason it best fits the evidence, constraints, and organizational priorities. Make cost, timing, dependencies, residual risk, and implementation readiness visible. State approval conditions, implementation gates, safety stops, measures, and the evidence that would cause the recommendation to be reconsidered.

A recommendation is not stronger because it sounds certain. It is stronger when its confidence matches the evidence. Use direct language: "I recommend Option B because..." Then state the principal tradeoff and the largest uncertainty. This allows executives to test judgment instead of searching for what the presenter may be hiding.

Stage 6 - Secure commitment and close the loop

End with the exact decision, owner, conditions, action owners, due dates, communication route, and review date. Confirm whether the answer is approve, modify, defer, decline, escalate, or return for specified evidence. A request that ends with "we will discuss it again" has not produced a governed next step unless the next question, owner, and date are recorded.

Healthcare already uses structured communication and repeat-back to reduce ambiguity in time-sensitive team communication. AHRQ's TeamSTEPPS materials describe SBAR as a concise structure for situation, background, assessment, and recommendation or request, and check-back as a way to verify that information was received and understood. An executive decision is not a clinical SBAR, but the closed-loop principle still matters: document what was decided, who understood it, what conditions apply, and when evidence returns.

One page and five minutes

The one-page brief and five-minute presentation should carry the same decision spine. The page is the durable record. The verbal brief allows emphasis, challenge, and clarification.

Use this one-page sequence:

decision line - decision, owner, deadline, scope, and reason now;

issue and impact - bounded current condition and material consequences;

evidence - three to five decision-changing facts with limitations;

options - credible choices and comparable tradeoffs;

recommendation - preferred option, rationale, cost, timing, and conditions;

risk and implementation - dependencies, residual risk, gates, owner, and measures;
and

commitment - decision recorded, actions, due dates, communication, and review.

Use the five minutes deliberately. In the first thirty seconds, state the decision and recommendation. In the next minute, explain why the issue matters now. Use the next ninety seconds for the evidence and uncertainty. Use another minute for options and tradeoffs. Use the final minute for implementation, risk, the decision request, and the date. Keep the appendix ready for questions.

This is not a rule that every discussion must last five minutes. Complex governing, clinical, capital, compliance, or strategic decisions may require substantial review. The discipline is to make the decision visible within five minutes even when the complete deliberation takes longer.

Three messages rebuilt for decisions

The following fictional before-and-after examples show how to make the next decision explicit. Their values and local authority assignments are teaching assumptions, not market rates, staffing standards, or recommendations for a particular organization.

Staffing: from a broad concern to the next coverage decision

Before: "We are critically short. Everyone is burned out, call is terrible, and we need at least six more positions. We have been trying to recruit for months, but the market is difficult. Staff are threatening to leave, and we cannot keep doing more cases with fewer people."

The concern warrants a timely response. A separate, bounded coverage request can help the responsible leaders act while the longer-term staffing analysis proceeds.

After: "By Friday, approve up to \$48,400 for a six-week qualified interim-coverage plan, subject to the existing staffing, competency, fatigue, and purchasing controls. The verified roster has a 320-hour RN gap and a 160-hour surgical-technologist gap over those same six weeks. Coverage estimates are \$100 per RN hour and \$75 per technologist hour, all-in for this teaching case: $\$32,000 + \$12,000 = \$44,000$, plus a 10% contingency of \$4,400. The role-specific gaps occur in the identified late-day intervals; a daily average would conceal them.

"The alternatives are qualified temporary coverage, an authorized reduction in scheduled capacity, or a mixed plan using verified internal availability and targeted capacity changes. I recommend the temporary plan only where qualified coverage can actually be secured. Confirm recruitment priority for existing funded vacancies and review the annual establishment separately. The six-week gap does not establish a permanent FTE requirement. Review actual hours and cost weekly, reassess on day twenty-one, and reduce or modify the schedule through the authorized route if required capability cannot be provided."

The revised message provides a checkable ceiling and a defined coverage period while preserving the separate permanent-staffing decision. It does not promise that spending authority will produce qualified people.

Capital: from failing equipment history to investment choice

Before: "Our imaging equipment is old and keeps breaking. Biomed has repaired it several times, surgeons are frustrated, and the vendor says support is becoming limited. We need a new unit before something happens."

After: "By month-end, authorize completion of a purchase-versus-lease comparison and confirm the permitted interim operating plan. The mobile imaging unit had seven unplanned outages affecting nineteen cases in six months: six room moves, four delays longer than an hour, two rescheduled cases, and seven shorter delays. Repair and rental expense totaled \$96,000. Biomedical engineering must confirm the support horizon and current conditions for use. These records justify review; they do not establish that replacement is the only safe option.

"The \$740,000 purchase quote excludes implementation and training. The lease requires a comparable lifecycle calculation, including support, term, end-of-term conditions, and the same operating horizon. A twelve-month bridge is an option only if the clinical and technical owners approve its backup, maintenance, and operating constraints. Today's request is authority to finish that comparison and maintain the authorized interim protection. It is not final purchase approval."

The after version distinguishes the immediate authorization from the final purchase decision and prevents urgency from becoming a substitute for governed evidence.

Flow: from a red metric to an enterprise capacity decision

Before: "Turnover is still too high. The team is not moving fast enough, surgeons are complaining, and we need everyone to focus on getting below thirty minutes."

After: "Authorize a six-week flow test in two services, with an executive owner for recovery-capacity decisions. Median patient-out to next-patient-in turnover is 34 minutes. Direct observation of twenty-four transitions also found PACU holds delaying the preceding patient's exit—time outside that turnover interval. We will track those holds separately. Cleaning, instruments, anesthesia, transport, and next-patient readiness contributed at different points. Neither one cause nor a universal thirty-minute target has been established.

"Compare three feasible approaches: resequence afternoon work within approved scheduling rules; provide targeted, qualified recovery coverage when the evidence supports it; or test a combined readiness and capacity plan on a small scale. I recommend the bounded combined test, with the responsible partners validating its resources before it starts. The principal uncertainty is which constraint limits the pathway on which days. Track total progression, separate intervals, clinical safeguards, staff workload, and cost. Review at six weeks to continue, adapt, or stop."

The metric creates attention. The brief converts it into an enterprise learning and authority decision without prescribing unsafe speed.

Prepare the appendix, not the ambush

Concise leaders still know their details. Build an appendix that can answer foreseeable challenge without turning the main brief into storage. Include definitions and methods, detailed trend views, counts and denominators, financial model, assumptions, sensitivity, option comparison, implementation plan, risk register, stakeholder review, and source material as appropriate.

Prepare for predictable questions: Why now? What changed? What happens if nothing changes? How do you know? What alternatives were excluded? What is the full cost? Can it be phased? What work will stop? Who owns implementation? What risk remains? When will benefit appear? What evidence would change your recommendation?

Answer the question asked. If the answer is in the appendix, retrieve it. If it is not validated, say so and give the owner and date. Challenge is not automatically rejection. It may be the executive performing the work the brief was designed to enable.

Do not surprise a decision-maker with material risk in a routine meeting when an earlier authorized escalation was required. Early notice can be brief: what is known, what is controlled, what remains uncertain, which route is active, and when the next update will arrive. The formal brief can follow when the evidence and options are ready.

Failure modes that weaken executive credibility

Starting with the chronology

History feels complete to the presenter and expensive to the listener. Lead with the present decision. Provide only the history required to understand it.

Sending a dashboard without interpretation

The receiver should not have to decide which signal matters, whether the definition is valid, or what action the leader recommends. Carry forward Chapter 17's metric discipline.

Hiding cost, uncertainty, or downside

Executives will test them. Naming them first demonstrates judgment and reduces the risk of an approval built on incomplete assumptions.

Asking for support

Support is not an executable decision. Name the approval, authority, resource, barrier removal, consultation, or escalation needed.

Treating the preferred option as inevitable

Show credible alternatives and the current-state consequence. If an option is excluded, state the reason and the authority behind the exclusion.

Using urgency to outrun governance

Immediate containment may be necessary. Permanent staffing, capital, clinical, contracting, policy, privacy, or professional decisions still follow the routes that govern them.

Leaving without closure

A verbal yes is not a complete implementation system. Confirm conditions, owners, due dates, communication, and the evidence-review date.

Safety, ethics, and authority guardrails

Do not use this review as a substitute for an emergency pathway, clinical protocol, chain of command, incident response, peer review, medical-staff process, employment action, financial approval, legal advice, regulatory interpretation, disclosure control, or governing-body decision.

Protect patient, employee, peer-review, quality, contract, payer, legal, proprietary, and confidential business information; use only the minimum authorized information for the audience and purpose.

Validate material data, definitions, attribution, comparisons, financial assumptions, and sources. Correct material errors promptly and document what changed.

Do not minimize risk, suppress unfavorable evidence, manipulate a display, or omit a material dependency to make approval more likely.

Do not overstate causation, clinical benefit, savings, contribution, capacity, workforce benefit, implementation readiness, or certainty.

Distinguish an immediate containment decision from a long-term operating, capital, staffing, or strategic resolution.

Obtain the required clinical, quality, finance, HR, legal, compliance, privacy, procurement, medical-staff, executive, and governing review for the consequence involved.

Preserve dissent, important uncertainty, and minority professional concerns through the authorized route; consensus in a meeting does not erase unresolved safety or authority boundaries.

Record the decision, conditions, owners, dates, communication, and review evidence. Escalate when the response is unclear or when risk moves beyond local authority.

Hospital and ASC decisions must follow the applicable governing-body responsibilities and local delegated authority. A persuasive brief does not transfer approval power to the presenter or replace required clinical, medical-staff, financial, or legal review.

Hospital and ASC lens

In a hospital, executive decisions often cross nursing, operations, finance, medical staff, quality, HR, supply chain, technology, facilities, compliance, legal, and governing structures. The brief should identify enterprise dependencies and required consults rather than presenting a departmental solution as self-authorizing. A multi-hospital system also needs local context, enterprise effect, standardization implications, and the decision level requested.

In an ASC, the same person may act as administrator, operational leader, financial partner, and governing-body presenter. Keep the decision and review records explicit precisely because roles are concentrated. Small volume can make rates volatile; limited redundancy can make one vacancy, asset, vendor, or transfer dependency material. Show counts, cash and financing effect, owner conflict where applicable, QAPI connection, implementation coverage, and operating resilience.

Monday morning: rebuild one unresolved request

Owner: You, the operational owner, the evidence or finance partner, and the authorized decision partner.

Due date: Complete one decision brief, challenge it with one qualified partner, and schedule or route the decision by Friday.

Action: Select one unresolved issue that has produced repeated discussion, a long deck, or an unclear request. Write the decision sentence first. Complete all six stages. Limit the main brief to one page, move supporting material to a controlled appendix, and practice a five-minute verbal version. Ask the challenge partner to state, in their own words, the decision, recommendation, largest tradeoff, largest uncertainty, and next commitment. Revise any element they cannot recover accurately.

Measure: By Friday, the issue ends in one documented decision, modification, deferral, decline, escalation, or evidence request with an owner and date. The test is not whether the presentation was praised. It is whether the correct authority could understand the choice and close the loop.

Measure the shift

Measure whether executive communication is producing responsible decisions rather than more presentation:

decision clarity - briefs name the decision, owner, deadline, scope, and consequence of delay;

completeness - material clinical, workforce, operating, financial, risk, option, and implementation conditions are visible;

Response timeliness: Time from receipt of a request to acknowledgment, triage, and a decision or specified evidence request. Record missing information separately so incomplete requests do not disappear from the queue.

rework - requests returned because the purpose, evidence, authority, cost, options, or implementation plan was unclear;

commitment closure - decisions become owned actions with conditions, due dates, communication, and review;

forecast credibility - material cost, timing, volume, staffing, adoption, and benefit claims are compared with actuals;

communication integrity - corrections, dissent, uncertainty, protected information, and unfavorable evidence remain controlled; and

decision usefulness - executives and implementation owners can accurately state what was decided and what happens next.

Do not optimize for fast approval. A clear decline can be more responsible than an approval built on hidden assumptions. Optimize for timely, testable, ethical decisions and reliable follow-through.

Chapter notes and selected sources

The brief structure and fictional examples are educational communication aids. They do not replace clinical communication standards, governance rules, disclosure requirements, or staffing and capital approval processes. One-page and five-minute formats are practical options, not mandatory limits.

Agency for Healthcare Research and Quality. TeamSTEPPS 3.0 communication tools, including SBAR and Check-Back.

U.S. Government Accountability Office. Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Program Costs. GAO-20-195G. 2020.

U.S. General Services Administration, Digital.gov. Principles of Plain Language and Organize the Information. Retrieved September 27, 2026.

Electronic Code of Federal Regulations. 42 C.F.R. Sections 482.12 and 416.41.
AONL Nurse Leader Core Competencies; ACHE Healthcare Executive Competencies Assessment Tool.