

# Ethical leadership in cardiothoracic surgery in an era of consolidation: A framework for trust, transparency, and workforce stability

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Supplemental material is available online.

Cardiothoracic (CT) surgery compresses time, risk, and interdependence. Patients grant extraordinary latitude to surgeons and teams—often after brief encounters—on the understanding that judgment will be exercised solely in their interests. This fiduciary orientation has long defined our professional identity. Yet, the terrain is changing. Hospitals increasingly operate as corporate enterprises; private equity has entered the delivery system; and productivity measured in relative value units (RVUs) governs compensation in many practices, with downstream effects on scope, growth, and professional autonomy.<sup>1-3</sup> At the same time, public scrutiny of concurrent and overlapping surgery has clarified how easily trust can be destabilized when disclosure, expectations, and surgeon presence are not aligned.<sup>4</sup> Administrative burdens—from previous authorization to documentation—have expanded to the point of delaying care and displacing bedside work, a phenomenon now described as “administrative harm.”<sup>5</sup> In parallel, moral distress and burnout have risen to levels that threaten workforce sustainability in CT surgery.<sup>6</sup>

The “era of consolidation” refers to the accelerating concentration of hospitals, physician practices, and training programs into large health systems and private equity-backed entities, reshaping labor markets, governance structures, and professional autonomy in CT surgery. Ethical leadership in CT surgery therefore requires explicit integration of macro-level forces—consolidation, private-equity ownership, workforce fragility, and administrative complexity—because these forces shape the ethical terrain as directly as clinical judgment. This review argues that ethical leadership in CT surgery must be understood not

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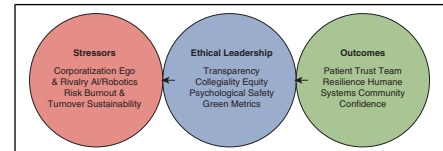
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Framework linking ethical stressors to leadership actions in CT surgery.

## CENTRAL MESSAGE

In an era of consolidation, ethical leadership in cardiothoracic surgery must make trust, transparency, and workforce stability operational—protecting patients, teams, and the profession itself.

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as a personal virtue or individual style, but as a system of governance—one that shapes incentives, distributes authority, protects institutional missions, and determines whether trust, safety, and sustainability can endure.

Although guidelines and professional standards are essential to safe, reproducible care, ethical leadership must also preserve the art of surgery—clinical judgment informed by experience, nuance, and individual patient context. Protocols and algorithms, often derived from limited or nonrepresentative populations, are not universally generalizable and may unintentionally perpetuate disparities if applied without discretion. Leaders should therefore resist equating standardization with virtue and instead cultivate environments where judgment, experience, and patient-specific reasoning remain central.

One recurring risk in high-pressure environments is “normalization of deviance,” where small departures from best practice become routine because they appear to “work” most of the time—until they do not.<sup>7</sup> Just culture frameworks, which distinguish human error from at-risk and reckless behavior, offer a way to learn without reflexive blame while maintaining accountability.<sup>8</sup> Here, we map the ethical challenges now confronting CT surgery and offer pragmatic responses across overlapping operations,

corporatization and incentives, administrative harm, psychological safety and moral distress, transparency and consent, training, and equity (Figure 1).

### AN ETHICAL FRAME: PROFESSIONALISM, NORMALIZATION OF DEVIANCE, AND JUST CULTURE

This work is motivated by both explicit ethical concerns and long-standing, often unspoken tensions within CT surgery. Recent legal cases involving concurrent and overlapping surgery brought these tensions into public view, exposing how deviations from professional standards can undermine patient trust when transparency and accountability are absent. In several high-profile instances, surgeons managed multiple simultaneous operations while patients were supervised by trainees during critical phases, without adequate disclosure or safeguards.<sup>4,9</sup> Although limited overlap may be defensible under strict standards, departures from those standards increase patient risk and violate foundational ethical commitments recognized by clinicians, staff, and the public alike.<sup>10</sup>

These practices did not arise in isolation. Federal investigations highlighted how production pressure and misaligned incentives contributed to the persistence of unsafe norms, with substantial institutional benefit over time.<sup>4</sup> When volume or efficiency is implicitly prioritized over disclosure and patient expectations, ethically questionable practices may come to be viewed as routine rather than exceptional. The ethical concern therefore lies not only in individual decisions, but in systems that quietly reward risk while diffusing responsibility.

Ethical analysis in CT surgery begins with professionalism: fidelity to patient welfare, respect for patient autonomy, and justice in allocation at all levels. Professionalism is expressed not only in bedside conversations, but in how care is organized—through scheduling, staffing, consent processes, documentation practices, and the ways surgeons relate to one another across hierarchies. When

system-level failures place clinicians in ethically compromised positions, moral distress is experienced at the bedside, even if its origins lie elsewhere.

Normalization of deviance provides a useful lens for understanding how practices such as undisclosed overlapping cases, routine understaffing, or perfunctory consent can become invisible to insiders because they appear to “work” most of the time, a phenomenon described by Vaughan in high-risk industries.<sup>7</sup> Visibility often returns only after a public failure exposes the accumulated drift. Just culture reframes these moments. Rather than defaulting to blame, it asks what contextual factors made the next error likely, distinguishing inadvertent human error from risk-taking under pressure and from reckless disregard for patient safety.<sup>11</sup>

For CT surgery, this framework demands differentiated responses to wrongdoing while relentlessly improving systems. Practical applications include explicit documentation of critical portions of operations, conversational time-outs that reinforce shared understanding, structured debriefs, and—above all—honest, inclusive dialogue that does not minimize risk.<sup>12</sup> Leadership operationalizes these principles through policies that require disclosure and presence during critical steps, staffing models that protect psychological safety, and governance structures that insulate ethical standards from purely financial imperatives.<sup>13</sup>

### CONCURRENT AND OVERLAPPING SURGERIES

In CT surgery, surgeon presence during the “critical steps” of an operation is central to ethics and patient trust. These steps—such as cannulation, initiation of bypass, valve implantation, and decannulation—are the moments when patients reasonably expect their named surgeon to be present. Defining them explicitly promotes consistency and reduces ambiguity for patients, trainees, and teams.

Consent must therefore be substantive rather than procedural. Clear language specifying the presence of attending surgeons during critical steps, while acknowledging



**FIGURE 1.** Ethical stressors, leadership responses, and outcomes in cardiothoracic surgery. A conceptual framework is shown depicting how systemic and cultural stressors—such as corporatization, digital risks, sustainability challenges, ego, and turnover—are countered by ethical leadership responses, including transparency, equity, sustainability, and psychological safety. These responses ultimately sustain patient trust, team resilience, and humane systems.

supervised trainee participation in noncritical portions, respects patient autonomy and preserves education. Patients deserve to know who will be with them, and when.

In this context, “attending presence” should be understood as accountable availability and situational awareness during defined critical portions, coupled with deliberate, graduated entrustment of trainees—not constant physical control. Transparency and trust should extend to trainees as active participants in care, so that education and patient safety advance together rather than in competition. These standards are proposed to strengthen trust and accountability—not to promote defensive medicine or fear-driven supervision that undermines clinical judgment and training.

Investigations have shown that overlap is sometimes poorly documented, including instances of simultaneous timeouts in separate operating rooms.<sup>4</sup> In other settings, production pressure can normalize surgeon absence during critical portions of cases. What begins as an exception may become accepted practice—a form of normalization of deviance—until standards erode and trust is lost.

Although overlap is sometimes framed as efficiency, patient perspectives are consistent: when it is not explicitly disclosed, trust is undermined. Even when outcomes appear comparable, the ethical obligation remains. Autonomy requires disclosure, and in surgery, speed must never be privileged over presence.

Responsibility for this standard rests with leadership. Undisclosed overlap should be treated as a systems issue rather than an individual workaround. Safeguards include standardized consent language, operative documentation of attending presence during critical steps, and periodic review. Transparency also supports training, as patients are more accepting of team-based surgery when roles are explained honestly.

At its core, the debate over overlapping surgery is not about metrics or loopholes. It is about trust. Patients already ask about experience and readiness. They now also deserve a clear answer to a simpler question: *Will you be there when it matters most?*

### **CORPORATIZATION, PAYMENT INCENTIVES, AND PROFESSIONAL AUTONOMY**

Corporatization and payment incentives increasingly shape CT surgery, often in ways that strain professional autonomy and ethical judgment.<sup>13</sup> Heart teams now operate within fragmented contractual structures, with surgeons, cardiologists, anesthesiologists, and intensivists responding to different financial incentives. RVU-based compensation undervalues time-intensive conversations, reoperations, and complex decision-making, subtly privileging throughput over deliberation. When financial imperatives influence timing or case selection, the ethical tension becomes clear: incentives designed for efficiency can conflict with individualized, patient-centered care. Ethical leadership requires

governance structures that protect clinical judgment, including dyad leadership models that grant clinical leaders explicit authority to delay or decline unsafe scheduling without fear of retaliation. Compensation frameworks that incorporate outcomes, safety behaviors, teamwork, and protected time for teaching and quality improvement better align incentives with professional values. Professional societies can reinforce these norms by benchmarking ethical climates—not only outcomes—through metrics such as staffing ratios, surgeon turnover, and investment in education, particularly in corporatized environments. As distinctions between academic and private practice blur and volume increasingly drives culture, leadership must actively safeguard the teaching mission and ethical foundations of the field. A related concern arises when programs preserve the appearance of academic surgery without sustaining its obligations. Academic identity is not defined by title or affiliation alone; it is demonstrated through scholarship, mentorship, intellectual openness, and fair opportunity for surgeons to contribute. When authority becomes excessively centralized, leadership can drift toward micromanagement, territorial control of referrals or operative opportunity, and opaque decision-making. Such environments may maintain clinical throughput, but they do not reliably produce scholarship, durable programs, or the next generation of surgical leaders. Ethical leadership must, therefore, protect not only patient care, but also the professional conditions under which colleagues can contribute meaningfully and develop fully within the discipline.

Importantly, the distinction is not between academic and private practice—many private practices sustain exemplary professionalism, mentorship, and collegial culture—but between institutions that uphold the obligations of the profession and those that merely adopt its titles.

Because teaching and supervision predictably increase operative time, governance models should explicitly recognize education as labor—through protected time and/or RVU credit for teaching, mentorship, and academic contributions—so that educators are not structurally pressured to “make up” productivity by cutting corners.

As distinctions between academic and private practice blur, a parallel risk has emerged: institutions that retain academic titles without sustaining academic mission. When scholarship, mentorship, and inquiry are subordinated to relentless procedural throughput, training environments may produce technically capable surgeons without cultivating critical thinking, ethical reasoning, or future leaders. Professional societies can reinforce these norms by benchmarking ethical climates—not only outcomes—through metrics such as staffing ratios, surgeon turnover, protected educational time, and investment in mentorship and scholarship. As distinctions between academic and private practice blur and volume increasingly drives culture, ethical leadership must actively safeguard the teaching mission and the academic mission—not as branding, but as governance.

The pressures experienced at the bedside—moral distress, psychological safety, and constrained judgment—are downstream manifestations of broader governance choices. We therefore turn next to consolidation, incentives, and administrative processes that shape risk and professional life at scale.

### HEALTH-SYSTEM CONSOLIDATION, ECONOMICS, WORKFORCE, AND ADMINISTRATIVE HARM

Health-system consolidation has reshaped CT surgical practice, creating regional labor markets in which 1 or 2 systems function as dominant employers.<sup>14</sup> In such settings, surgeon mobility is constrained, especially with noncompete clauses magnifying the ethical impact of leadership on retention, psychological safety, case selection, and patient outcomes. Federal analyses have documented accelerating consolidation through hospital and physician-practice mergers, often associated with greater prices and inconsistent quality gains.<sup>14,15</sup> When employment options narrow, leadership quality becomes a determinant not only of workforce stability but also of patient safety, underscoring the need for governance that explicitly addresses labor dynamics alongside clinical protocols. Private equity ownership adds further complexity; emerging evidence links some acquisitions to greater adverse events, increased complications, and staff turnover, highlighting the ethical necessity of transparency, outcome-linked incentives, and governance structures that insulate clinical judgment from purely financial imperatives.<sup>16,17</sup> Regulatory environments, including Certificate-of-Need variation, further shape access and equity: in some regions, service expansion reflects reimbursement opportunity rather than population need, reinforcing the importance of leadership decisions grounded in public health considerations rather than market capture alone.<sup>18</sup>

Within this consolidated landscape, “administrative harm” has emerged as a parallel ethical concern: patient risk created by bureaucratic processes that delay, distort, or fragment care. Bureaucratic processes—such as previous authorization delays, documentation burden, and rigid throughput expectations—can delay coronary revascularization or valve intervention, contributing to myocardial infarction, heart-failure decompensation, or loss of surgical candidacy.<sup>19</sup> Ethical leadership requires making such harms visible through metrics like time-to-authorization and time-to-surgery, assigning accountability for delays, and creating escalation pathways when administrative processes threaten safety.<sup>20</sup> At the same time, leadership must preserve clinical nuance: not all patients benefit from immediate operation, and evidence from coronary disease trials and guideline frameworks underscores that outcomes depend on thoughtful timing and patient selection as much as technical success.<sup>21-23</sup> Distinguishing harmful delay from appropriate restraint is itself an ethical act. In consolidated systems, leaders must

therefore steward incentives, workforce stability, and administrative processes with the same rigor applied to infection control or mortality review, recognizing that governance choices shape not only efficiency but trust, equity, and preventable harm.

An underexamined consequence of consolidation is the concentration of clinical volume, influence, and decision authority in a small number of dominant operators. High procedural volume is often equated with excellence, yet when leadership, scheduling authority, referral control, and block-time allocation converge around a few individuals, programs become vulnerable to micromanagement, suppressed dissent, and fragile succession. Such concentration creates single-point-of-failure risk: innovation slows, younger surgeons struggle to mature independently, and teams may become reluctant to challenge unsafe norms. Ethical leadership must therefore include intentional distribution of opportunity, transparent governance of operative resources, and succession planning that prioritizes program resilience over individual throughput.

### MORAL DISTRESS, PSYCHOLOGICAL SAFETY, AND THE SURGICAL WORKFORCE

Workforce demographics intensify ethical strain in CT surgery. Nearly one quarter of US surgeons are older than 65 years of age, with retirements projected to outpace replacement, whereas geographic maldistribution further limits access. Each preventable midcareer attrition event—whether driven by moral distress, burnout, conflict, or discrimination—represents a system failure with downstream consequences for regional surgical capacity and patient access.

CT surgery carries distinctive moral stressors, including decisions about timing of high-risk operations, transplant candidacy under scarcity, and aggressive interventions in frail patients under institutional or production pressure. Moral distress arises when clinicians recognize the ethically appropriate course of action but feel constrained by systemic barriers such as policy restrictions, resource limitations, or productivity targets among both civilians and military.<sup>24,25</sup> Without structured opportunities for reflection and debriefing, moral distress erodes trust, disengages clinicians from teams, and contributes to burnout and attrition.<sup>6</sup>

Psychological safety is therefore operational, not aspirational—the lived ability to say “this case is unsafe” or “we should pause” without fear of reprisal. Teams with greater psychological safety report concerns earlier, challenge questionable practices, and engage in more robust ethical deliberation.<sup>E1</sup> Leaders play a decisive role by modeling openness, responding constructively to dissent, and closing feedback loops. Organizations should measure psychological safety alongside clinical outcomes using validated tools and treat it as a core performance indicator.<sup>E2</sup>

Humane scheduling and adequate staffing remain indispensable, because burnout cannot be “wellnessed away.” Organization-directed interventions—redesigning workload, staffing, schedules, and control over work—are consistently more effective than individual resilience strategies alone.<sup>E3</sup> Designing surgical work that respects cognitive and physical limits is therefore a core ethical obligation, essential to judgment, teamwork, and patient safety.

A related but often unspoken contributor to moral injury is the internal maldistribution of operative opportunity. Operating-room management literature recognizes block time as a scarce institutional resource whose allocation affects equity, professional development, and program resilience.<sup>E3</sup> When combined with productivity-linked compensation, these dynamics can leave programs vulnerable when dominant surgeons retire without clear succession planning, reinforcing the need to frame operative opportunity and succession as matters of ethical resource governance rather than personality or merit.<sup>E4</sup>

When operative opportunity, visibility, and advancement are persistently concentrated, moral distress may arise not from clinical decisions alone but from perceived futility of professional growth—an experience increasingly reported by midcareer surgeons and trainees in otherwise varied volume programs.

### TRANSPARENCY, INFORMED CONSENT, AND TRUST

Informed consent is a relationship, not a signature. In CT surgery, where risks include stroke, renal failure, and death, consent must enable genuine understanding and shared decision-making. Yet many consent documents exceed average health-literacy levels, limiting comprehension and undermining autonomy.<sup>E5</sup> Decision aids can improve understanding and alignment with patient values, but only when coupled with meaningful clinician engagement.<sup>E6,E7</sup> These obligations intensify in the context of overlapping surgery, where disclosure of the attending surgeon’s presence during critical portions is recognized as a material fact that must be communicated plainly.<sup>10</sup>

Consent should therefore identify a single responsible attending surgeon, specify who will perform the critical operative steps, and clarify team roles. Qualitative studies show that patients ground trust primarily in the interpersonal relationship formed with their surgeon, often assuming—without explicit discussion—that institutional structures reliably support that surgeon’s work.<sup>E8</sup> In high-stakes surgery, this human bond is central.

Trust is also reciprocal. When surgeons acknowledge uncertainty or system limitations, patients often respond with greater—not diminished—trust. In surgery, this interpersonal dimension is decisive, because patients ultimately consent to the judgment and hands of one surgeon. Simple

rituals of continuity—reintroducing the attending surgeon on the day of operation and reaffirming roles—help anchor trust, reduce anxiety, and make consent tangible in the person who will perform the critical steps.

Technical excellence without moral clarity is insufficient in CT surgery. Ethics and professionalism must function as core competencies—introduced early, reinforced during training, and sustained across a surgeon’s career, including leadership roles. Practical approaches such as simulation of disclosure conversations, facilitated reflection on moral dilemmas, and plain-language risk discussions help translate ethical values into daily practice. Contemporary certification and revalidation frameworks reinforce this expectation by requiring ongoing assessment of professionalism beyond formal training.

Professional identity is shaped less by curricula than by observation. Role modeling forms a powerful hidden curriculum, with direct clinical consequences. Coworker reports of unprofessional behavior by surgeons are associated with higher postoperative complication rates, underscoring that culture and conduct are patient-safety issues, not merely interpersonal concerns.<sup>E9</sup> Conversely, leaders who slow the system to clarify consent, address safety concerns, or acknowledge ethical tension teach that judgment and integrity outweigh throughput.

Ethical leadership also governs how colleagues are treated. Evidence across healthcare systems demonstrates that bias, opaque disciplinary processes, and lack of institutional support—particularly affecting vulnerable or internationally trained physicians—erode psychological safety and weaken teams.<sup>E10</sup> Such environments suppress speaking up and compromise collective decision-making, with downstream effects on care quality.

Burnout and moral distress further threaten workforce stability. Organizational factors—workload intensity, staffing models, scheduling control, and leadership behavior—are consistently more predictive of burnout than individual resilience. Ethical leadership therefore requires stewardship of working conditions as a moral obligation, not a wellness add-on.

Finally, ethics must be practiced visibly. Duty-of-candor standards emphasize timely disclosure, apology (give and take), and learning when harm occurs—expectations leaders must model and embed.<sup>E10</sup> Integrating ethics-focused case review into continuing education, using multi-source professionalism feedback, and maintaining simple rituals of continuity reaffirm a core truth of surgery: culture, like technique, determines outcomes.

### EQUITY AS ETHICAL ACCOUNTABILITY IN SURGICAL HEALTH CARE SYSTEMS

Equity in CT surgery is often framed as an outcome, but in practice it is a measure of ethical accountability—of whether leadership is willing to examine how policy,

TABLE 1. Leadership actionability matrix

Ethical stressor	Leadership response	Example metric (dashboard)	Outcome signal
Corporatization and ownership	Disclose ownership; align incentives to outcomes, not volume	Postacquisition adverse event rate; % compensation tied to outcomes	Transparency, safer incentives
Overlapping operations	Plain-language consent + attending presence for critical steps	% high-risk cases without overlap; % consents documenting presence/critical portions	Trust, accountability
Consent readability	Standardized templates; teach-back; time for questions	Readability $\leq$ 8th grade; teach-back documented rate	Understanding, safer decisions
Continuity of surgeon	Day-of-surgery reintroduction; role reaffirmation	Readmission to index surgeon rate; 30-d outcomes by continuity	Trust, safety
AI/robotics governance	Bias audits; explainability; human-in-the-loop override; event tracing	% tools with passed bias audit; override/documentation rate; device-related adverse events	Fairness, explainability
Sustainability (or footprint)	Reusable kits; efficient perfusion; lower-impact anesthetics	Carbon per case; % reusable sets used	Stewardship, cost
Language access	Interpreter-first scheduling; materials in preferred language	Interpreter coverage rate for pre-op/consent; no-show rate by language	Equity, comprehension
Culture: ego/rivalry	Psychological safety; mentorship; shared leadership models	360° professionalism score; debrief participation; coworker report rate	Team cohesion, safety
Retention and leadership	Coach early; fair evaluations; track exit-interview themes	Voluntary turnover; % citing leadership in exits; time-to-fill	Stability, continuity
Administrative harm	Fix bottlenecks; publish service-line access metrics	Median time-to-authorization; cancellation rate due to denial	Access, patient experience

Illustrative examples linking common ethical stressors in cardiothoracic surgery to leadership responses, measurable process metrics, and outcome signals. This matrix emphasizes that ethical leadership is operational and can be tracked through routine quality dashboards. AI, Artificial intelligence.

financing, and organizational design determine who receives timely and effective care. Certificate-of-Need variation illustrates this tension. In some regions, oversight has concentrated volume in ways that preserve quality, team proficiency, and program stability; in others, rapid service duplication has followed reimbursement opportunity rather than population need.<sup>18,E11</sup> Ethical leadership requires anchoring decisions about program expansion, technology acquisition, and site of care in community need rather than market share.

At the health-system level, corporatization and productivity-based incentives can subtly privilege throughput and payer mix. Equity functions here as a corrective lens. Accountability must move upstream to access-defining processes—time to surgery, authorization delays, interpreter availability, and no-show rates—measured and stratified by race, language, and payer, and reviewed alongside traditional quality metrics. Integrating interpreter availability into scheduling and consent workflows exemplifies equity as patient safety rather than accommodation.<sup>E12</sup>

Persistent disparities make the stakes clear. Black patients remain less likely to receive advanced heart-failure therapies, women are referred later for valve intervention, and language discordance compounds inequity when professional interpreter use is inconsistent.<sup>E13</sup> Designing

systems in which equitable access is the default—rather than relying on individual clinicians to compensate for structural gaps—is a core obligation of ethical leadership.<sup>E14</sup>

Equity also extends beyond national borders. The Lancet commission on global surgery framed access to safe, timely surgery as a human right, yet experience shows that equipment donation without parallel investment in training and systems rarely succeeds. Durable partnerships emphasize longitudinal team development, registries, tele-mentorship, and shared benchmarking. For CT surgeons practicing in high-income systems, equity is not peripheral humanitarianism but professional responsibility.<sup>E15</sup>

## FUTURE DIRECTIONS

The future of CT surgery will be judged not only by survival curves, but by whether the systems we build remain worthy of trust—among clinicians and the public alike. Innovation without governance is fragility. Artificial intelligence and robotics increasingly shape risk estimation, imaging, and recommendations; without transparency, bias testing, local validation, and explicit human-in-the-loop accountability, confidence erodes quietly and predictably.<sup>E16</sup> Ethical leadership does not slow progress; it makes oversight explicit before failure or litigation defines it for us. If ethical leadership is to function as a durable

governance framework rather than a retrospective critique, it must extend into emerging domains where power, risk, and responsibility are again being redistributed.

Sustainability is no longer optional. CT operating rooms while a cash-flow for hospitals generate disproportionate environmental impact through anesthetic gases, single-use supplies, and bypass circuits. Measuring carbon cost per case alongside morbidity and mortality signals that safety includes the world to which our patients return.<sup>E14</sup>

We include sustainability because it is now a governance issue: operating rooms are both clinical safety environments and resource-intensive systems. Ethical leadership can make sustainability operational through procurement standards, reusable sets where safe, anesthetic choice, and perfusion practices that reduce waste—tracked alongside outcomes so that stewardship is measurable rather than rhetorical.

Ownership and incentives require the same clarity. Financial structures can shift priorities toward throughput while presenting change as efficiency. Ethical leadership responds by making ownership visible, aligning incentives with outcomes and longitudinal value, and insulating clinical judgment from non-clinical pressure. Table 1 links common ethical stressors in CT surgery to measurable process metrics and plausible leadership responses suitable for routine governance.

## CONCLUSIONS

CT surgery has always carried a simple promise: technical excellence in the service of human dignity. What threatens that promise today is not a lack of skill—it is the slow drift of systems that reward volume over value, opacity over clarity, speed over presence, and rivalry over stewardship. Corporatization, administrative friction, overlapping operations, and moral distress are not background noise; they are ethical real-time and evolving stress tests. They expose where leadership has been reduced to management, and where culture has been mistaken for “how things have always been.”

Ethical leadership is where values become operational. It looks like consent that is truthful and legible, with a clearly accountable attending surgeon and transparent roles. It looks like incentives that follow outcomes rather than throughput. It looks like dashboards that count what we used to ignore—equity in access and experience, psychological safety, workforce stability,<sup>E16</sup> and the environmental cost of the work we do—because what we refuse to measure, we eventually excuse.

We should also say the quieter part plainly: we must treat each other well. A specialty cannot remain worthy of public trust while its own people are exhausted, isolated, undermined, or quietly pushed out. The feuds of the past were dramatic; the modern versions are often subtle—opaque advancement pathways, uneven allocation of operative

opportunity, weak succession planning, and concentrated authority without counterbalance. When that happens, patients do not simply lose a surgeon; they lose a team, a program’s continuity, and a community’s confidence. Ethical leadership therefore includes a human obligation as concrete as any checklist: to build climates where surgeons can grow without shrinking one another—where mentorship is real, fairness is visible, and legacy is shared rather than hoarded.

We are entering an era that will judge us not only by survival curves or case volumes, but by whether our systems remain worthy of trust—within our teams and in the eyes of the public. On the eve of uncertainty of full-blown World War II, King George VI once reached for a simple image: stepping forward without a guaranteed light, guided instead by something steadier. In CT surgery, that “steadier” thing must be ethical leadership—clear enough to earn trust, strong enough to protect people, and humble enough to put the next generation in a better place than we found it. The question is not whether our field will keep advancing. It will. Surgical excellence cannot flourish in environments where authority replaces mentorship, volume replaces scholarship, and loyalty replaces fairness. The question is whether, as we advance, we will still recognize ourselves in what we have built.

## Conflict of Interest Statement

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**Key Words:** cardiac surgery, ethics, outcomes leadership

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