

Prof. Michael Boyer: every hospital should strive to deliver safe, effective, high-quality care

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Professor Boyer has been a medical oncologist for more than 20 years, specialising in the treatment of thoracic and head and neck cancers. He was appointed Chief Clinical Officer at the Chris O'Brien Lifecare located in Sydney in 2011.

Prof. Boyer was the Director of the Sydney Cancer Centre and former Area Director of Cancer Services for the Sydney South West Area Health Service. He also has an appointment as a Clinical Professor within the Central Clinical School of the University of Sydney. He is the Conjoint Chair of Medical Oncology and Thoracic Oncology at Lifecare. In 2010, he was made a member of the Order of Australia for his work as an educator, a clinical trials researcher and for his involvement in the development of integrated care facilities for people suffering with cancer.

Michael continues to be actively involved in research, focusing on the testing of new anticancer drugs for the treatment of lung cancer. He has been involved in the Lifecare project from the very beginning, alongside his friend and colleague Chris O'Brien, and remains dedicated to helping guide the clinical direction of the facility.

Passionate and enthusiastic about his work in both clinical and administrative roles, Michael sat down with us and shared his views about leading a hospital towards its goals and aims, what leadership means to him, and how his profession as an oncologist has shed light on the importance of work-life balance. Below is *JHMHP's* in-depth interview with Prof. Michael Boyer (*Figure 1*).

On his personal experience

JHMHP: Can you briefly introduce a little about yourself and your position as Chief Clinical Officer?

Prof. Boyer: My name is Michael Boyer. I'm Chief Clinical Officer here at Chris O'Brien Lifecare. I'm also Professor of Medical Oncology at the University of Sydney (*Figure 2*). Chris O'Brien Lifecare is a cancer hospital. It's a hospital that only treats patients with cancer



Figure 1 AME editors met with Prof. Michael Boyer in his office in Sydney.

and diagnoses people with cancer. It does everything from screening to diagnosis, surgery, chemotherapy, radiotherapy, and supportive care. As a hospital, it has 125 inpatient beds, 5 linear accelerators, brachytherapy equipment for radiation, a 44-chair day therapy unit for the administration of chemotherapy, and then all the things you would expect to go along with that: 8 operating theatres, imaging, pathology, and so on.

JHMHP: How did you come to the appointment of Chief Clinical Officer? Could you briefly let us know what is your scope of work in this role?

Prof. Boyer: A chief clinical officer here functions like a director of medical services. Ultimately, I am responsible for quality and safety of the medical and clinical care that's delivered here at the Lifecare. It's sort of an administrative role, but I am a clinician, so I do spend about half of my time actually seeing patients. I think that's a very great strength to have, to mix actual coal-face clinical work with an administrative role where you are



Figure 2 Prof. Michael Boyer AM, MBBS, FRACP PhD. Chief Clinical Officer of Chris O'Brien Lifehouse, Conjoint Chair of Medical Oncology (Thoracic Oncology).

responsible for ensuring that that clinical work happens in a safe and effective way, so I bring both those things into the mix. In doing that, I got into the role after a number of administrative roles previously, and also with my involvement in the establishment of Lifehouse; I was involved in the physical and organizational design and the creation of this institution.

JHMHP: What would your normal day-to-day look like?

Prof. Boyer: I really have two different day-to-days; I have days where I'm really being a clinician where I'm seeing patients. On those days, I'm just like any other doctor: I sit in my office, patients come in, I see them, patients go out, another one comes in, and so on, and I do some of that in the ward as well when I have patients in hospital. On my other days, when I'm acting in a more administrative role, I have meetings, I'm involved in various committees that I have particular interest in, or responsibility in some of the IT systems that happen here. I am involved in meetings to do with quality of care, like our quality and safety committee, our drug and therapeutics group, our blood transfusion group and so on. Depending on which day it is, I attend a different one of those meetings. Finally, I am a member of the hospital's executive and also the board of directors, so from time to time I have meetings with the board of directors and meetings with the hospital executive.

JHMHP: What are the major challenges of your role? Could you share with us some of the more memorable moments in your time as Chief Clinical Officer?

Prof. Boyer: I think the most memorable moment for me was opening this place. You know, this is a very young organization that only opened in 2013. There was a lot of work to get us to that point, because this kind of development and organization had not been done before, so I worked very hard from about 2007/2008 all the way to 2013 to make this happen, so the most memorable thing is actually opening it. Of course, getting something open is only half the struggle. Getting it running properly, getting it efficient, and have everything running smoothly has taken the next few years. So, when you asked me what the challenge is, the challenge is to make the place live up to its promise. Its promise is to really enhance cancer treatment by bringing together research, education, clinical care and making all of that happen in a way where all the people are close by and interact. It's easy to say but it's extremely hard to do, so the challenge is to make it happen and to make it happen well.

JHMHP: What is your philosophy in leading a team, especially a clinical team?

Prof. Boyer: Leadership is an important aspect of most administrative-types roles. By definition, they are leadership roles. I think as a leader there are a number of things that you have to bear in mind. First, is that you're meant to be a leader; you're not meant to be everybody's friend. That means that you cannot carry on your activities in a way where you try to make everybody like you. That doesn't mean that you're going out of your way to make people dislike you, but you can't make decisions based on what you think people will like. So the first thing you have to do is to be very clear—and that doesn't just come from me, it comes from the entire organization—what is our strategic direction and goal? And then making decisions that move you towards that goal. Sometimes that will be things that people don't like, so you have to be prepared to explain why and how these decisions get us to the place we want to be. That's one really important aspect of leadership. The second important aspect I think, is setting the right culture. As a leader, I see myself as being responsible for making sure that we have a culture in the organization that respects the values that we think are important. Here at Lifehouse, respect, collaboration, talent, innovation and discovery are

all really important values to us, and as a leader, I need to make sure that number one, I demonstrate those values and those behaviours, and number two, that I hold the rest of my team accountable for that. If they don't, we need to discuss why they don't: do they not think it's important, do they not understand, or do they just not know? So we have to talk about those things. The final part of leadership for me is all about people development. Whatever my role is here, I will be passing through; I will be gone someday. If you are really good leader, you could be gone tomorrow and the whole place should still go on as though nothing had changed. As a good leader, it is important that the rest of your team has been trained up to have the skills to do all the jobs that they need to do, to be self-motivated, to do things without a leader. That's a very hard thing to do but that would be the kind of things that we would have to work towards.

On his speciality

JHMHP: *How would you say your experience in clinical roles in treating lung cancer, mesothelioma, and head and neck cancers contribute to your current position in the hospital?*

Prof. Boyer: I've been treating lung cancer and actually thoracic cancer, so lung cancer and mesothelioma for nearly 30 years, and head and neck cancer for nearly the same amount of time. They are things I enjoy, so it's a lot of fun treating those patients. I mean it can be very sad sometimes, but I do find it very stimulating, exciting and interesting. To me, they're important because they represent a challenge: the challenge of looking after people well at a time of their lives where they're very vulnerable; it can be very frightening for them. The ability to incorporate that clinical work together with broader research programs and the aims of the organization is very important as well. It allows us to do things in a way that really maximizes what patients get out of treatment both in terms of their survival but also in their quality of life and how they're feeling. That applies to all the diseases that you've mentioned, so whether it is head and neck, or mesothelioma, or lung cancer. To me, the issues around it are much the same. Obviously, the specific details of how you treat lung cancer are different from how you treat head and neck cancer, but the specific details are not the important part, I don't think. To me, the overall framework that matters is good multidisciplinary care. That means that as a medical oncologist, which I am, I can't treat

these people alone. I need radiation oncologists, surgeons, physicians, X-ray experts, and pathologists to help me, and sometimes I also need psychologists and social workers. You need a really big team, and the key bit of care is how you get that team together working in a way that has the patient as the focus. Having that team come together will also bring about all sorts of research ideas both in terms of direct patient care research and also implementation research: How do we take an idea that's a good idea and how do we actually put it into practice? A bit of our research focus is based on new drug discovery and development, but a big part of our focus is also on implementing the things that we know will already work. One of the questions is: How do you organize care in a way that patients can get it in the most effective and efficient and timely way possible?

JHMHP: *Are you heading any research projects right now? We understand that the Lifehouse runs various research projects on radiation and medical oncology, as well as breast and head and neck cancer research. Could you tell us a little more about the research that goes on in the Lifehouse?*

Prof. Boyer: Sure. There's a lot of research that goes on here, ranging from the trials of new drugs and new devices, through to psychological research, supportive care research, radiation research, and very innovative radiation devices for shielding, and surgical research, on how to best do operations and procedures. The full spectrum is about a few hundred research projects. For me specifically and personally, I'm involved predominantly in clinical trial research and predominantly in trials for drugs in lung cancer. I'm involved in a number of trials and research projects including some of which I'm the lead investigator. In addition, I mentioned some of the implementation and health services research. We have an extensive collaborative research group that stretches across a number of hospitals here in Sydney, where we are looking at a number of elements in care in lung cancer. We look at how people get into the system, what the diagnostic steps are, what the delays in the system are, how they treat them and what the outcomes are, and really building up a cohort so we understand in every different way what the experience and issues for patients with lung cancer are going through in Sydney in 2017. We work with a lot of other places, and I am the Clinical Lead of that project, but there is a project that spans three other hospitals in Sydney and a couple of regional hospitals elsewhere in the state of New South



Figure 3 Prof. Michael Boyer: every hospital should strive to deliver safe, effective, high-quality care (1).

Available online: <http://asvidett.amegroups.com/article/view/23006>

Wales. The project is progressing well so far. It's still fairly new; we only kicked that off in June this year, so it is a new project and is planned to run for the next 2 to 3 years. Right now, we are at the beginning of it, but we will see how it goes.

JHMHP: *You have held multiple senior administrative positions including Head of Department of Medical Oncology, Director of Sydney Cancer Centre, and Area Director of Cancer Services. What would you say is the main difference between all these roles and your current one? What sort of experience did you take away from these roles that may have helped you in your position right now?*

Prof. Boyer: My current administrative role is sort of built on my previous administrative roles that I've been in charge of. You start with smaller roles and hopefully you do them well, and then you move into a slightly bigger role, such as the head of a department. Before I was even the head of the department, I was the head of some activities within the department, and then I moved on to become the head of the department, and then the head of the organization in the Sydney Cancer Centre, and now Clinical Head of a large cancer hospital. Each of those carries with it slightly more responsibility, a broader scope, so you have to do more, more people reporting to me either directly or indirectly, and they've just been progressively larger and larger roles. You take away something from each of them. I mean, you learn as you do these roles how to do things. A lot of it is learning how to manage people and how to manage situations. There is a small amount of technical knowledge, but predominantly it is about people management, and

that takes some time. Some people are very good at that at the beginning and other people take a little bit of time to develop, but as you get better and better at it you can take on larger and larger roles. I'm lucky I've had some really great mentors, people who have guided me. The person that this building and facility is named after, Chris O'Brien, was a head and neck surgeon. He was a great mentor and a great teacher of how to do these roles. Another person called Jim Bishop was a great teacher of mine. Our current CEO, Eileen Hannagan, is a nurse, not a doctor, but she's a wonderful leader also and has taught me a lot about leading people and leading organizations.

JHMHP: *You seem to have a lot on your plate. How do you manage your time and maintain work-life balance since you have so many roles at once?*

Prof. Boyer: Being an oncologist is a fantastic way to remind you of the importance of work-life balance. You know, in my clinical role, every day I see patients who were living life with no problems, everything going well, until they're suddenly diagnosed with what might be a life-threatening illness. What that reminds me is to make every day count, because you can't really be sure about what's going to be around the corner. You know that the sun's going to come up tomorrow, but other than that you can't be very sure about what's going to happen, so you have to live in a way that provides you with the things that you enjoy, that you want to do. To me, that means work-life balance. That means going away on holidays, spending time with your family, doing the things that interest you, not just at work, because I'm lucky that work interests me a lot, but the things outside of work. Friends and family are very important, and I spent as much time doing those things as I reasonably can.

On hospital management

JHMHP: *Is there a common goal all hospitals should aspire to work towards in its strategic development? (Figure 3)*

Prof. Boyer: Well, I think the strategic goal might differ for each hospital, but there are a few key planks that have to be the same. I think every hospital has to strive to deliver safe, effective, high-quality care that adds value to the healthcare system. I think that's very important and I think that's the case no matter what kind of hospital you are. Now obviously, the specific strategic goals that the hospital might

have will differ depending on where that hospital is, what kind of work they do, where the hospital is at in terms of its life cycle. A brand-new hospital would have different strategic goals from a hospital that's been there for 50 years, because they're at a different stage in their evolution or their life cycle, but underpinning at all, I think, is that same safe, effective, quality care that's got to add value to the healthcare system. You're doing stuff not just to show that you're doing it or for the sake of doing it; that's not value, that's activity, and there's a very big difference between the two. I think in terms of our more modern approaches to value, we have to look at the outcomes that matter, both in terms of survival if we're talking about cancer, but also the quality of life and what value the patient puts on the care they've received.

JHMHP: What would you say is the most important thing to keep in mind when determining the direction of a hospital's development?

Prof. Boyer: I think there isn't just a single answer to that, because I think what you have to keep in mind is: what is the overall aim of this hospital? I know it might sound silly, because the aim of a hospital is to make people well again. But if you look at our own example here at the Lifehouse, sure we want to make people well, but we also have an aim to educate people, like staff for the future, and an aim to research, so we actually have several aims. One of the goals and jobs of the Board of Directors and the hospital executive is to bring together all those different aims, prioritize them, and come up with a strategic plan that takes those things into account. So, I do think that it differs from hospital to hospital, but there is a common underpinning, which is that safe high-quality care.

JHMHP: Could you please share with us the importance of cooperation between different healthcare institutions? How do we better facilitate communication?

Prof. Boyer: I think it's very obvious that no single institution can do everything, and that applies whether you're talking about clinical care or research or anything, really, and so finding good partners to work with becomes quite an important task. In some cases, that's because it's the fastest way to get research findings to happen, in others, it allows you to share knowledge with someone else who has done something that works, and if you collaborate with

them, you can do the same thing. Certainly, in the Australian healthcare system, that's recognized. There are networks of hospitals that work together in a variety of areas, and there are things that are just a part of the landscape, but it might be different in other parts of the world.

JHMHP: What are the challenges of implementing policy into the day-to-day operations of the hospital? How can we overcome them?

Prof. Boyer: I think the biggest challenge is to get things done consistently in the right way every single time. You can always tell a person to do something; there's no problem with taking a piece of paper, giving them the piece of paper and telling them to read it, do it. However, they'll do it that one time, and then they'll forget about it. Therefore, the challenge is how do you get your staff engaged with what you're trying to achieve, so that when you have a policy or some way of doing things, they're not just mechanically following a set of instructions. They're doing it because they understand the purpose, the goal, and how it fits into the broader aims of the hospital. I think engaging staff and getting them interested in what we're doing becomes a key part. Getting champions locally at each local level who can take policies and ideas and have them implemented becomes important.

JHMHP: Would you say that the red tape around it also contributes to making policy implementation challenging?

Prof. Boyer: I would seriously hope that we don't in this hospital, because we work very hard to eliminate that. While that may be true in other hospitals, over here we have a very flat structure; we don't have multiple layers of bureaucracy or red tape. We clearly have things that we need to comply with, and that's what you'd expect, but we've worked very hard to allow actual frontline staff to be able to interact with our most senior members of the executive easily, and that becomes helpful. The other thing that I think is important in doing that is providing the right kind of support. Now, that differs in hospitals, but in this hospital which is a cancer-only hospital, this is hard going, you know, we have a lot of dying people, and the staff feel that, so we need to provide them with the support so they know that we, the executive, understand how hard they're working, and how difficult their roles are and provide them with the opportunity to debrief, to talk to each other, and to support each other.

JHMHP: *What would you say is a common problem or challenge that you can see in hospitals or healthcare institutions in New South Wales/Australia right now?*

Prof. Boyer: Well there are many, but the one that comes to mind particularly in the public healthcare system, is balancing the demand and expectations of services with the ability to provide these services. There's a bit of tension there, and if you organize yourself well and make yourself as efficient as possible, you minimize that tension. However, that tension remains, because the demand for healthcare is effectively infinite, and we can't provide infinite service. That's not possible; you don't want to be spending every cent in the Australian economy on healthcare, so we do need to balance those things. There's a big piece of engaging with consumers and getting them involved in some of the decision-making and prioritization, so they have ownership over that part of the problem as well. Health is not something that the system does to people, or at least it shouldn't be. It should be an enterprise where you have the healthcare system and the recipients of health care working together to optimize the kind of healthcare that's received and valued.

JHMHP: *Would that sort of tension between demand and supply be viewed as less of a problem in institutions like the Lifehouse?*

Prof. Boyer: I don't think it is our biggest problem, but it is still there in the background. I mean, we don't have unlimited resources here either, and so we do have to find some way of saying "well, this care or treatment is not valuable enough to justify doing it instead of something else", so we do need to prioritize.

JHMHP: *What are your thoughts on working with international experts that have experience in hospital management?*

Prof. Boyer: I think like research or any other aspect of healthcare, not just collaboration but also knowledge transfer is very important. The world is a very big place, so there will clearly be other people who have faced some of the problems and issues we come up with, and they've worked out the answers, so we should learn from them. Similarly, there will be some things that we have solved that others can learn from us, so the idea of collaborating and transferring information and solutions from one group

to the other is a very important one. Here at Lifehouse, in Sydney, we have a lot of visitors, they come from China, the Middle East, Europe, and we meet with them, we show them around, we learn what their issues are, and try and tell them what solutions we've got. That gesture is reciprocated; we sometimes go to similar institutes in other parts of the world to learn from them, and that helps us be better.

JHMHP: *What aspects of the Lifehouse are you most proud of when introducing the center to readers or colleagues from outside of Australia?*

Prof. Boyer: I'm proud of the whole thing, I really am, because everything from the physical facility, the physical structure, right through to our staff and how they're trained, how they're involved with the organization, through to the research we do, the patient care we deliver, I'm proud of it all. I love working here, and I love trying to make it a better place.

JHMHP: *We understand that the vision of the Lifehouse is to create an integrated cancer treatment center that meets the needs of cancer patients without having them to travel from place to place. What steps were involved in making this possible?*

Prof. Boyer: I think that these steps really start from the recognition that it's important, so if you don't think that it's important you're not going to do it. Step one is recognising what the problem is, and how do you do that? You talk to people. In particular the people that you talk to are the patients, so you understand from their perspective what are the things that are missing. We got the message loud and clear, that some of the support was missing, that the ability to coordinate all the services under one roof was missing, the ability to have some complementary care was missing. So we set about consciously to design an organization that incorporated those missing elements, if you'd like. There's no magic to it: it's identifying the problem, making out how to solve it, and then doing it.

JHMHP: *What methods does the Lifehouse use to evaluate the outcomes and efficacy of services and treatments? Are there specific measurements or criteria you would look at to determine if a certain area is generating satisfactory results?*

Prof. Boyer: We use different measurements in different parts of the organization, from the point of view of what

was the patient's experience when they were here, we use what we call a net promoter score (NPS) to see if patients received good care, would they recommend us to someone else, and if they will use us again if they needed the same care. So that's one level, and on the second level, we assess patient's symptoms and how they're feeling. We use a thing called the Edmonton Symptom Assessment System (ESAS) to look at that, and then we incorporate that into our treatment planning for that individual patient. In other specific areas, we use other quality-of-life measures to evaluate how patients' quality of life changes during the journey, and ultimately we look at patient survival. But because we've only just started just about 4 years ago, that's hard to get data about at the moment. It'll take a little longer until we have that data.

JHMHP: *Could you let us know what changes we could expect to see from the Lifehouse in the next five to ten years?*

Prof. Boyer: The first thing that I think we're going to be doing, and what we have been doing so far, is to expand our suite of services. We started off with a limited number of surgical specialties, and our most recent addition earlier this year was the addition of sarcoma and orthopaedic surgery. Neurosurgery started a little earlier. Thoracic surgery started a little while back but is growing quite rapidly now, and so we're going to see that expand and cover every area in cancer which we've now just about got to. The next thing will be, I think, growth in some of our research programs. And beyond that, I don't know. We can only deal with it one step at a time.

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(Interviewer: Bella Poon, JHMHP, jhmhp@amegroups.com)