
Leadership Conference spotlights surgeon influence

by Diane S. Schneidman, Manager, Special Projects, Communications

Approximately 100 ACS Chapter Leaders and Young Surgeon Representatives gathered in Washington, DC, June 3–6, for the 2007 ACS Leadership Conference, where they learned how to enhance their leadership skills and influence health policy. Providing the attendees with this information were members of Congress, surgeon leaders, ACS staff, and other Washington insiders. The College's Divisions of Advocacy and Health Policy and Member Services coordinated the presentation of the 2007 ACS Leadership Conference.



A view of Capitol Hill in Washington, DC.

Keys to success

ACS President Edward M. Copeland III, MD, FACS—the Edward R. Woodward Professor and chair, department of surgery, University of Florida, Gainesville—provided the keynote address at the meeting. His speech focused on lessons in leadership that he has learned during his distinguished career, including the following observations:

- The closer you get to being history, the more you learn to appreciate it.
- It is essential to encourage and practice behaviors that enhance patient safety. If a test is ordered, know the result. If a tube is inserted, be sure it's working. Talk to the patient. Be prepared for the unexpected.

- The friendship and respect of peers cannot be overstated. Be collegial with associates. Err on the side of inclusiveness, not exclusiveness.
- It is best to maximize your potential without hurting others. Remember, a career lasts a long time.
- By striving to make those around you successful, your success will grow.
- Sometimes you need to mentally change places with your colleagues. Try to see the situation from the other person's perspective, and be the spokesperson for your colleagues' opinions.
- It's important to maintain an open-door policy, but you

also need to protect time for yourself.

- You can learn as much from the mistakes of others as from their successes.
- To maintain your sense of optimism, investigate every negative event for its positive impact.
- It's good to develop an outside interest in something besides operating in which you can succeed and compete.
- Good judgment needs to be combined with influence and patience.
- The art of "skillful neglect" eliminates 50 percent of the problems a department head experiences.
- It is a privilege to have the

life of another person placed in your hands. It is a unique privilege to train those individuals who assume the responsibility for the lives of others.

Pay for performance

A prominent political topic discussed during the meeting was reimbursement and the movement toward pay for performance (P4P). Frank Opelka, MD, FACS, Chair of the ACS Patient Safety and Quality Improvement Committee and Chair of the national Surgical Quality Alliance (SQA), led a panel discussion on this concept, also known as value-based purchasing. According to Dr. Opelka, the movement toward P4P stemmed from several factors, including rising health care costs, gaps in care, the decreasing capacity for employers to offer health insurance benefits, and the increasing number of uninsured Americans.

To play an influential role in the development of P4P, the surgical community needs to generate valid outcomes measures, Dr. Opelka said. These measures should demonstrate the observed versus expected ratios for the entire operative team (not just the surgeon) and should be risk-adjusted. Under a value-based model, surgeons will need to provide evidence that they are providing “the right care at the right time for the right reason,” Dr. Opelka added. He noted that the College formed the SQA to arrive at measures that account for the unique nature of surgical services.

Debra L. Ness, MS, president of the National Partnership for

Women and Families, provided the consumer perspective, asserting that the existing health care system is failing patients. Costs are out of control, quality is inadequate, and information is scant. Furthermore, as health care spending outpaces inflation, more businesses are being forced to shift insurance costs to their employees, with the money coming out of wages and benefits. As a result, many working Americans have a hard time meeting their financial responsibilities. “Medical bankruptcies account for about 50 percent of all personal bankruptcies,” according to Ms. Ness.

Furthermore, patients have a “50-50 chance of getting the right care,” Ms. Ness said. Medical errors occur too frequently, variations in quality are evident across populations, and racial disparities continue to exist, she added.

To resolve these problems, the health care system needs greater transparency, payment reforms, and increased use of health information technology (IT). Transparency will lead to better quality of care because “what gets measured and publicly reported improves more and faster,” Ms. Ness said. Payment reform is necessary because “the current system has enormously perverse incentives,” rewarding volume instead of outcomes, she added. Health IT is essential for quality measurement and for comparative effectiveness research that will lead to evidence-based medicine and clinical guidelines.

James Cowan, MD, MPH, head of clinical programs and

operations for Aetna, Inc., provided the payor’s perspective. Dr. Cowan noted that currently, “good care” is defined on the basis of whether outcomes match expectations, medical science is applied, and resources are used efficiently. Presently, payors rely on claims-based performance measures. However, “claims-based measurement does not measure many aspects of clinical care,” such as a patient’s weight and blood pressure, and therefore it has limited accuracy, he said. In order to implement P4P, more definitive methods of measuring quality are needed. “We need your help to make this work well,” Dr. Cowan added.

Julie Lewis, Associate for Quality Programs, ACS Division of Advocacy and Health Policy, explained the Physician Quality Reporting Initiative (PQRI), which the Centers for Medicare & Medicaid Services (CMS) was preparing to launch at the time of the meeting as a likely precursor to P4P. “The PQRI is the first national program linking reporting to payment for physicians,” Ms. Lewis said. Physicians who participate in the PQRI pilot project, which is in effect July 1 through December 31, 2007, receive a bonus of up to 1.5 percent of their allowed charges for all claims reported during that six-month period.

The 74 quality measures used in the PQRI were developed by physicians’ groups and represents a great collaborative effort, Ms. Lewis noted. The American College of Surgeons developed six measures that are applicable to many surgi-



Representative Sessions



Representative Boustany



Representative Price

cal specialties. Other surgical and medical organizations that contributed to the development of the measures include the American Academy of Ophthalmology, the Society of Thoracic Surgeons, and the American Medical Association's Physician Consortium for Performance Improvement.

Members of Congress

Over the course of the meeting, seven members of Congress spoke about health system reform, reimbursement, liability, and other legislative issues of concern to surgeons.

All of the representatives who participated in the meeting agreed that the current health system is in critical need of reform and that the nation cannot continue operating under the status quo, but they differ in their opinions about how best to resolve the problems. Rep. Pete Sessions (R-TX) said the main argument

is over whether the nation should adopt a single-payor or consumer-driven system. "I happen to be one of those who don't believe universal health care that follows a single-payor model would be good at all," he said. Instead, he favors a consumer-driven approach that would provide tax cuts and incentives for people to pay for their care. "People need affordable care with an emphasis on prevention," Representative Sessions added.

Other members of Congress echoed Representative Sessions' views on health system reform. Rep. Charles Boustany, MD, FACS (R-LA), said, "We should open the insurance market and open it widely." He also said he believes consumers should have access to information that will help them to make wise decisions about their care. "Families should be able to take control of their health care" and should be given

incentives to invest in health savings accounts.

Similarly, Reps. Tom Price, MD, FACS, and Phil Gingrey, MD, both Republicans representing congressional districts in Georgia, endorse a consumer-driven system. "A government-run system would be a disaster for medicine," Representative Price said.

However, other members of Congress, including Pete Stark (D-CA), Chair of the House Ways and Means Subcommittee on Health, question the effectiveness of a market-driven system. "I don't think it will save us money to go with a market-driven system," Representative Stark said. Instead, he favors incremental movement to a universal health care system that builds on Medicare.

Reps. Earl Pomeroy (D-ND) and Bart Gordon (D-TN) stopped short of offering any specific proposals regarding health system reform and in-

stead encouraged the meeting participants to offer suggestions to their members of Congress. "When it comes to health care, you're the experts," Representative Pomeroy said. "We have got to figure out how we heal a system that is unsustainable in its current condition. We can all agree on that," he added.

Members of Congress also expressed their concerns about Medicare reimbursement and the use of the sustainable growth rate (SGR) to calculate updates, agreeing that the methodology is ill conceived. Several members of Congress, however, said that the 9.9 percent reduction in physician Medicare payment scheduled to take effect in January 2008 probably will be delayed. "My suspicion is we will kick the can down the road another year or two," Representative Price said. He also said that the long-term fix to the SGR is fundamental reform of the Medicare payment system.

Representative Stark also predicted that the 9.9 percent payment reduction was unlikely to occur next year. "We'll probably postpone cuts in their entirety for a couple of years. It's a zero-sum game at this point," he said.

"We should eliminate the SGR all together," Representative Pomeroy said. "This has become a problem too big to fix."

Most of the Congressmen also suggested that expanded use of electronic medical records and quality measures would be useful in reducing costs, improving patient safety, and making the move to P4P.

"Electronic medical records are hugely, hugely important, and the President has pushed for [their use throughout the nation]," Representative Gingrey observed. "They save lives and save money" by reducing the likelihood of errors.

The health care system needs to be more efficiently run, and health IT is one possible mechanism for achieving that goal, added Representative Gordon, who chairs the House Committee on Science. However, at this point, there are concerns about the interoperability of IT systems and patient privacy.

Representative Stark and other members of Congress who spoke at the meeting also noted that physicians should receive some reimbursement for making the move for electronic medical recordkeeping. "Then maybe we can start a P4P system" and more accurately measure quality of care, he added.

"Quality is extremely important," Representative Price added. However, he warned that it is very important to consider who is defining it. "Only specialty societies can define quality," he added.

In addition, the members of Congress addressed the emergency surgical care issue. Representative Sessions noted that, "Our emergency rooms are backed up with people who don't have insurance," and this reality is putting financial strains on the entire health care system.

To help reduce the trends that are affecting patients' ability to receive quality emergency care, Representatives Sessions and Gordon have introduced

the Access to Emergency Services Act of 2007, H.R. 822. The bill calls for the creation of a national bipartisan commission to examine the factors impeding the delivery of care in U.S. emergency departments, Representative Gordon explained. In addition, the legislation calls for increasing physician payments for services provided to Medicare beneficiaries under the Emergency Medical Treatment and Active Labor Act.

The congressmen also discussed medical liability reform. Representative Gingrey said he has introduced a bill containing provisions that are similar to those in California's Medical Injury and Compensation Reform Act. He is looking for bipartisan support to ensure passage of the legislation. Representative Gordon said that he has supported medical liability reform bills in the past, but did not get the sense that the Congress was making any real effort get the law enacted. "We have to think outside the box on this," Representative Gordon said. "Let's look at what is going on in the states" to find alternatives.

In addition to addressing issues of concern to surgery, the representatives gave the meeting participants some advice about how to talk about their concerns to their elected officials during meetings and on political advocacy in general.

Representative Price said that surgeons should always start their conversations with a focus on the patient, using phrases such as "I can't take

care of my patients because...,” or “My patients can’t get proper care because....”

“The most important component [of political advocacy] is to make sure that you know your member of Congress and that your member knows you and what you do,” Representative Sessions added.

“Be patient with us. We welcome your advice,” Representative Stark said.

Inside Congress

Judy Schneider, a policy analyst with the nonpartisan Congressional Research Service, reprised her entertaining and educational presentation from the 2005 Leadership Conference. Once again, she provided insights into how Capitol Hill operates and how surgeons can influence the legislative process.

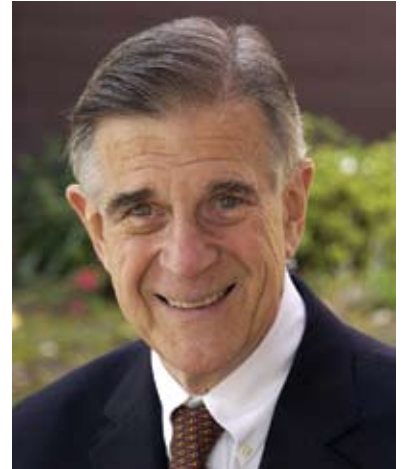
“Congress was not created to pass law, but to prevent bad law from getting enacted,” according to Ms. Schneider.

Three factors drive Congress—policy, politics, and procedure. “The Senate is a very political chamber,” Ms. Schneider said, adding that committee chairs are often selected on the basis of seniority, rather than knowledge of policy. Fortunately, “The committee system is not as integral to the [Senate’s] legislative process as you would think,” Ms. Schneider said. “Most work is done on the Senate floor.”

On the Senate floor, all senators are equal. “The Senate lives and dies by two words: unanimous consent,” Ms. Schneider said. Debate on the Senate floor ends when the



Representative Gingrey



Representative Stark



Representative Pomeroy



Representative Gordon

chamber is able to invoke cloture, which process “entails 60 senators voting to tell you to shut up,” she added.

“As unimportant as the committee system is for the Senate, that’s how important it is in the House,” Ms. Schneider added. “The House lives and dies by rules and procedures.” In the

House, she said, committee and subcommittee hearings often are staged “to get America riled up.” As a result, we now witness “celebrity hearings” on a regular basis. “America responds to celebrity. I’m not saying it’s right or wrong, but it’s a statement of fact,” Ms. Schneider noted.

Most importantly, representatives are sent to Washington to develop policies that serve the interest of the constituents of their districts. "House members have to do the right thing for the people back home," Ms. Schneider said. "If you don't tell them what to do, somebody else will," she added.

Ms. Schneider encouraged the meeting participants to be resolute in their discussions with members of Congress and to not be intimidated by their power. "Most [senators and representatives] are very average people whom we have asked to do a very difficult job," she added.

ACS advocacy staff

Christian Shalgian, Manager of Congressional Affairs in the ACS Division of Advocacy and Health Policy, briefed the participants on the issues being discussed in Congress that are of greatest concern to this organization.

Topping the list is Medicare reimbursement for physicians' services and the scheduled 9.9 percent reduction in payment beginning in January 2008. According to Mr. Shalgian, Medicare physician payment will be cut 41 percent between 2008 and 2016 if the SGR remains in place, adding that Congress has the following three options for addressing the pay cut: Do nothing and let the reduction go into effect, stop the cut in 2008 and for another year or two thereafter, or enact full-blown reform. While the latter alternative may seem most appealing, overhauling the Medicare reimbursement sys-

tem will cost the nation \$250 billion, he said. The College's message on Medicare payment is that Congress should stop the pay cut and enact large-scale reform to preserve patient access to quality care.

One mechanism for replacing the SGR that has received widespread consideration in Congress, CMS, and the Administration is pay for performance. "This is not going away. We are not going to be able to stop this train," Mr. Shalgian said, noting that CMS is already setting the stage for P4P through pilot testing of the PQRI.

Other federal issues of concern to the College include stagnant funding for cancer research, the expense surgical practices will incur when adding health information technology, funding for graduate medical education, trauma systems development, the overburdened emergency workforce, medical liability reform, and expanded scope of practice for nonsurgeons, Mr. Shalgian said.

Mr. Shalgian offered further advice for those meeting participants who were planning to visit their legislators' Capitol Hill offices during the conference. He warned that many meetings will take place with a senator's or representative's health aides, rather than with the actual member of Congress. "Do not dismiss congressional staff," Mr. Shalgian said. These are the people who often tell the member how to vote.

He also told participants to follow up on their visits to Capitol Hill. "[Advocacy] is all about relationships—relationships with staff and members

of Congress," Mr. Shalgian said. "You want them to use you as a resource for information on health policy."

Jon Sutton, Manager of State Affairs, and Melinda Baker, State Affairs Associate, Division of Advocacy and Health Policy, presented an overview of state legislative issues. Specific state-level matters of concern to the College at this time include changing requirements for maintaining state licensure, certificate of need requirements for surgeons who operate ambulatory surgical centers, liability, provider taxes, and expanded scope of practice for nonphysicians, Mr. Sutton said.

Ms. Baker explained how the ACS State Affairs staff can help chapters and College members bring about change at the state level. First, they are available to speak at chapter meetings on specific issues as well as advocacy skills. State Affairs staff also can be instrumental in planning a day at the state capital, developing and promoting a position on a bill, and preparing testimony, Ms. Baker added.

Leadership development

In addition to the sessions on advocacy and health policy, the conference comprised three concurrent sessions on various aspects of leadership skills.

During one workshop, Stephen R. T. Evans, MD, FACS, professor and chair, department of surgery, Georgetown University Hospital in Washington, DC, talked about change in institutional environments. According to Dr. Evans, change entails conquering technical

and adaptive challenges. Technical challenges are tangible and amenable to authoritative expertise and standard operating procedures. Adaptive challenges, which represent 90 percent of the obstacles that leaders face, are more complicated and call for changing people's values, attitudes, and behaviors. These transformations require experimentation, discovery, and adjustment, Dr. Evans said.

To effectively bring about change, leaders should make observations, ask questions, offer interpretations, and take action. Dr. Evans noted that surgeons often skip the middle steps and go directly from making observations to taking actions. Effective leaders "let the issue ripen," he said. They ask what's on other people's minds, gauge how deeply people are affected by the problem, and consider what other authorities are saying and doing.

Surgeons have the potential to be effective leaders because they are intelligent, tenacious, hard-working, empowered, high-profile individuals, Dr. Evans said. Furthermore, they identify and fix problems every day. On the other hand, some surgeons possess characteristics that work against their viability as change leader. They consider themselves among the intellectual elite and see the world as black and white. These individuals are often seen as too busy, resistant to change, dissatisfied with their careers, and egocentric, he noted. The strongest leaders, according to Dr. Evans, demonstrate personal humility and professional



Representative Reed



Dr. Warshaw

will. They are driven to make their institutions or organizations great, and they attribute success to those around them and failure to themselves.

"Real leadership—the kind that surfaces conflict, challenges long-held beliefs, and demands new ways of doing things—causes pain," Dr. Evans warned. "When people feel threatened, they take aim at the person pushing for change. As a result, leaders often get hurt both personally and professionally," he said.

Mary E. Maniscalco-Theberge, MD, FACS, a general surgeon in Reston, VA, and Past-President of the Metropolitan Washington Chapter of the College, and John H. Armstrong, MD, FACS, of University of Florida, Gainesville, addressed the issue of engaging young surgeons in the profession. "We as leaders need to be passionate about what we do," including efforts to bring young people into the fold, Dr. Maniscalco-Theberge said.

Today's surgeons of the future

are members of Generations X (born between 1965 and 1977) and Y (born between 1978 and 1995), she said. Members of Gen X focus on productivity in the workplace, are motivated by time off, have a low sense of loyalty to the company, view money as a means to an end, and value time with their families. They thrive on change, work fast, are straightforward, are not intimidated by authority, do not like structure, multitask, and achieve goals on their terms. They want "direction without dictation," Dr. Maniscalco-Theberge observed.

Members of Gen Y have been raised during times of considerable prosperity and globalization, and their parents, mostly Baby Boomers, showered their children with attention and high expectations. As a result, members of Gen Y tend to have a great deal of self-confidence. Because they grew up in the computer age, they are fluent in technology. They expect structure in the workplace,



Kansas Chapter visitors to Capitol Hill. Left to right: Tyler Hughes, MD, FACS; Carlo Chan Jurani, MD, FACS; Charles (Chip) Wheeler, Executive Director; and David George Pauls, MD, FACS.



New York visitors to Capitol Hill: Michael O. Bernstein, MD, FACS, Brooklyn-Long Island Chapter; and Evan Geller, MD, FACS, Eastern Long Island Chapter.

acknowledging and respecting chain of command; prefer to collaborate; and are highly tolerant of social and cultural differences. They like clear instructions and deadlines and thrive on their mentors' approval, Dr. Maniscalco-Theberge said.

In short, the members of the generations just entering or considering a future in surgery are very different from the surgeons who are heading the departments of surgery, looking for younger partners, or training residents. "It's not the way it's always been, and we need to get over it," Dr. Maniscalco-Theberge said. "We cannot make them be like us, but we can all have the same shared goal of providing the best patient care," she added.

"In many senses, we are herding cats," in the effort to engage

young members of the profession, Dr. Armstrong said.

Before an organization or institution can effectively recruit new members, it needs to know itself, Dr. Armstrong said. Ask some basic questions: What does your organization do? What's your focus? What is your mission? What is your "brand"? Who do you serve? Dr. Armstrong suggested conducting market research to find out what the organization's members and prospective members think about the organization.

To build and sustain membership, an organization needs to forge a relationship with its members. The strength and longevity of this connection depends on the organization's ability to communicate with members, offer meaningful activities, and create a commu-

nity of trust. "Recruitment is only the beginning. Retention is where the rubber meets the road," Dr. Armstrong added.

In addition, Patricia A. Clark of Communication Strategies in Ogden Dunes, IN, led a session on how surgeons can communicate effectively with the media and the public. Some tips that Ms. Clark provided include the following:

- Have an objective in mind before responding to any question.
- Anticipate difficult questions and be sure you understand the question before answering. Ask for clarification if necessary.
- Before answering a question, correct any misinformation, misstatement, or incoherent assumptions on the part of the individual posing the query.

• Don't be afraid to say, "I don't know."

• Monitor your body language and maintain eye contact.

- Be succinct and direct.
- Be a good listener.
- Avoid jargon.

Other events

The program also included a reception on Capitol Hill. Sen. Jack Reed (D-RI) spoke

at that gathering, welcoming the surgeons to Washington and providing words of encouragement for their efforts on Capitol Hill.

Subsequent to the meeting, the College awarded the Arthur Ellenberger Award for Excellence in State Advocacy to Andrew L. Warshaw, MD, FACS, from Boston, MA, for his many years of advocating for patients and for the surgical

profession. Traditionally, this award is presented during the Leadership Conference; however, Dr. Warshaw was unable to attend the meeting because of scheduling conflicts.

Finally, the meeting concluded with the chapter leaders and young surgeons visiting the Capitol Hill offices of the respective members of Congress to advocate on surgery's behalf.

Papers being accepted for 2008 Resident Trauma Papers Competition

The ACS Committee on Trauma (COT) is now accepting papers for the 2008 Resident Trauma Papers Competition, which will be held during the COT's annual meeting March 13–15, 2008, in Washington, DC.

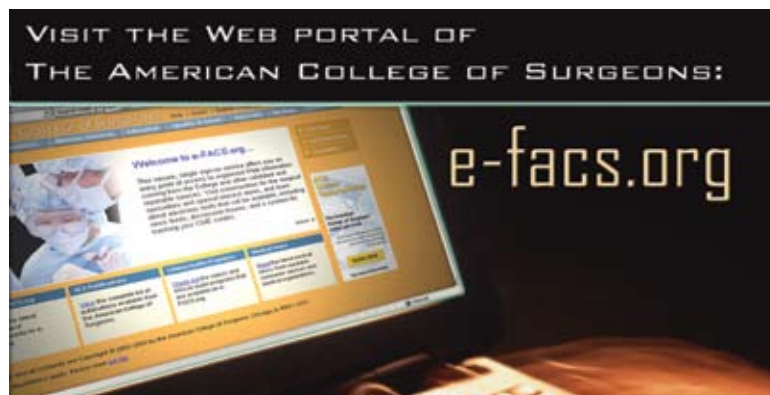
The Resident Trauma Papers Competition is open to general surgical residents, surgical specialty residents, and trauma fellows. The papers should describe original

research in the area of trauma care and/or prevention, categorized as basic laboratory research or clinical investigation. Papers should be sent to the appropriate ACS state/provincial chair. The list of chairs' names can be found at <http://www.facs.org/trauma/regional.html>.

The papers competition has been funded by the Eastern and Western States COTs, Region 7 COTs, Wyeth Phar-

maceuticals, and the American College of Surgeons.

Deadline for submission of papers to the region chief is November 14, 2007. Further information can be obtained on the ACS Web site at <http://www.facs.org/trauma/traumapapers.html> or by calling Bridget Blackwood, ACS Trauma Programs Coordinator, at 312/202-5380 or e-mail bblackwood@facs.org.



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