

The Leadership Forum

a publication from the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM)

From the Editors Hello, Forum Readers!

We write this column from the SGIM Annual Meeting in Denver, Colorado, where we have spent several exciting days learning about leadership, discovering important work in the field of General Internal Medicine, meeting new colleagues, and catching up with friends. Our

time there has left us with a renewed sense of energy and passion for editing *The Leadership Forum*—the voice of ACLGIM. In this issue, we offer an interview with Dr. Cynthia Chuang, work from the Summit on retaining leaders of high potential, and from the Hess Institute—advice on leading

in complexity. We hope that you enjoy this issue, and the start of a new academic year.

—Neda Laiteerapong, MD, MS, FACP, and Elisha Brownfield, MD, FACP
Editors, ACLGIM *The Leadership Forum*



Neda Laiteerapong Elisha Brownfield

Perspectives on Leadership An Interview with Cynthia Chuang, MD, at the Winter Summit

Neda Laiteerapong, MD, MS, FACP



Cynthia Chuang

Dr. Chuang (cchuang@pennstatehealth.psu.edu) is professor of medicine and public health sciences and chief of the Division of General Internal Medicine at the Penn State University College of Medicine.

How did you get to be the division chief at Penn State?

To be honest, I never aspired to be a division chief, but it is a position I now love. After completing the general internal medicine fellowship at Boston University, I came to Penn State 14 years ago for my first faculty position and to pursue a clinician-researcher career. I subsequently got a K award and NIH and PCORI funding. That was a good career. I was doing well as a researcher and got promoted to associate and full professor.

Success in research opened the door for other opportunities for me.

Doing well at one thing leads people to assume that a person could do well at something else, which is not always true. When the prior division chief got another opportunity, my department chair at the time told me that I would be the right internal candidate for the job. That wasn't part of my plan. I hadn't done any leadership/managerial

training and there were a lot of relevant skills that I didn't possess. On the flip side, I had been in the division long enough that I knew the faculty and staff well, understood their needs, and wanted to be their advocate. I understood many of the struggles division members were having—and felt like these were things I could tackle. After a lot of soul searching and negotiations with my family, I actively sought out formal and informal leadership training and proudly accepted the position.

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Perspectives on Leadership

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Your scenario is probably very unusual. How did you prepare yourself to be division chief?

There was no external search conducted for the division chief position—frankly, I was appointed by the department chair, which made me rather uncomfortable. Although I knew I had the support of my colleagues, I believed I owed them the opportunity to evaluate me. Thus, I met with about 20 faculty members and asked them to interview me. I was also data gathering, looking to understand what people thought the next division chief should be doing. I also met with other division chiefs in the department for their advice and to understand their views of the division of general internal medicine. Through

that process, I learned a lot about what people loved and didn't love in our division. By asking for everyone's input, I got buy-in. I ultimately also gave a "job talk" to the division so I could present a preliminary vision.

At the Winter Summit, you've led a discussion on Addressing Women's Leadership Growth. How'd you get interested in this topic?

I am a women's health and reproductive health researcher, so equal rights for women has always been an important issue to me. However, if I had been asked as a medical student if women had the same opportunities as their male colleagues in medicine, I may have said yes. My medical school and residency classes were half men, half women. I was not aware of any unfair treatment at the time. But in the last couple of years, I now see inequity all the time. It is very distressing. I haven't yet been able to figure out whether things have gotten worse or if I just wasn't paying close enough attention before. I am curious what others think of that.

So it sounds like your view has changed over the years. What's changed your view?

I see a lot of microaggressions that may not be obvious to everyone. As division chief, I have often found myself as the only woman in a meeting, and it has been hard at times to get the attention of the group to say, "Hello, I have something to say." I've seen women both in and out of the division treated inappropriately—both men and women physicians commonly encounter unprofessional interactions when talking with consultants, but I find them to be more commonplace with the female faculty. These incidents often involve young, female faculty members and it affects their ability to find joy in what they do. I also see that female medical students and residents are treated inappropriately much more often than one might expect, and it not often handled appropriately, in my opinion. In other departments, I have seen junior faculty women lose opportunities because they wanted to work part-time opportunities or have

maternity leave. We should have overcome these types of issues by now, but unfortunately, we have not.

A topic that is brought up a lot recently is the fact that the number of women in leadership in academic medicine has been flat over the last decade. What are your thoughts on the causes of this problem?

There's good literature on implicit bias, which may be the cause. Deans, members of the C-suite, and department chairs, who are often men, may have a harder time including people of different backgrounds when hiring into leadership positions. People feel more comfortable hiring and working with people who may look like and think like them. Also, women are often not being taught to think of themselves as leaders, perhaps because they are not seen as many women leaders in their institutions so they may not seek out leadership positions.

... women are often not being taught to think of themselves as leaders

Even in my situation, I had not prepared myself for a leadership position because I hadn't really considered it as a career path for myself. This problem of course exists for both young women and men—many leaders in academic medicine have not received formal leadership training.

What do you foresee for the future of women in academic medicine? Do you think the trends will change?

The trends will change if we proactively work toward advancing women in academic medicine. A senior faculty member that I greatly admire in my division told me a while ago that I would make a great division chief and he would love to work for me. His comment made me laugh and I didn't take him seriously. After he told me that again repeatedly over the next couple of years, I finally realized he was serious and I came to believe him. I challenge SGIM members to find the future GIM women leaders that they work with, and start telling them that they look forward to working for them one day.

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Words of Wisdom

High Potentials: Challenges and Strategies to Promote Talent in Your Organization

Carlos Estrada, MD, MS, and Molly B. Conroy, MD, MPH

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New ideas and talented people who can both innovate and get things done are vital to the success of academic medical centers. Drawing an analogy with air travel, a high-potential faculty member is akin to a competent pilot who ensures a smooth onboarding process, prepares for the flight, and makes a successful landing. High potentials have already

shown their ability to get things done well by completing a few short-distance flights. As leaders, we want such individuals to be prepared to fly longer flights, find new routes, and continue to land successfully. However, individual and institutional barriers may prevent this.

A group of approximately 50 GIM leaders from around the country dis-

cussed challenges and strategies to promoting and retaining high potentials at the 2017 ACLGIM Winter Summit. The scope was limited to existing “junior to mid-level” faculty in divisions or departments. Using a facilitated process that builds on individual and collective generation of ideas, the leaders created the following list of challenges and solutions:

Challenges	Solutions
Clinical pressures for productivity and clinical tracks without a pathway for promotion	<ul style="list-style-type: none"> • Mentoring • Structured annual reviews • Find/point to opportunities (ex: teaching, allow shadowing in your practice)
Low visibility of some high potentials to leaders, or poor recognition of their own potential	<ul style="list-style-type: none"> • Be deliberate about identifying high potentials and ask for help • Identify strengths, interests, and passions. Use tools like the Meyers-Briggs, Strengths Finder, and DISC • Look inside and outside your inner circle (avoid “parochialism”) • Incentivize your leaders to sponsor/mentor junior faculty (tap into intrinsic motivation, raise funds to support travel/recognition) • Create an ACLGIM “visiting professor” program for high potentials
Limited opportunities available at the present time	<ul style="list-style-type: none"> • Convey a strong message, “I want you!” • During the process, prepare and equip self and faculty with future expectations • Align with current/ potential opportunities—something will emerge (people retire, get promoted, etc.)
High potentials may leave, and attempts to retain may create a sense of unfairness among other faculty	<ul style="list-style-type: none"> • Identifying levers for Intrinsic motivation (Drive, Daniel Pink) • Reframe definition of “favorites” (“Yes, I play favorites, Do you want to be one?”) Coach and provide feedback • Perform a 360° evaluation—allows moving to self-reflection and actionable items • Revisit fairness with the faculty—the support requested by someone who is thinking about leaving may help increase support for others • Educate about existing resources, if the high potential wants more that cannot be provided, will help find the best job elsewhere
Biases that create and perpetuate disparities for women and URM minorities	<ul style="list-style-type: none"> • Acknowledge, track, and be deliberate • Employ advocacy and sponsorship • Help faculty to recognize their own potential • Involve all faculty in solutions

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View from the Hess Institute 2018 Leadership in Complexity—Succeeding in the Setting of Unknown Unknowns

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Our environment in academic medicine has become more complex, volatile, and unpredictable, with both external and internal forces driving complexity. As such, the skills for leadership have changed, requiring more adaptive thinking and abilities. Complexity is the domain of unknown unknowns. That is, cause and effect cannot be known in advance; interactions among system elements are nonlinear and tightly coupled such that small changes can produce disproportio-

tionately large effects. Solutions emerge from the dynamics within the system and cannot be imposed from outside with predictable results.

Traditional leadership relies on alignment and control with change efforts driven from the top down, with the assumption that a future state is knowable. The traditional job of the leader is to focus on the gap and steps required to close it by employing vision, strategy, critical steps and milestones, bringing to bear analysis, ex-

perts, and data. In the setting of complexity, the job of the leader is to mind the system rather than mind the gap. The leader sets boundaries and charts a direction, but not a destination, focusing on possibilities rather than probabilities, encouraging and fostering experimentation.

Our role as a change leader in the setting of complexity is to help others make sense of what is going on around them, allowing emergence rather than defining solutions *a priori*.



Call for New Editorial Board Member

The ACLGIM Leadership Forum is the quarterly publication of ACLGIM, which updates and informs leaders in General Medicine of healthcare policy trends and management skills useful in their leadership roles in academic medicine, clinical care, research and teaching.

Responsibilities include: With the Editor and Associate Editor, guide and secure the quarterly publication of the Forum (about 4 articles/ issue; 2,000 words total/ issue).

Over the three year term, the board member will rotate through the associate editor and editor positions.

Interested? Please send CV and a brief 100-200 word statement of interest to Jillian Gann at gannj@sgim.org by July 15, 2018.

Contact Jillian Gann at gannj@sgim.org for more information.
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