

The Leadership Forum

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

From the Editor Hello, Forum Readers!

March is an exciting time of year for ACLGIM!

Ideas from the Winter Summit are being enacted and final arrangements for the Hess Institute are being made. In this issue, we highlight Eileen Reynolds' forthright account at the Winter Summit of her work promoting equity and transparency in leadership, which serves as a model for other institutions.

Also, with an eye toward the SGIM Annual Meeting theme, Thomas Payne summarizes his Winter Summit talk that argues for why SGIM members should lead the field of health informatics. In addition, we asked Lyle Dennis, who works with SGIM's Health Policy Committee, to tell us why ACLGIM members should be involved in health policy. Finally, we asked Robert Rock, a

fourth-year medical student, to describe a unique integration of art and medicine to discuss diversity.

We hope you enjoy the articles as much as we do and look forward to seeing you in Denver!

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



Neda Laiteerapong Elisha Brownfield

Report from the Winter Summit Equity and Transparency in Leadership

Elisha Brownfield, MD, FACP

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How do you approach equity and transparency in leadership within academic medical centers? For Dr. Eileen Reynolds, Immediate Past-President of SGIM and Chief of the Division of General Medicine and Pri-

mary Care at Beth Israel Deaconess Medical Center in Boston, answering this question has been a multi-year journey, which she presented at the ACLGIM Winter Summit. Reynolds and her team reviewed the evidence

and found that women in academic medicine have the same career aspirations as male counterparts, yet are promoted more slowly and are paid less than men for the same job.

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Eileen Reynolds

Report from the Winter Summit

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Women are equally as likely as men to get their first NIH award, but less likely to submit another; collaborate with larger teams; to be called “Doctor” less in Grand Rounds introductions; and, are underrepresented in academic medicine leadership.

In spring 2014, a group conversation with a visiting professor catalyzed an evaluation of gender equity in the Department of Medicine at Beth Israel Deaconess Medical Center. The Department chair openly addressed concerns, and tapped Dr. Reynolds in her role, as the new Vice Chair for Education, to explore the Department’s gender parity climate and develop plans to address issues. An initial exploration started with faculty “listening

sessions” attended by the chair and data collection from the department. The administration of an anonymous, validated survey with nationally normed data designed to assess the culture and existing practices in academic medical centers (C-Change Survey: <http://www.brandeis.edu/cchange/surveys/cfsdescription/index.html>) was conducted among both women and men faculty.

The department formed the Committee on Advancement of Women in spring 2016. The group analyzed the data, and created a summary of requests and recommendations to improve equity for faculty members. As a result of the group’s requests, a salary equity assessment was conducted by an independent accounting firm; job descriptions are being standardized; unconscious bias training is now conducted for all leaders; and, improvements have been made to the parental leave policy. The department also proposed a new policy on faculty meeting times requiring that no department-wide meetings occur before 8:00 a.m. or after 5:00 p.m. Promotion counseling and readiness assessment for all faculty are being augmented, and division chiefs received training on institutional promotion practices. To coincide with “Women in Medi-

cine” month, the committee created a celebration of the history of female faculty members. New pictures of these leaders have been hung prominently on walls previously dominated by pictures of men. To address the concern about lack of access to leadership positions, the department now requests transparency for every leadership opportunity that involves a title, budget or leadership role. These openings are now publically posted with a clear written job description and a defined selection process.

Dr. Reynolds highlighted some of her lessons learned. She noted that this process has been time consuming for all leaders and staff. As with all major changes, there is a constant need to train new faculty and variable commitment of faculty to the effort. Dr. Reynolds stated that the major culture change is slow but palpable. Faculty have come to expect transparency, and a new gender equity dashboard is being created with data about faculty demographics for leadership roles, new hires, committee composition, speakers, awards, and faculty departures. While there is more work to do, Dr. Reynolds feels that the effort has been successful in creating positive steps to enhance gender equity in her department.



Thomas Payne

Report from the Winter Summit Health Informatics: A New and Growing Field

Thomas Payne, MD, FACP

Dr. Payne (tpayne@u.washington.edu) is the medical director of information technology services and professor of medicine at University of Washington Medicine. He also is the past chair of the American Medical Informatics Association.

Health information technology (IT) and health informatics may seem to be synonymous, but they differ: One provides the technology and the other provides theory and approaches to manage health information to yield benefits in clinical outcomes. The following are three reasons I’m opti-

mistic about our ability to benefit from the growing volumes of information available in clinical care:

1. more natural user interfaces to gather information include use of voice, coupled with automatic

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- speech recognition and natural language processing to extract meaning from natural language.
- managing this growing volume of information will also improve so we are not overwhelmed. A simple example of how this is now occurring is likely available today in your electronic health record (EHR)—the ability to search for concepts in a patient’s record. Searching for “dyspnea” will find notes where albuterol and an echo showing aortic stenosis are mentioned. How is this possible? Because the notes (and labs, and other data) were tagged with SNOMED CT terms, and the SNOMED concept network leveraged to link the concept behind dyspnea with related, clinically important concepts.
 - truly helpful decision support exists today and is growing. We can match patterns of findings with conditions to be considered in the differential diagnosis. We

can identify stable patients who may not remain stable, for early intervention.

These examples highlight why the field of health informatics is much more than health IT. Semantic networks, Bayes’ theorem, the user interface, the complexities of workflow, and the human experience of care are all part of informatics. There is now a subspecialty of clinical informatics for those devoting their careers to informatics.

I encourage you learn more about it.



Lyle B. Dennis

Words of Wisdom

Why ACLGIM Members Need to Stay on Top of Public Policy

Lyle B. Dennis

Mr. Dennis (ldennis@dc-crd.com) is a partner at Cavarocchi-Ruscio-Dennis Associates, LLC, in Washington, DC.

At the outset, I want to say what a pleasure it was to meet so many of you in person at the Winter Summit. While I have met and worked with those of you involved in the SGIM’s leadership or with the Health Policy Committee, I was especially pleased to speak with so many of you for the first time.

So, why should public policy matter to leaders in general internal medicine?

Suffice it to say that nearly everything that leaders in general internal medicine do is impacted in some way by the federal government, and many actions are also impacted by state governments, such as the following:

- For researchers, the funding levels for AHRQ, NIH, VA research, and even the defense health research programs all matter.
- For educators, the many health professions-related programs that are funded through HRSA can have a positive impact on their day-to-day work; and,
- For clinicians, the policies that are adopted by the Center for Medicare and Medicaid Services (CMS) determine coverage,

payment, and other parameters of caring for patients.

While all this matters, you all have “day jobs” that command your attention. How can you keep up?

SGIM makes a number of resources available to you that cut through a lot of the noise and focus in on the things that make a difference for you. In addition to this publication for chiefs and leaders:

- E-News** is published every two weeks and contains a wide-variety of news important to SGIM members, including frequent articles about health policy, Capitol Hill Day, and other related matters.
- HP Update** is published in the week between editions of E-News. It is written by either Dom Ruscio, Erika Miller, or me and focuses on very specific items related to health policy and is often paired with a call to action through SGIM’s *CongressWeb* software.
- SGIM Forum**, published monthly, often contains articles written by the chairs or members of the Health Policy Committee’s

subcommittees that deal with clinical practice, education or research.

- The **All-Member Forum**, located on GIM Connect, gives all members the opportunity to engage in a robust discussion of current policy issues, particularly those that may be of personal interest to the member.

The leadership of SGIM and ACLGIM have recognized the critical importance of health policy and its impact on its members’ work lives. All of the resources listed above will help add to your comfort in addressing health policy issues. In addition, you have a unique opportunity that many more members can take advantage of. Sign up to participate in one or more of the Health Policy Committee’s subcommittees’ monthly conference calls.

SGIM has many of the leading experts in the nation on these calls—and many rank-and-file members who are the next generation of leaders. We strongly encourage participation to generate a broad diversity of opinions to maximize the impact of general internal medicine on health policy.



Robert Rock

Words of Wisdom

Making the Invisible Visible: Art, Identity, and Hierarchies of Power

Robert Rock, Cyra Levenson, EdM, and Cindy Crusto, PhD

Mr. Rock (Robert.Rock@yale.edu) is a fourth-year medical student at the Yale School of Medicine (YSM), and co-creator and co-facilitator of the Making the Invisible Visible art tour, which has been incorporated into the mandatory curriculum at the YSM in New Haven, CT. Ms. Levenson (CLevenson@clevelandart.org) is director of education and academic affairs at the Cleveland Museum of Art, whose research interests include critical pedagogy, creativity and cognition, visual literacy, and object-based teaching. Cleveland, OH. Dr. Crusto (cindy.crusto@yale.edu) is an associate professor (psychology section) and assistant chair for diversity in the Department of Psychiatry, YSM, and director of program evaluation and child trauma research at The Consultation Center, New Haven, CT.

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In a healthcare system plagued by racial and ethnic inequities in outcomes, creating effective solutions requires engagement with a diversity of perspectives. This belief in diversity as an engine for innovation guides *Making the Invisible Visible: Art, Identity, and Hierarchies of Power (MIV)*—a three-hour art tour where Yale School of Medicine medical trainees explore the social, cultural, and historical context of the perpetuation of bias in Western society as a framework for discussing bias in patient-provider interaction.

Prejudice is not unique to medicine, but the beliefs that individuals bring to the profession serve to perpetuate or dismantle the culture sustaining our unjust system. Addressing bias within medical education is critical because of the power academic institutions hold over access, research, and healing in society.¹ The designers of MIV seek to increase awareness of flawed understandings by exploring the prevailing biases within the groups controlling access to institutional leadership, curriculum content, and to the profession out-

right. Communities from across the university are leading the way in breaking down the walls isolating medicine from a national discussion. At the Yale School of Medicine, MIV is one foray into creating space for critical discussion that will spark the necessary unlearning required to promote justice in practice and society.

References

1. Hoberman J. Why bioethics has a race problem. *Hastings Center Report*. 46:12–18.doi:10.1002/hast.542.