

The Leadership Forum

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

"To be the voice of ACLGIM and communicate about leadership challenges and solutions in academic medicine to members, the SGIM community, and other stakeholders."

Editorial Corner From the Editors

Elisha L. Brownfield, MD; David Margolius, MD; Maureen Lyons, MD



Elisha Brownfield David Margolius Maureen Lyons

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Welcome *Leadership Forum* readers to 2019! Although we are now a few months into the new year, we continue to reflect on our time at the ACLGIM Summit back in December by bringing you some highlights from that meeting. Keynote speaker Dr. Nancy Spector, executive director of the Executive Leadership in Academic Medicine (or ELAM) program, addressed gender equity in medicine leadership. Drs. Abi-

gail Lenhart and James Clements discussed their Division of General Internal Medicine's approach to addressing physician burnout. We bring you reports from these talks as well as perspectives in philanthropy from Jim Hodge at the University of Colorado School of Medicine. In addition to keynote sessions, attendees at the Summit participated in interactive breakout sessions and Drs. Kathryn

Teng and Peter Cram summarize theirs on promoting diversity. As we draw closer to the national SGIM meeting (May 8-11, 2019) we are also thinking about leadership models and opportunities within our larger organization. We interviewed Dr. Bennett Lee, past chair of SGIM's Board of Regional Leaders, for his perspective.

Happy reading, and we hope to see you all in Washington DC!

Leaders in Action An Interview with Bennett Lee, MD

Dr. Lee (bennett.lee@vcuhealth.org) is a past chair of the Board of Regional Leaders for the Society of General Internal Medicine (SGIM) and the ambulatory clerkship director at Virginia Commonwealth University School of Medicine.



Bennett Lee

There are many leadership positions within SGIM, one of which is membership on the Board of Regional Leaders. Dr. Bennett Lee sat down with the *Leadership Forum* for an interview during the SGIM Annual Meeting in the spring of 2018.

1. Can you describe the role of the Board of Regional Leaders (BRL)?

Since I have been on the board, I have seen the role evolve. Over the past two years, the board has shifted its focus from the sharing of best practices among the regions, to

looking strategically at goals for the regional meetings and creating better synergy with those for national SGIM. The board also serves as an incubator for new ideas and allows the regions to have two-way communication through the SGIM National Council.

2. How did you end up being involved on the Board?

When I was serving on the Board as the president of the Southern region, there were a lot of changes going on and I was interested in the work we

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Leaders in Action
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were doing. I also wanted to learn more about the governance of regions, and the council, and how that worked. Dan Tobin asked the current presidents who would be interested in serving as the chair, and I threw my hat into the ring.

3. What else should our readers know about the BRL?

This is an incubator for our future SGIM leaders. This is a group with a lot of po-

tential, and we need to talk about developing leadership skills for this group. There is a lot of variability in career “age” among the presidents. This brings a challenge about what skills are needed. We are aligning with ACLGIM for the first time to see how ACLGIM can help us with this.

4. What advice do you have for people who want to be more involved in regional leadership?

Don’t be shy about expressing your in-

terest. Take advantage of mentoring opportunities on the regional and national level. Volunteer for meeting activities on the regional level and show your enthusiasm. Don’t underestimate the importance of networking—the more people you know and who get to know you, either collaborating, or cold calling about developing workshops, etc.—the easier it is to get involved.

View from the Summit 2018
Beating Burnout Together

Elisha Brownfield, MD



Abigail Lenhart James Clements

Dr. Abigail Lenhart (lenhart@ohsu.edu) is an assistant professor of medicine and the wellness champion for the Division of General Internal Medicine and Geriatrics at Oregon Health & Science University in Portland, Oregon where she practices primary care. Dr. James Clements (Clemenja@ohsu.edu) is an assistant professor of medicine at Oregon Health & Science University (OHSU). He practices hospital medicine at OHSU and is the assistant director of the clinical hospitalist service at OHSU in Portland Oregon.

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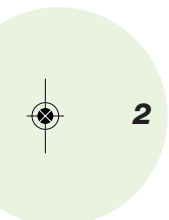
The syndrome of burnout among physicians has received a great deal of media attention in the recent past, with reports of its increasing prevalence in the medical community and harmful effects on patient care and physician wellness. While acknowledgement of the problem is a step towards addressing it, many healthcare organizations struggle to put effective solutions in place. Drs. Clements and Lenhart have led the Oregon Health & Science University’s (OHSU) approach to the problem of burnout in primary care and hospital medicine and presented their process at the ACLGIM Winter Summit. They emphasized the need for individualization of tactics by organizations, departments, and divisions and provided a forum for attendees to develop unique solutions while learning from one another.

Drs. Clements and Lenhart divided their approach by Inpatient and Outpatient General Internal Medicine teams and emphasized a stepwise method: Pick a burnout *framework*—several are available in the literature—assess perceptions and measure against reality using data, get buy-in, make changes and follow up. On the inpatient team, faculty were surveyed to measure burnout. Clinical issues, such as staffing, delegation, and protocol orders, and support for addiction care were addressed. Per-shift RVU incentives were introduced and opportunities for decision making input including business meetings, town halls, and divisional e-

mails were either begun or augmented. A “Wellness” committee was established and subsequently new group mentoring teams began. Opportunities for social interaction were increased with the addition of book clubs, parties, a faculty onboarding “buddy” program, and new hire dinners. Enhanced leadership development training was instituted, efforts were made to increase the transparency of the faculty promotion process, and a recognition program was implemented.

On the Outpatient service, data was gathered on faculty burnout (Mini Z), workgroup culture (Team Culture Scale), and after-hours electronic health record (EHR) work. Addressing the issues of burnout became a leadership priority and each clinic designed its own intervention. Interventions included a retreat to focus on communication, site newsletters, as well as “potluck” luncheons. Faculty received targeted training in EHR efficiency and one clinic instituted patient care huddles. A primary care workgroup consisting of faculty and staff was created and charged with finding solutions to work flow issues and spreading best practices.

The origins of physician burnout are complex, and institutions may benefit from taking a deliberate approach to finding unique solutions that fit their organization. The OHSU method may provide a structure to General Internal Medicine groups who desire to address this important issue.





Nancy Spector

View from the Summit 2018 Achieving Leadership Gender Equity in Medicine: Collaboration, Innovation, and the Imperative for Systemic Change

Nancy D. Spector, MD

Dr. Spector (nds24@drexel.edu) is a professor of pediatrics and the associate dean of faculty development at Drexel University College of Medicine. She also serves as the executive director of the Executive Leadership in Academic Medicine (ELAM) Program in Philadelphia, Pennsylvania. Dr. Spector was an invited speaker at the 2018 ACLGIM Summit in Phoenix, AZ.

The Hedwig van Ameringen Executive Leadership in Academic Medicine (ELAM) Program is a year-long part-time fellowship for women faculty that addresses the challenges of advancing women leaders in academic medicine, dentistry, public health, and pharmacy. Over 24 years, the program has had remarkable success with a measurable impact on the number of women in academic leadership positions. More than 1,000 ELAM graduates are leaders at 258 institutions around the world, helping to narrow the gender gap in academic medicine.

But despite the success of many of our graduates, we are a long way off from achieving equity at every level of leadership. We have found that while leadership training and optimizing the network for women is critically important, it is time to move beyond “fixing the woman.” It is time to accelerate the impact by making critical systemic change through evidence-based and best practice approaches. This includes establishing policies that ensure equity by the following:

- analyzing the inequities in our organizations and institutions,

- engaging male allies in creating supportive institutional and organizational environments, and
- using novel, evidence-based approaches and innovative diffusion techniques through social media.

It also includes the use of sponsorship—recognized as a critical piece in the puzzle of how to help advance women’s careers—and collaborations with campaigns such as #BeEthical, a call to action for healthcare leaders to recognize that workforce gender equity is an ethical imperative.

View from the Summit 2018 ACLGIM Winter Summit 2018 Breakout Session: Promoting Diversity in Academic Medicine

Kathryn Teng, MD; Peter Cram, MD



Kathryn Teng



Peter Cram

Dr. Teng (kteng@metrohealth.org) is associate professor of medicine at Case Western Reserve University School of Medicine. She practices primary care medicine at the MetroHealth System and leads the Division of General Internal Medicine and the Adult Health & Wellness Service Line at the MetroHealth System in Cleveland, Ohio. Dr. Cram (peter.cram@uhn.ca) is professor of medicine at the University of Toronto. He practices in the hospital setting and is the director of general internal medicine and geriatrics at University Health Network and Sinai Health System in Toronto, Ontario (Canada).

In 2004, the Association of Medical Colleges (AAMC) revised its definition of *under-represented minority* (URM) to include “those racial and ethnic populations that are under-represented in the medical profession relative to their numbers in the general population.”¹ Attendees of the Winter Summit session on “promoting diversity in academic medicine” agree with this definition, as it allows us to think of under-representation as continually evolving based on the changing demographics of society and the profession of medicine, and it allows us to match our recruitment of URM faculty to match our local patient populations. As such, diversity in the health sciences could include women in leadership and men in primary care fields, and could be expanded to include

diversity in religion, culture, education, gender, or orientation.

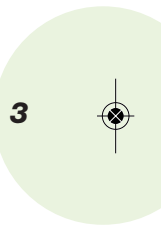
Because the candidate pool of URM faculty is often small, it becomes difficult to match the faculty pool to mirror our local populations. Some ideas and solutions developed in the 2018 breakout session included the following:

1. Groom minorities early, even in high school, to build the pipeline of candidates. One example is the Cleveland State University (CSU) Urban Health partnership with Northeast Ohio Medical School (NEOMED) to provide opportunities for URM faculty in medicine to gain acceptance, and ultimately excel, in

medical school. The hope is that participants will eventually join the primary care workforce in underserved areas of Cleveland.

2. Begin URM recruitment early. This may start with collaboration within the other schools (School of Arts & Sciences, School of Business, etc.) within one’s own university.
3. Build regional and national networks to identify mentors for URM faculty and to partner for recruitment.
4. Provide time support for mentors and mentees to participate in mentorship programs, and particularly, to mentor URM faculty.
5. Senior leadership needs to set a culture of inclusion and demonstrate

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attention to diversity. This may be done by inclusion of verbiage in a mission statement, creation of an Office of Inclusion & Diversity, creation of committees to address inclusion and diversity, and providing time and financial support to allow time for participation in activities that support inclusion and diversity.

Perhaps the most important action we can take to recruit talented faculty—under-represented or not—is to role model and express enthusiasm for careers in health care within our local communities. We need to speak about the joys of being a doctor and our ability to make a lasting impact on the health and wellbeing of individuals and communities. Medicine is an honorable profession, and we must promote medicine as

an attractive career option for our brightest and most talented students.

References

1. AAMC. <https://www.aamc.org/initiatives/urm>. Accessed February 1, 2019.

View from the Summit 2018 Philanthropy and the Physician-Patient Relationship: Shift Needs to Happen

Mr. James Hodge



James Hodge

Mr. Hodge (james.hodge@ucdenver.edu) is associate vice chancellor in the Office of Advancement at the University of Colorado School of Medicine. He has 34 years of experience in healthcare philanthropy.

When you hear the word fundraising, what are some of the images, perceptions, and emotions that come to mind? *Begging. Selling. Outside influence. How will this affect the doctor-patient relationship?*

These were some of the answers from the audience at the ACLGIM Summit this past winter. But it doesn't have to be this way. A shift in our field around philanthropy is needed. Philanthropy is not about money; it is about meaning, purpose, and legacy.

We need a shift from a needs-based perspective to a vision-based perspective. When leaders focus on needs, they end up sounding... *needy*. Benefactors feel like philanthropic ATMs. When leaders focus on vision, they stop telling and selling and start com-

selling. This is more aspirational for institutions and more inspirational for benefactors.

As leaders in general internal medicine, you have a unique position in your institution and in your patients' lives. Use this role to elevate the next big idea and introduce a bigger narrative. Be open to the natural tendency of patients to be grateful for care and recognize that it is gratifying for patients to give and advance research, clinical care and training in medicine.

Benefactors can become partners and co-creators of a shared future. Inspire and engage your faculty to envision what your department would look like at its best. When you next hear the word *fundraising*, think of raising sights and improving care in the future.

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