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The Leadership Forum

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


Neda Laiteerapong Elisha Brownfield

From The Editors

Summer is over, and fall has begun again. We're certain that you are busy and revving up for an exciting year! We are pleased to be in our new role shaping *The Leadership Forum*—the official publication of ACLGIM. This issue features a new series—Leaders in Action—which includes interviews with current leaders in general medicine. The goal of this series is to highlight the diverse leadership roles general internists have in health care, advocacy, and government. This month we highlight ACLGIM President Elizabeth Jacobs who answers our questions about her personal leadership journey and the role of ACLGIM.

Next is a Perspectives in Leadership article written by Taylor Purvis, a second-year medical student at Johns Hopkins School of Medicine, who describes a less-known leadership style—the Lao Tzu type of leader. Lastly, we present "Reflections from the Winter Summit." This article was written by a group of ACLGIM members who were so inspired by their table-top discussion of "challenging" physicians that they composed an excellent anecdotal summary of five physician phenotypes style.

We look forward to working with you on *The Leadership Forum*! We also want to thank former editor April Fitzgerald for her tremendous work and dedication to the *Forum* and for making the editorial transition as seamless as possible. Please send your comments and suggestions to us at nlaiteer@medicine.bsd.uchicago.edu or brownfe@musc.edu.

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

Liz Jacobs

Leaders In Action
An Interview with Liz Jacobs

Elisha Brownfield, MD

Dr. Jacobs is ACLGIM president and associate vice chair for health services research in the department of medicine and professor of medicine and population health sciences at the University of Wisconsin-Madison.

The following responses were gathered and paraphrased from an interview with ACLGIM President Liz Jacobs.

How did you get to be in your current leadership position of ACLGIM president?

That is an excellent question. I began attending the ACLGIM meetings six to seven years ago based on the advice of my division chief at the time, Jen Smith at Cook County Hospital. Jen introduced me to ACLGIM and its benefits and suggested I become involved. After my appointment as associate vice chair for health services research in the department of medicine, I found ACLGIM to be a great place to learn about issues facing leaders in general internal medicine (GIM). Former ACLGIM President Tracy Collins invited me to co-chair a

continued on page 2

continued from page 1

leadership summit for the group, and my leadership of the organization naturally grew from my involvement.

Academic health care is experiencing major changes. How has this impacted your decisions as a leader?

These changes have empowered me to speak out about the possible impact they will have on patient care and research. For example, with the decrease in federal research dollars, we have shifted how we evaluate research support in our department. We now recognize that obtaining NIH R01 funding is more difficult and have come to value multiple forms of support. These changes have also strengthened my interest in the value proposition of academic health centers. Should we all try to be like nonacademic health systems or highlight our unique qualities, such as our drive for innovation? In a strictly market-based system, it will be hard for academic medical centers to compete. We must demonstrate how our value to the health care system as innovators and educational institutions is important and unique.

What do you see as the role of ACLGIM in shaping future leadership? How can ACLGIM support leaders?

ACLGIM will continue to provide opportunities to lead and serve through mentorship and career development opportunities within ACLGIM and SGIM. We work closely with SGIM to make sure that what we do as an organization is synergistic with their goals and plans. We will continue to advocate for the needs of general internists as well. Together with SGIM and Mark Linzer (director of the division of GIM at Hennepin County Medical Center), we have discussed launching a "train-the-trainer" program on work-life wellness to develop a pool of members knowledgeable in this area who could serve as resources.

We also would like to bring more people into our membership and make sure we are valuable to both junior and senior members. We want to make sure that we continue to provide an environment where chiefs can learn from each other and connect on issues important to them. Additionally, we need to provide a venue for new and emerging leaders in GIM to access important knowledge and skills critical to being an effective leader in a wide variety of roles: research, teaching, organizations, and clinical care.

What advice would you give for our members as they go through these turbulent times?

I have seen a lot of changes over time—HMO expansion, for instance—and my advice to members is to "Take heart"! Things change, and they typically change slowly. If the change is not working well, the pendulum often swings back. The good news is that I see a shift in payment reform toward alignment with what we care about as general internists: high-value and high-quality care. General internists can bring a lot of value to this type of capitated coverage system. I do think it is critical that we be alert about changes and formulate our responses constructively. In terms of research and academics, be aware that there have always been fluctuations in funding and structure, and we have weathered these storms before.

Taylor E. Purvis

Perspectives In Leadership

Foremost a Servant: Re-imagining Leadership in Medical Education

Taylor E. Purvis

Ms. Purvis is a second-year medical student at Johns Hopkins University School of Medicine (JHUSOM) in Baltimore, MD, and can be reached at Tpurvis2@jhmi.edu.

What do you think of when you envision a leader in medicine? Present this question to a group of medical students, and they are likely to describe a confident attending physician who is extroverted and domineering. Student leaders are seen as those individuals who enjoy public speaking, voice their opinions boldly, and take on important roles in student interest groups.

continued on page 3

continued from page 2

This portrayal of traditional leadership ignores an alternative—and possibly superior—model: a Lao Tzu type of leader who is best functioning when nearly invisible to his/her followers. Lao Tzu was an ancient Chinese philosopher and founder of Taoism. A Lao Tzu type of leader subordinates his/her self-interest to the interest of his organization and functions foremost as an enabler of his/her followers. This leader rejects the zero-sum game as a metaphor in the pursuit of success and strives to enlarge the pie rather than clamor for a larger slice. The leader is honest and appreciative and understands that there are greater goals than promotional status and international reputation. The values of the Lao Tzu type of leader, or servant-leader, are often formed during adolescence and frequently have underpinnings in spiritual realms. I first learned of servant leadership as a child at church.

While servant leadership is recognized as an effective and profitable model within the business world,[1] this leadership style may be difficult for medical students and educators to measure, discern, and convey in recommendation letters. While courses during medical education may touch on the intangible values underlying inspirational and humble leadership, successful implementation of these skills ideally would be imperceptible to medical educators and students. How can students identify Lao Tzu-type leaders and strive to emulate them?

When medical educators introduce servant-based leadership in their curricula, they should urge students to consider the fit of the style to their values. Discussion of the servant-leader may require medical educators to engage in larger discussions of morality, religion, and purpose—all of which are important issues to discuss with the next generation of physicians. Most importantly, introducing different leadership models during medical education—including quieter and service-minded leadership styles—ensures that the future generations of physicians fundamentally exist to promote the wellbeing of the broader community.

References

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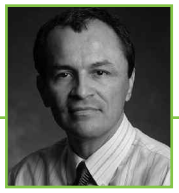
Mark Earnest


Carlos Estrada


Dan Hunt


Elizabeth Trowbridge


Alisha Parada

Reflections From The Winter Summit

Leadership Challenges in Managing a Faculty Workforce

Mark Earnest MD, PhD; Carlos Estrada, MD, MS; Dan Hunt, MD; Elizabeth Trowbridge, MD; and Alisha Parada, MD, FACP

Dr. Earnest is general internal medicine (GIM) division head at the University of Colorado; Dr. Estrada is division director at the University of Alabama at Birmingham and senior scholar at the Birmingham VAMC Quality Scholars Program; Dr. Hunt is division director of the Emory Division of Hospital Medicine; Dr. Trowbridge is division chief of GIM at the University of Wisconsin; and Dr. Parada is medical director and assistant chief of GIM at the University of New Mexico Health Sciences Center.

At the 2015 ACLGIM Winter Summit, we as a group began to discuss the biggest challenges with managing our faculty workforce. The conversation proceeded in cycles. Someone would open with a statement such as, "I have someone who…" As the details of the challenge were described, heads would begin to nod around the table in recognition. In the short span of an hour, we had created a taxonomy of five distinct "problem" faculty types. This unscientifically generated list represents a sample of challenges startlingly familiar to most of us.

Fortunately, as the list emerged, so did some tips for managing those problems. Recognizing the value of the conversation, we decided to capture the fruits of our discussion so that our collective experiences could be shared with a broader audience.

Five "Problem" Faculty

1. *The Eeyore*. It would appear that every division has an Eeyore, the character from the *Winnie the Pooh* children's series. These are the people you can count on to be negative. While Eeyores can be helpful in playing the devil's advocate and making sure new ideas are adequately vetted, they are resistant to change. If left alone, their black cloud can cast a shadow on everyone.
2. *The Martyr*. Unlike Eeyore, the martyr is not primarily negative so much as enthusiastically suffering. Martyrs tend to publicly assume more responsibility while smiling furtively or advertise the ample burdens they bear with quasi-cheerfulness. Their response to change is not so much resistance but recognition that change is itself a burden that they will bear along with all their other crosses. As someone in the group mentioned, the martyr's credo is: "Unless I'm suffering, life is not right."
3. *The Perfectionist/Procrastinator*. The perfectionist/procrastinator is the outwardly conscientious and perhaps even legendary clinician

continued on page 4

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Reflections from the Winter Summit

continued from page 3

who has an inbox full of unresolved results, incomplete charts, and unanswered messages. We have competing hypotheses as to the underlying problem. One potential explanation is a pathological perfectionism that leads to procrastination. Another explanation is that individuals may simply prioritize other "more pressing" or appealing tasks. Based on our experiential sample, the overflowing inbox appears to be a particularly refractory problem. There are a few examples of repeated interventions followed by periods of compliance that ultimately collapse in dramatic relapses.

4. *The Manipulator*. A passive-aggressive approach to grievance seems to underlie this "problem" faculty member. Manipulators often triangulate problems—sowing doubt here, planting ideas or information there, and constantly working to make things happen while keeping their fingerprints off the resulting outcomes.
5. *The Underperforming Star*. What do you do about a faculty member who could be a superstar but is content to just get along? How do you challenge complacency or instill motivation in those who don't seem to be able do it themselves?

In thinking through this "problem" faculty taxonomy, several universally useful pearls emerged. The collective wisdom of the group got us energized!

1. *Have a "cup of coffee conversation."* Gerry Hickson at Vanderbilt noted that a "cup of coffee conversation" solves a large percentage of problems associated with unprofessional behavior. This is a brief one-on-one personal conversation that simply describes an event or behavior as a problem and asks the recipient of the information to work it out. Every story has multiple sides—the purpose is not to take sides or define the "truth" but rather merely quote the behavior.
2. *Identify, acknowledge, assist, and address underlying issues (e.g. family stressors, depression, personality disorder, substance abuse, etc.).* Everyone acknowledged that the root of many problems lies outside the workplace. This is particularly true when a problem represents a deviation from a well-established pattern of performance or behavior. Helping to identify the issue may be necessary before any progress can be made in addressing the work-related problems.
3. *Make expectations clear and follow up*. A commonly described experience was that faculty problems resolved when expectations were made clear. As one person observed, "You can't change personality, but you can change behavior if you are clear in setting expectations." For example, an Eeyore is unlikely to become a Tigger, but he/she can be expected to refrain from certain comments. A perfectionist/procrastinator will learn the allowed limits to preferred behaviors. Similarly, helping an underperforming faculty member set his/her own higher expectations can lead to better performance, particularly if you are willing to follow up on the goals that have been set.
4. *Talk to someone you can trust*. Confidentiality limits our ability for candor among our work colleagues. Nevertheless, it is helpful, if not critical, to get input and feedback from time to time. Participants mentioned a number of people that they could go to for advice and help in thinking through these challenges. Often finding someone in a similar position outside his/her home institution was the most helpful. ACLGIM is a venue for this type of exchange.
5. *Know when you can't fix it*. As internists, it seems we are all compelled to solve the problem, and yet there was recognition that some problems can't be solved. Second and third chances are fine, but is a fourth or fifth productive? While you struggle to save one faculty member, what is the impact on those who are doing their job as expected? Some problems sadly are unsolvable. Many around the table relayed that these are the most difficult decisions they have to make but that sometimes there's no other option—the only outcome is to part ways.

Under-performing or challenging faculty confront all leaders in academic medicine. It is important for leaders to acknowledge these challenges and share best practices in addressing them. Although we in GIM aspire to use evidence-based approaches in our clinical, research, and education roles, we believe that "sharing the narrative of experience" is a powerful adjunctive tool in our leadership roles. We hope our informal taxonomy and suggested approaches stimulate ongoing inquiry and conversation.