

The Leadership Forum

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

Words of Wisdom

Creative Economics: Balancing the Budget and Faculty Morale in Tough Times

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Erin Dunn Snyder



Roger Smalligan

Many states are running budget deficits, and in searching for ways to balance them, education funding is in jeopardy; medical schools are no exception (1, 2). For example, Texas Tech had to deal with a 5% cut in state funding last year and may be facing up to another 10% cut this next year; the National Institutes of Health is facing a \$1.6 billion cut (3). The cuts strike fear into the hearts of deans, administrators, department chairs, division chiefs and faculty members alike. Faculty meetings can quickly become full of "doom and gloom" without great solutions in sight. At a recent lively discussion of Chiefs and Leaders at the Southern SGIM meeting, the discussion quickly turned to strategies to manage money while maintaining faculty morale.

One strategy is to get paid appropriately for the work that faculty is already doing. Physician directed billing, rather than relying on a coder to capture charges, can ensure that charges are captured for every patient each day. From there, compare local billing codes to national averages. If needed, add a regular coding refresher session to faculty meetings so that fac-

ulty are clear on the necessary components for the most common

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charges. When faculty feel like they are being paid well for the hard work that they are doing, they may have more buy-in to other cost saving strategies.

Divisions can search for new funding sources. Faculty are often wary about additional responsibilities and one of the authors (RS) found an innovative solution. He asked the Dean for permission to reward faculty above and beyond their salaries if they would agree to manage patients at a local rehabilitation hospital in their spare time. The Dean agreed to a 50/50 split for this type of "extra" work. Mostly done by faculty without young children, they carry 2-4 rehab patients, and work either in the early morning, at lunch, or in the evenings. This brought in an additional \$20,000 to each participating faculty member and \$20,000 to the department. An added benefit to this new work is the

increased continuity of patient care since many of the patients had been discharged directly from our university teaching services.

Leaders in academic medicine across the country are facing the same dilemma, how to make the "numbers" work with less money coming in from traditional sources. It takes innovative solutions to bridge the budget gap while maintaining faculty morale.

1. Douda, Dennis. WCCO-TV, CBS affiliate Minneapolis, MN. 3/1/2011. Available at: <http://minnesota.cbslocal.com/2011/03/01/looking-budget-cuts-have-university-of-minnesota-medical-school-worried-sick/>
2. Bein, Barbara. Budget Woes Force Indiana University Medical School to Cut Incoming Class Size. AAFP News Now. 4/20/2010. Available at: <http://www.aafp.org/online/en/home/publications/news/news-now/resident-student-focus/20100420indiana-cuts.html>
3. Hunt, Albert. Republican Budget Cuts at the heart of Medical Research. Bloomberg. 2/20/2011. Available at: <http://www.bloomberg.com/news/2011-02-20/republican-science-cuts-imperil-u-s-prominence-commentary-by-albert-hunt.html>

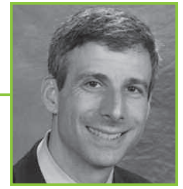
Perspectives in Leadership

The SGIM Research Dataset Compendium

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Alex Smith



Mike Steinman

The Society of General Internal Medicine (SGIM) Research Committee has released the SGIM Research Dataset Compendium. The Dataset Compendium contains information on publicly available datasets that may be of interest to new and established SGIM members seeking to conduct research on high-quality

existing data (available at www.sgim.org/go/datasets, or as a link from the Research section on the main SGIM website).

The Dataset Compendium includes a description of and links to over 40 high value datasets used for health services, clinical epidemiology, and medical education research. Each dataset description includes information about the subjects and measures in the dataset, the reason the data were collected, "real world" commentary from expert users, information about cost and availability, important web links, and example publications. An introductory guide to secondary dataset analysis targeted at junior researchers is included. Members of SGIM can request a one

To our knowledge, the compendium is unique in its level of detail and use of expert opinion for finding

The Dataset Compendium contains information on publicly available datasets ...

and evaluating featured datasets. However, it covers only a small fraction of the hundreds of publicly available datasets, many of which are indexed in other online resources. The SGIM Dataset Compendium provides links to these resources and other tools for researchers interested in conducting secondary data analysis. Questions and comments about the compendium are welcome.

1. Smith AK, Ayanian JZ, Covinsky KE, Landon BE, McCarthy EP, Wee CC, Steinman MA. Conducting High-Value Secondary Dataset Analysis: An Introductory Guide and Resources. *J Gen Intern Med.* 2011;26:920-929.

BRFSS data has been widely used for research...

time telephone consultation with an expert user of the dataset.

Example: Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) comprises an annual series of telephone-based surveys on health behaviors, preventive health, and access to health care with a focus on chronic disease and injury. Over 350,000 adults are interviewed each year in all 50 states plus selected US territories, facilitating inter-state comparisons. In addition, individual states may supplement the core survey with additional questions, allowing substantial flexibility. BRFSS data has been widely used for research and to inform legislative efforts related to health. Data are free and publicly accessible. In addition, the Web Enabled Analysis Tool (see link above) allows users to do on-the-spot cross-tabs and logistic regressions of BRFSS data.

Papers published

Hausmann LR, Jeong K, Bost JE, Ibrahim SA. Perceived discrimination in health care and use of preventive health services. *J Gen Intern Med.* 2008;23:1679-84.

Dataset accessibility and cost

Data is free and directly downloadable off the BRFSS website. Import utilities and data management utilities for SAS are available on the website.

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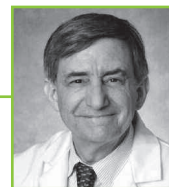
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Words of Wisdom

Unlimited! ACLGIM Unveils New Program to Diversify Leadership in Academic GIM

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Mark Linzer



Tracie Collins

At the May ACLGIM Leadership Institute meeting, we introduced the first UNified Leadership Training in Diversity (UNLTD) fellow, Dr. Cristina Gonzalez. Dr. Gonzalez is an academic hospitalist from Montefiore Medical Center. "Unlimited," recognizes emerging leaders, predominantly from underrepresented backgrounds. UNLTD fellows are chosen by the Disparities Task Force (DTF) mentoring subcommittee. Fellows are given a \$500 stipend and an invitation to attend the ACLGIM Leadership Institute

Providing opportunities to advance the careers of young leaders is a mission of our organization, and focusing these efforts on those from underrepresented communities is especially important.

where they are introduced to a mentor, provided opportunities to expand their networks, and trained in new leadership skills.

A team wrote a grant for UNLTD in 2004, however funding was not obtained due to a shift in foundation

funding priorities. The team waited 6 years for an opportunity to re-submit, but no opportunity surfaced, so ACLGIM and the DTF discussed collaborating in the area of mentorship. Dr. Linzer then provided funding to jump start the program.

Dr. Gonzalez trained at Cornell, and has been on staff at Montefiore since 2007. She has lectured on Latino/Latina health, provided Spanish language patient education, taught Spanish to physicians, and chaired the Minorities in Medicine interest group. ACLGIM members had substantially expanded their networks by meeting her.

At the ACLGIM dinner, Dr. Jim Byrd announced a matching gift to the initial donation, and Dr. Dawn DeWitt pledged additional support particularly for women and international emerging leaders. ACLGIM is incredibly grateful for these donations that will allow us to select 2-3 UNLTD fellows per year.

Dr. Russ Phillips, President of ACLGIM, shares the following: "Providing opportunities to advance the careers of young leaders is a mission of our organization, and focusing these efforts on those from underrep-

resented communities is especially important. Bringing young leaders into our organization is both enriching for young leaders and for all of ACLGIM, and should be a primary focus in the coming year."

Dr. Tracie Collins, Co-Chair of the DTF, states: "The DTF is quite pleased with the efforts of Dr. Mark Linzer and ACLGIM to support leadership in medicine by faculty from underrepresented backgrounds. Such generosity and commitment highlight what amazing leaders we currently have within academic GIM. Enhancing the GIM leadership pipeline with persons from diverse backgrounds will only further strengthen medicine throughout the country."

At the ACLGIM Winter Summit meeting, *the Executive Committee decided that diversifying leadership was a core goal of the organization. We now have an "unlimited" commitment to this goal. If you are interested in supporting leadership diversity and can provide funding (\$500) to sponsor an UNLTD fellow, please contact us. We look forward to creating a more diverse future together! We are grateful to Ms. Sara Poplau for editorial review.*



April Fitzgerald

Perspectives in Leadership

Giving Negative Feedback—A Primer for Physicians

Dr. Fitzgerald teaches "Leadership Skills for Medical Students" at Johns Hopkins School of Medicine. Please send your submissions for *Perspectives in Leadership* to Dr. April S. Fitzgerald, MD, afitzg10@jhmi.edu.

The *Perspectives in Leadership* article written by one of our Associate Editors, Dr. Fitzgerald, highlights an important skill in leadership, giving negative feedback. Physician Leaders are

often faced with situations where they must reject qualified individuals for positions, turn down well-written grant proposals, or pass up an article submitted for publication. Physician Leaders must

also be willing to give negative feedback to keep their organizations on-track. Dr. Fitzgerald offers tips on how physician leaders can deliver feedback in a professional way to preserve relationships and morale.

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Physicians are high-achieving individuals. Some of the ways academic physicians strive to achieve are by writing articles and applying for funding, awards, and new positions. With these endeavors, rejections inevitably occur. The reception of a rejection can be an opportunity to learn and grow, or it can be a painful wound that damages an individual's self-esteem and morale. The means and tone of a rejection will have a large impact on determining the lasting effect.

Receiving disappointing news or negative performance feedback should ideally be formative and should not harm the leader's relationship with the recipient. Here are some basic rules for giving negative feedback or delivering a rejection:

1. **Who:** Negative feedback should be private and one-on-one. Additional individuals in a room or copied on an e-mail will serve as an audience increasing embarrassment and impacting morale. The discussion should be treated as confidential.
2. **Form:** Negative performance feedback should be given in-person. Telephone is a poor substitute for a face-to-face meeting, and e-mail should be avoided due to its one-sided nature and difficulty expressing tone. If rejecting someone for a position or grant, an in-person meeting might not be feasible. A phone call or personal letter may be the best choice. However, a form letter is not appropriate for colleagues. A good leader takes the effort to individualize a rejection letter.
3. **Timing:** Negative feedback should be given as soon as possible after an event. If there is an emotional component to the feedback that might influence the leader's manner of delivery or judgment, a short time-delay to let emotions ebb is appropriate. However, long delays lessen the likelihood of a formative discussion and can negatively impact morale.
4. **Message:** Inquiry as a first step will help you gauge an individual's insight, appreciate their perspective, enhance your understanding, and calibrate the appropriate level of response. Give feedback that is specific and clear, descriptive not judgmental, and focus on what can be changed. Never disparage a colleague's previous training or current institutional affiliations. Use explicit suggestions to convey your commitment to the individual's capability and future career development.
5. **Proportionality:** Negative feedback should be a proportional response to the event that occurred. Escalation should be actively avoided and counteracted. Maximizing the negative effect of feedback is not a goal, while preserving the relationship is one.
6. **Demeanor:** A good leader pays close attention to the message being conveyed. Rejection of a work product should not be a rejection of the individual nor a chance for aggrandizement of the organization. Be thankful for individuals who put time and effort into an application to you, and remind them how much you value and think well of them. At the end of a face-to-face meeting, shake hands to show you are on their side.

Leadership skills must be learned. With practice, physician-leaders can deliver negative feedback and rejections to their colleagues in a manner that preserves the relationship and dignity on both sides.