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The Leadership Forum

an ACCGIM publication for leaders in academic general internal medicine

Leadership and the Art of Interpretation.

Patience Agborbesong, M.D.

I live in an area of the country that has a growing Latino population and I often use the services of a Spanish language interpreter when seeing some of my hospitalized Latino patients. I have a working knowledge of Spanish but I am not fluent enough to conduct patient interviews on my own. Most of the Spanish language interpreters with whom I work, know that I have some command of the language. Occasionally, I'll work with an interpreter with whom I am unfamiliar and he or she is usually surprised when I ask that a message to a patient be re-phrased because the original meaning was not conveyed as I intended. I am sure by now you are wondering what any of this has to do with leadership. As a "young" hospital medicine group leader, I spend a great deal of my time in the role of interpreter. I serve as interpreter for various groups in the hospital but the main two groups consist of clinicians and non-clinician business administrators who are sometimes worlds apart in both worldviews and culture.

Merriam-Webster's Collegiate Dictionary (11th edition) says an interpreter is "one who translates orally for parties conversing in different languages." Interpretation deals with the spoken word while translation deals with the written word (usually documents.) Most of the time, I function as an interpreter and occasionally as a translator. Lately, I have been thinking about what makes for a good interpreter. What follows is not meant to be an exhaustive list.

First, a good interpreter has a profound knowledge of both languages. Language reflects culture and worldviews so you must understand the nuances and cultural preferences of both the source and target languages and blend these for complete audience comprehension. Unlike a translator, you need to be able to interpret in both directions on the spot when necessary.

Second, a good interpreter is knowledgeable in the subject matter. In my case, I have to have a firm command of both medicine and business. It is possible to speak a language and be ignorant about a specific subject area. The really good interpreters know the subject matter in addition to the languages.

Third, a good interpreter is a great listener. This is an important communication skill even when both parties are speaking the same language but becomes absolutely crucial when communicating across cultures and worldviews.

Fourth, a good interpreter strives for accuracy. You must successfully convey the message by the originator as intended without changing or leaving out anything. This requires an ability to express thoughts, ideas and concepts clearly and accurately in both languages.

Fifth, if confidentiality is required, a good interpreter observes the strictest level of discretion.

Last but not least, a good interpreter keeps up his or her skills. In my case, I keep up my clinical knowledge and skills and I am getting additional training in business and management. Hospitals are relational places and relationships are built through communication. I enjoy learning the art of interpretation in my role as leader and I am not doing too badly with my Spanish lessons.

An Interview with Carolyn Voss, MD

By Anna Maio, MD

Carolyn Voss, MD, former Chief of the Division of General Internal Medicine (GIM) at the University of New Mexico, was promoted to Executive Director of Ambulatory Services and Assistant Dean of Clinical Affairs in 2006. Anna Maio, Division Chief at Creighton, recently had a conversation with Carolyn to discuss her leadership strategies.

Q. *What does your current position entail?*
A. The role had been created about three years ago to bring the group practice and hospital together. My primary job is to enhance all clinic services by bringing hospital administration and faculty together while overseeing all ambulatory clinical operations. I often translate "doctors' speak". My primary focus every day is the delivery of outstanding patient care. They chose me for this job because, while I was division chief, I was very successful—so the general internal medicine clinics, the hospital, and THE medical group turned to me to lead new projects.

Q. *What does a day or a week look like for you?*
A. Twenty percent of my time is still spent in clinical practice. Then I have a lot of time in meetings—as much as six to seven hours a day. I spend time with staff and faculty and visit all of the clinics regularly. My job involves gathering the right people together to problem-solve.

Q. *How did you make the leap into a formal leadership role?*
A. Looking back on my career, I understand that I was asked to lead because, when I found myself that in the midst of a problem, I needed to be part of the solution. So I took problem-solving on and worked on developing relationships. I did this as a junior faculty member because of a need in my division. At that time, the current division chief asked me to be co-chief on the clinical side. When he unexpectedly vacated his position as division chief, I was asked to step in. I credit my chair at the time for listening to my ideas and being very thoughtful in allowing me to move forward.

Q. *What are your thoughts on the future of general internal medicine?*
A. I am extremely optimistic. General internal medicine is perfectly situated with the knowledge base and skills as well as a tradition of being outcomes driven for a leadership role in healthcare redesign. GIM will be essential to help develop health care as we move forward in new models such as the chronic care model and the advanced medical home. The groundwork has been laid and we are engaged and ready to move forward.

Q. *Do you have any leadership pearls you would like to pass on?*
A. There are no secrets to effective leadership. But, in the front of my mind, I always make a conscious effort to meet people where they are. I always try to listen and to think about the other party's agenda. It's important to try to place ego aside.

Q. *Do you have any tips on how to motivate faculty to adopt a shared vision?*
A. I try to keep in mind the big things as opposed to the little things. I think role modeling as a clinician is important—I still do clinic. I am very cognizant of figuring out whose values are not in sync with mine and don't try to take them somewhere they aren't able to go. I sometimes find myself pulling back and changing directions. It is important to remain flexible and change your mind, when appropriate.

Q. *What is the future of women in academic medicine?*
A. I have spent a lot of time thinking about this. Although it has been many years since a large number of women have entered the academic medicine work force, there is still a huge gap

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between the number of assistant and full professors and the number of women faculty serving as chairs and deans is still very small. I believe that the culture of academic medicine is not inviting to women and minorities. Women's priorities may not fit in fundamentally with standard medicine and leadership may not be a satisfying career choice for them. I believe the culture must change or we risk alienating half of the potential leadership pool. There has to be relationship building and listening and we need to change the way we do business.

Q. *How to you maintain work-life balance?*
A. I create sacred time for myself and try to be present when with family. My husband and I share a hobby of ballroom dancing and we set aside time for that.

AGCIM

GENERALIST LEADERS ENGAGE IN ANNUAL SUMMIT

ACGIM sponsored its third annual Leadership Summit in Phoenix on December 7th –8th, 2008. Nearly 50 leaders from academic GIM divisions gathered at the Sanctuary at Camelback Mountain to hear presentations and exchange ideas on some of today's most critical issues affecting general internal medicine.

The opening session began with a group from Northwestern University (led by David Baker, MD) who shared the elements of the patient-centered medical home being implemented in their academic practice. Separate presentations were given on advanced access, communication, and quality improvement using an advanced EHR, patient education and self-management, and financial implications. Next, Greg Rouan, MD, Richard Lofgren, MD, and Eugene Rich, MD, discussed national policy implications and demonstrations of the Patient-Centered Medical Home (PCMH) model ongoing around the country.

Day Two focused on transitions of care. Vineet Arora, MD, and Jeanne Farnan, MD, presented their work from the University of Chicago around transitions. The session began with an engaging "Transitions Theater" during which participants were able to observe several problems leading to patient safety errors during hospital to home (discharge) transitions. Jeffrey Greenwald, MD, then led a session describing innovations to improve discharge safety. Break-out groups allowed participants to explore these issues more fully.

The ACGIM Executive Committee led by Dr. Fred Brancati thanks the program directors, Drs. Deb Burnet and Dr David Rose, who organized and led the sessions. The Executive Committee welcomes your ideas about topics for Summit 2009.

Dr Greg Rouan discusses policy implications of the patient centered medical home with Summit participants.

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A Call for Meta-Leadership

By Valerie Weber, MD

Academic medical centers are organized into silos. As leaders, we concentrate on the goals and objectives of our particular silo. As the leader of a department of general internal medicine, I have often found myself in the position of battling for resources with the heads of other organizational silos or protecting my silo's resources from being plundered by others. I have always thought that this was the "name of the game," so to speak. I have measured my success as a leader and the success of other leaders, based on the resources amassed. For example, "He runs a division of 40 general internists with a research budget of $11 million dollars." Or, "Last year, I completed a $1.2 million renovation of my ambulatory clinic, doubling our space."

Recently, this thinking has been challenged by a leadership concept I have been exposed to in my studies at the Harvard School of Public Health (I am enrolled in a two-year Masters of Health Care Management program). Leonard Marcus, PhD, and Barry Dorn, MD, who teach the Program for Health Care Negotiation and Conflict Resolution, speak to the need for "Meta-Leadership" in healthcare.

What is meta-leadership? Just as a meta-analysis is used to connect the results of different research trials, meta-leadership is a practice that can create heightened connectivity across disciplines in healthcare. Marcus and Dorn argue that healthcare today desperately needs cross disciplinary coordination of effort and that this is hindered by the inclination of most leaders to advocate narrowly for their particular silo.

My premise? Silos harm patients. Here's the problem: although we can isolate ourselves within our silo, our patients don't have that luxury. A typical general internal medicine patient with diabetes, congestive heart failure, osteoarthritis, and osteoporosis will need to navigate across multiple silos to receive needed care. Although, as general internists, we often coordinate such a patient's needs, multiple silos (laboratory, radiology, cardiology, orthopedic surgery, etc) will also touch that patient. Meta-leaders are able to work with colleagues across disciplines to effect change-real improvements that help patients. For example, to improve the care of patients with hip fracture in the hospital, orthopedic surgery and general internal medicine must work together. This is often difficult, but the greatest opportunity to innovate to benefit patients lies in cross-disciplinary collaboration.

I recently had the opportunity to put this idea to the test. As Vice Chair of Medicine, I often hear of cross-silo conflicts that arise. But in one week, I heard of a particular conflict between two departments in my institution no less than three times. Before I could really think about the consequences, I heard myself volunteering to mediate the dispute. As of this writing, a very successful initial meeting was held in which clinicians who share patients daily began speaking about the key sources of conflict-and laying out steps to resolve them. I was amazed at how trivial the root cause of some of the conflicts were and how resolvable they might be by simple communication. I was also struck by how rewarding being a part of the solution could be. Dr Dorn has been engaged to teach ACGIM members these skills at the Leonard Hess Management Institute, to be held Wednesday, May 13th, 2009 in Miami, FL. I encourage all GIM leaders to attend this session (more information is available at www.acgim.org).

Meta-leaders often don't need formal authority, in fact the very definition of meta-leadership involves leading without authority. The ability to influence in the absence of formal authority is a characteristic of a great meta-leader. More important than authority are characteristics such as self-awareness, courage, curiosity, passion and integrity. Martin Luther King and Bono are a few examples of meta-leaders. You can surely think of others. And by reaching out across disciplines to improve patient care you can become one.