

# The Leadership Forum

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



Latha Sivaprasad

## WORDS OF WISDOM Musings of a Young Physician Executive

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I originally pursued medicine under so-called typical circumstances—my father was my childhood hero and a brilliant doctor; my mother was an engineer and a powerful female role model, and of course, I am Indian. So predictably, my natural bend towards science led me on a cookie-cutter path to a six-year medical program,

**...leaders in patient safety and quality, they happen to be running a fellowship at a nearby teaching hospital.**

internal medicine training, and then clinical work as a hospitalist for five years. Then over 5,000 patient encounters later, something happened which would change my career forever. I met two people, Drs. David Bernard and David Shulkin.

Both national leaders in patient safety and quality, they happen to be running a fellowship at a nearby teaching hospital. It is advised, "When your heart speaks, take good notes." I accepted the position. After the fellowship, they created my current role over three years ago. And my medical perspective has forever been altered.

Up to 77% of Americans dislike their jobs which is a worsening trend

in the last 20 years.<sup>1</sup> Supporting this notion is a Gallup Poll done in 2003 of 3,000 doctors which revealed that the rate of active disengagement was almost double compared to other industries.<sup>2</sup> This staggering finding inspired us to conduct a local Physician Satisfaction survey in 2008 at our 2-campus 1000-bed system. Over 75% of these physicians always or usually felt loyal to the hospital but sadly, less than 50% felt needed or valued. We also learned that many had no professional feedback within the last two years. Other businesses routinely conduct mid-year evaluations, something never done when I was a clinician at three different hospitals.

As I'm sure you do, I also work with really good people. They are trying to do the right thing in a busy and demanding environment that can impact family life, emotional well-being, and a feeling of purpose. Physicians support each other. Promoting, developing, and managing each other up is going to be critical in protecting our spiritual core and preserving professional meaning. We have to keep "fighting the good fight" in a more collaborative way.

And the optimal role for the Physician Executive? Well, I think it in-

cludes never forgetting to be the physician and patient advocate. We need to make sure that physicians' needs are translated correctly as they make it into senior management

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team agendas which dictate where funds are allocated. Shams-ud-din Muhammed hafiz said, "Greatness is always built on this foundation: the ability to appear, speak and act, as the most common man." Being a great physician executive means never forgetting how you started, as an idealistic and hard-working person trying to take care of the ill one person at a time. We need to marry the needs of both sides better to make a much happier, productive, efficient, and safer whole.

### References:

1. [http://workinprogress.blogs.time.com/2007/08/21/three\\_signs\\_of\\_a\\_miserable\\_job/](http://workinprogress.blogs.time.com/2007/08/21/three_signs_of_a_miserable_job/)
2. <http://www.gallup.com/poll/9475/can-hospitals-inspire-lasting-loyalty-doctors.aspx>

## PERSPECTIVES IN LEADERSHIP

### Social Media: The Time is Now

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Arash Mostaghimi

The time has come for academic General Internal Medicine leaders to take an active role in shaping the use of social media at their institutions. Online social media include websites such as Facebook, YouTube and Twitter that are built for sharing content among a user community. The use of these sites is having a tremendous impact on personal and

professional communication habits. In addition, businesses and health care institutions have begun to use social media to connect to consumers. As of November 2010, 890 US hospitals had a social media presence, accounting for over 2,300 sites. We must dismiss the view of social media as a 'young person's thing' and accept it as an established communication medium.

As with most innovation, the spread of technology outpaces study and policy, and the adoption of social media is not different in this regard. Social media bring several considerations for physicians and medical units. One can make a permanent mark on the web with just one click, either for good or bad. Best practices for physi-

how they maintain privacy, both for the physician and for patients. Leaders should use these discussions as a

**We encourage everyone to have a conversation about use of social media at your home institution.**

basis to create a framework for professional use of social media. For trainees, consider creating or adopting a curriculum that highlights professionalism when publicly blogging or posting online as a doctor.

**When:** Now. In a recent informal poll of our faculty, over half had a patient request to be their 'friend' on a social network. Several workshops at the 2011 SGIM meeting focused on social media.

**Why:** Social media can foster connections with distant colleagues, help shape ideas for projects, and publicize good work. (The workshop "From Twitter to Tenure" can show you more at SGIM 2011). A recent study also suggested that papers that are "tweeted" are more often cited. Social networking can also raise uncomfortable boundary issues regarding what is appropriate to post and share online, and how one should respond to patient requests.

**How:** Include the discussion as part of an upcoming faculty meeting, and create a curriculum on online professionalism for your residency program. For an online bibliography, visit [www.digitalprofessionalism.org](http://www.digitalprofessionalism.org)

The expanded use of social media among physicians is inevitable. By proactively starting the discussion, GIM leaders can thoughtfully guide the use of these resources at their institution.

Research Group Blog:

<http://www.themetrc.org>

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cians have not uniformly been developed for social media. Although few institutions have created policies for employee use of social media, the American Medical Association recently published a policy for social media use by physicians.

We encourage everyone to have a conversation about use of social media at your home institution. Here is the "who, what, when, why, and how" for having that discussion.

**Who:** Your faculty, your residents, and your students. These conversations might be best in individual groups, but themes of professional identity and responses to patients are generalizable.

**What:** Discuss how people use social media (e.g. for professional, personal, or combined purposes) and



Thomas McGinn

## Words of Wisdom

### From Chief to Chair: Tapping a pool of highly qualified leaders

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**A**s I start my second year as a chair of medicine, a striking “lesson learned” is that leading a division of general internal medicine (DGIM) is unparalleled preparation for this position. Having come directly from the division chief’s spot, I know that successful chiefs of DGIM master many of the same skills and build the same experience that are essential for an effective academic chair of medicine, across diverse settings and with a remarkable variety of staff and colleagues. They live and breathe on a

**General internal medicine also has a strong culture of professional development...**

daily basis the most pressing concerns of academic health center administrative leadership—increasing case mix index, reducing LOS, cutting readmissions, and expanding the primary care base, among many others.

I’m grateful—and relieved—that serving as division chief gave me a unique perspective on so many of the moving parts that create a successful department of medicine. Like chairs, many chiefs of GIM manage large, complex organizations composed of disparate sections with multiple functions and diverging goals: hospital medicine, ambulatory care practices, major educational programs, and clinical research units. We juggle budgets, productivity and incentive plans, mentoring, professional development, team-building, quality monitoring and improvement, and many other demanding leadership and management tasks, all with a careful eye on politics and community relations. Chiefs of GIM often oversee more providers and staff than those of other DOM divisions—sometimes more than entire departments, such as urology or orthopedics.

General internal medicine also has a strong culture of professional development for us as well as our future leaders—a discipline that serves chairs well. GIM chiefs pride ourselves on developing junior faculty as educators and researchers, and we constantly renew and improve our skills—to give just one example, our national meetings strongly focus on developing management, scholarship, and leadership.

Another example: Collaboration and teamwork are critical to successful management of a large, complex department of medicine. Chiefs of general medicine who build successful, sustainable programs are natural collaborators. Every project I undertook as a chief of GIM started with the understanding that success would come only if our division collaborated closely and consistently with specialists, nursing, and administration.

At the same time, however, a GIM chief does face several unique challenges when moving to chair of medicine. Most successful chiefs of GIM are experts at developing and monitoring productivity and incentives, using strategies such as national benchmarks that facilitate comparisons of faculty to colleagues in similar positions, both locally and

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nationally. DGIM faculty are often rather homogenous and provide naturally occurring samples, with faculty functions relatively well standardized across the field. This facilitates the creation and implementation of effective incentive and productivity plans. However, many of our subspecialty

colleagues in medicine are not so fortunate. For example, in pulmonary and critical care each faculty member may have to be viewed as a unique entity with unique incentive and productivity plans with no local comparison and no national or regional comparison. An invasive bronchoscopist has such a unique job in our system that we need to create an individual plan for her benchmarking against her own prior performance and other mutually-agreed-upon outcomes. The elements of an effective and meaningful plan remain the same, but creating the plan requires different skills, insight, and experience.

So if chiefs of DGIM are uniquely qualified to run academic departments of medicine, why are so few of them in those positions? It’s a complex phenomenon, with multiple factors at play. At research-intensive institutions, many chairs focus primarily (and understandably) on building their NIH-funded basic-science portfolios and thus seek out faculty with track records in basic-science funding. Some departments of medicine are attempting to build particular specialties that have a procedural bent, to complement their surgical programs.

At first glance, these considerations seem to answer the question and resolve the issue. From my new vantage point, however, it’s clear that in the long run it doesn’t make sense to bypass highly qualified leaders in GIM for chairs of medicine solely because they devote so much time to managing a complex organization rather than performing basic science research.

A more likely explanation is a somewhat puzzling traditional bias. Most chairs at AHCs have been specialists with a basic research focus. If these chairs are successful, leadership

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tends to assume that their successors should have the same background. To the contrary: building an academic DOM and building a powerful sustainable research enterprise, in both specialty and basic research, requires leadership and management skills more than it requires direct experience with specific areas of research or clinical work. Indeed, the capacity to re-

spond rapidly and effectively to shifts in institutional dynamics is a critical skill that successful chiefs of GIM have cultivated. We are likely to have direct experience of how to manage the multiple dimensions of change across the organization.

It's time to question assumptions and "think different" when it comes to building and rebuilding leadership

and management in academic medicine. At this critical juncture in the transformation of our nation's health-care system, we can't afford to bypass highly qualified leaders. So as new schools open and general medicine gains national attention, we are highly likely to see a shift in those who sit at the helm of our nation's 130 AHCs.

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### *Quality Improvement Skills for Reliable Care*

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**For more information:** [www.sgim.org/go/quality](http://www.sgim.org/go/quality)

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