

# The Leadership Forum

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

## The Leadership Forum's Sections

Carlos Estrada, MD, MS. Editor (cestrada@uab.edu)



With this issue, our organization debuts a new name, The Association of Chiefs and Leaders in General Internal Medicine (ACLGIM). Communications within our relatively young organization, 12 years, continues to evolve. The listserv is active and provides useful real-life discussions. The website, <http://www.acgim.org/>, is rich with information such as the "Chiefs' Toolkit," and upcoming events. Finally, the newsletter.

The newsletter serves as another communication venue amongst its members. With this issue, we reorganize the LF contents by introducing three sections, Perspectives in Leadership, Words of Wisdom, and the Harvard Business Review Corner.

The **Perspectives in Leadership** is a venue for faculty, trainees, staff,

and patients to let us know what they look for in a leader. We want to hear about their successes, experiences, and what keeps them going. They are the customers of our services. We have to listen to their voices to keep us straight and energized. In this issue Lt Col Rita DuBoyce, USAF shares her experience in the article "Working with Standardized Patients" on how she emerges as a leader.

The **Words of Wisdom** section is a venue for seasoned or younger chiefs and leaders to share their opinions, experiences, lessons learned, and words of wisdom. Navigating calm and troubled waters is more effectively done with a map and mentorship. The ACLGIM provides a unique type of mentorship through networking and sharing experiences. Mark Linzer and

Jennifer Smith share the table discussion during this past ACLGIM meeting, "The Safety Net Connects: an ACLGIM Table Discussion."

The **Harvard Business Review Corner** places a recent or classic HBR article into context. The case-based method often showcased in HBR is similar to the way clinicians learn - one patient at a time. We hope that the learning points be applicable to day-to-day operations as well as serve as reflective pieces for our souls and minds. *How can I apply the lessons from this article into my world next week?*

We thank Valerie Weber for successfully serving as newsletter since its inception, September 2008. The Editorial board, with his new Editor, invites submissions to these sections.

## Words of Wisdom

### The Safety Net Connects: an ACLGIM table discussion

Mark Linzer MD, Hennepin County Medical Center, Minneapolis MN (mark.linzer@hcmcd.org)

Jennifer Smith MD, Cook County Hospital and HHS, Chicago IL (jennifer\_smith@rush.edu)

On April 28, leaders from several safety net hospitals met to discuss an agenda for clinical care, teaching, research and leadership. Attendees represented hospitals from the West and East Coasts, the Midwest, the Southern region, and the Mountain zone. To our knowledge,

this is the first such meeting among safety net academic leaders. We hope to develop a listserv connection throughout the year to share challenges and successes.

Challenges at present focused on clinical care. Safety net hospitals are gearing up for health care reform, yet

few of us know what to expect. It is not clear what staffing ratios are appropriate for those caring for vulnerable, diverse and underfunded patients. Some states are markedly decreasing funding for the poor, and safety net hospitals are quickly planning ap-

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## Word of Wisdom

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proaches such as accountable care organizations. Pressure for productivity, uncertainty and variation were common themes. In the teaching realm, underfunding was often noted. For research, there are challenges identifying support for start-up packages for new faculty. In administration, there is often insufficient infrastructure to support the three missions.

However, attendees also described numerous opportunities. Innovation and persistence are required. Collaboration between hospitalists and other general internists offers many poten-

tial benefits. Discharge follow-up clinics are planned to decrease readmissions, and variability is scrutinized with an eye toward increasing efficiency. Proactive population management systems are being developed for vulnerable patients to decrease costs and improve disease management. Medical school support for teaching, also known as mission congruent teaching, can support teaching programs, as can billing appropriately for housestaff visits in clinic. Some sites have developed programs with teaching RVUs, and others have chosen faculty to lead medical school courses. Grants for residency training or faculty development are common mechanisms to support the teaching mission, and safety net sites are good candidates to apply for AHRQ or NIH funding for translational research. Fi-

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nally, safety net hospitals can contribute to the pipeline of future leaders in GIM. Once candidates are identified, leadership training through ACLGIM is encouraged.

If you are interested in any of the above topics, we will be glad to seek a safety net table discussion attendee with whom you can speak further! And if you are interested in joining our group, please let either of us (Mark or Jen) know. We are sincerely grateful to ACLGIM and the meeting coordinators for providing us this opportunity to connect. We believe this is just the beginning!

## Perspectives in Leadership

### Working with Standardized Patients

This Leadership Forum "Perspectives" article highlights leadership lessons learned from working with standardized patients. Written by an assistant professor at the Uniformed Services University, the author, Lt Col Rita DuBoyce describes why she established and maintained open communications in her leadership role. Communication is considered a key skill for leaders. Two-way communication helped her realize that standardized patients are individuals who are not "standardized" after all, and communication continues to play an important role in keeping the standardized patient program running successfully.

We welcome submissions from leaders and followers, both physicians and staff members. Please send your submissions for **Perspectives in Leadership** to Dr. April Fitzgerald at [afitzg10@jhmi.edu](mailto:afitzg10@jhmi.edu).

By Dr. Rita L. DuBoyce, M.D.

**M**y first interaction with standardized patients occurred when I was a preceptor. I viewed the standardized patients (SP's) as a group of actors who were given a script, performed their job, and then disappeared to a lounge after their encounter was over. In other words, a homogeneous group that is given a pre-existing script to perform—easy, right? I had a lot to learn!

After six weeks as a preceptor, I assumed a supervisory role for the simulation center course. Suddenly the autonomous standardized patients I had viewed as needing so lit-

Teaching points, physical exam findings, important history points are always on the pre-session agenda.

tle had more depth than anticipated and required quite a bit of attention.

My first lesson to share to anyone working with a standardized patient is the importance of meeting the individual behind the standardized facade. In the SP lounge, I realized that the SP group is not homogenous, far from it. Besides the visible differ-

ences of gender, race, and age, each SP arrives at the simulation center with different life-experiences and talents. They are individuals with varying degrees of clinical background. To my surprise, some SP's train students, residents, and fellows at multiple medical schools in our area, yet some have far less experience.

My second lesson is to realize that although there is a standard script for the SP's to portray, the variation in SP clinical knowledge and experience creates ambiguity. Many SP's have real medical conditions, and making their own medical conditions and physical findings mesh with a predetermined script is a challenge. Often it requires one-on-one attention to

help each SP integrate the "standardized script" into one that will be realistic, believable, and useful for the medical students.

My third lesson is to realize the importance of being present and available. I now meet with the simulation center staff and standardized patients before and after every session. Teaching points, physical exam findings, important history points are always on the pre-session agenda. Meeting regularly gives the SP's a chance to ask me clinical questions that might seem second nature to me as a physician but are not obvious to them. I also find this a good time to give a gentle reminder of the expected performance for a first or sec-

ond year medical student as compared to a resident or fellow. The post-session meeting allows me to gather helpful feedback for course improvement or to resolve any issues that arise.

Over the past two years, I have continued to work with standardized patients at the medical school simulation center. The words that previously came to mind to describe SP's such as "homogenous" and "scripted" are surrendered and replaced by words such as unique, enriching, and exceptional. In a single word, human.

**Rita L. DuBoyce, Lt Col, USAF, MC  
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## Harvard Business Review Corner

Patience Agborbesong, MD, Associate Editor pagborbe@wfubmc.edu

### The Decision-Driven Organization

Blenko MW, Mankins MC, Rogers P. *Harvard Business Review*. 2010;88:52-62.

**A**s a hospitalist, I stumbled onto leadership very early in my career or rather leadership ran into me! I was completely unprepared for the "turn around" situation in which I found myself and am forever grateful for the guidance and help provided by so many people along the way. One of the gems I discovered early on was the Harvard Business Review (HBR) which remains an interesting source of ideas and learning for me. One of my favorite learning activities is translating a principle or idea into my particular leadership context.

In the June 2010 issue of the HBR, change management is the main theme and the "spotlight" feature is the research article by Marcia W. Blenko et al. According to conventional wisdom, organizational structure is a key determinant of financial performance and other outcomes. This is one of the main reasons why CEOs love reorganizations especially when things are not going well. The main premise of the article is that good decision-making and the ability to execute those decisions quickly

and effectively play a more important role in performance and outcomes than organizational structure. The authors cite their recent Bain and Company study that looked at 57 reorganizations. They found that most company reorganizations had no effect and some even destroyed value. They recommend conducting a "decision audit" before any reorganization attempts and give "6 steps to a Decision-Driven Reorganization."

Since most of us are trying to figure out how to structure or re-structure the way we will be delivering care to our patients in this era of health care reform and cost containment, I think some of this information about "decision audits" and "Decision-Driven Reorganization" may prove useful or at least provide food for thought. I would like to highlight a couple of key points.

Before re-organizing your clinic, med-surg unit or section, conduct a "decision audit" by trying to understand the key set of decisions that are critical to your strategy. Determine the organizational level at

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which those decisions should be made and what level of authority the decision-makers need. Remember to address the 2 types of critical decisions that are commonly made. The big, one-time decisions that individually have significant impact and the smaller, routine decisions that also cumulatively have a big impact.

After you've done this, try to align the rest of the elements of your organizational system (for example, incentives and information flow) with those related to decision making. Last but not least, invest in helping decision-makers develop the competencies necessary for making and executing good decisions.

According to this study, if you sync your organizational structure with your decisions, the structure should work better.

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## Director for the Section of Decision Sciences and Clinical Systems Modeling

The University of Pittsburgh School of Medicine invites applications for the position of Director for the Section of Decision Sciences and Clinical Systems Modeling (SDS-CSM), based in the Department of Medicine, Division of General Internal Medicine. Candidates should have a demonstrated record of scholarship and independent research funding, mentoring and teaching. Applicants must have an MD and/or PhD.

As Section Director, the candidate will be responsible for developing an outstanding research unit focused on decisions sciences, modeling, comparative effectiveness and related areas. The Director will be responsible for faculty recruitment, faculty and staff career development, and collaborations across departments, schools, and institutes and centers. The faculty appointment will be associate or full professor in the tenure track. A generous resource package will be available to the successful applicant, including the ability and expectation to recruit 1-2 faculty annually.

Qualified applicants should send a cover letter, curriculum vitae, and a statement of research interests to: **Wishwa Kapoor, MD, 200 Lothrop Street, 933 West MUH, Pittsburgh, PA 15213 (fax 412 692-4825) or e-mail Noskoka@upmc.edu.** The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

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### General Description

The Public Citizen Health Research Group has a 38-year record in research-based consumer health advocacy/change with a particular focus on the safety and efficacy of drugs, devices and health care services. The Researcher/Deputy Director will have responsibility for research, leadership and management of a variety of projects and assist the Director in overseeing the work of the Health Research Group. This full-time position will be based at Public Citizen's headquarters in Washington, DC.

The Health Research Group maintains two Web sites, [www.citizen.org/hrg](http://www.citizen.org/hrg) and [www.WorstPills.org](http://www.WorstPills.org), which provide numerous examples of the research-based advocacy we have done. For more information about Public Citizen, visit [www.citizen.org](http://www.citizen.org).

### Requirements

An M.D. with a completed residency in internal medicine or family medicine is required. Additional training in public health, knowledge of statistics and epidemiology would be useful. Essential requirements include strong analytical and methodological capabilities, good writing skills, a record of published research articles, and proven managerial

skills. The latter should include an ability to plan, supervise, and monitor projects and allocate resources; mentor junior researchers; and supervise a small staff. Past experience in the area of drugs and/or devices is essential, as is the ability to deal with news media and respond quickly to fast-moving events. Person should be an imaginative self-starter with a willingness to tackle sensitive health policy issues.

### To apply

Please send résumé and a statement about your interest in this position to: **Sidney Wolfe, M.D., Director, Health Research Group at Public Citizen, [swolfe@citizen.org](mailto:swolfe@citizen.org)**

## DIVISION DIRECTOR OF INTERNAL MEDICINE SCOTT & WHITE AND TEXAS A&M COLLEGE OF MEDICINE

Scott & White and Texas A&M college of Medicine are seeking a Division Director of Internal Medicine with strong credentials in clinical care and education for out-patient based position in Temple. The current division includes 30 internists with a strong academic component with medical students and residents as well as an active research group, with special interest in outcomes research and quality and safety. Close collaboration includes areas such as women's health, lipid disorders, hypertension and vascular disease. The Director of this Division must have a vision of how primary care may change in the future and willing to look using technology and new models of care for chronic disease management.

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If living in beautiful Central Texas and practicing medicine in a collegial environment interests you, please contact: Pat Balz, Physician Recruiter, Scott & White Clinic. (800) 725-3627 or [pbalz@swmail.sw.org](mailto:pbalz@swmail.sw.org). For more information on Scott & White, please visit our web site at [www.sw.org](http://www.sw.org). Candidates must complete a formal application to be considered. Scott & White is an equal opportunity employer.



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