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The Leadership Forum

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

"To be the voice of ACLGIM and communicate about leadership challenges and solutions in academic medicine to members, the SGIM community, and other stakeholders."

Lauren Block

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Editorial Corner
From the Editors

Lauren Block, MD, MPH; Sunil K. Sahai, MD

Spring 2022 was a whirlwind of change. From loosening of mask restrictions to new variants and medications, the pandemic has provided a backdrop of new chapters and challenges. International conflicts, including the war in Ukraine and local struggles with social justice, provide moments of sorrow and opportunities for advocacy. In the educational world, match days offered exciting news for students and residency and fellowship programs as we gear up for the 2022-23 academic year. Many of us in SGIM and ACLGIM were fortunate to have an opportunity to reunite with colleagues, mentors, and mentees and make new connections at the first in-person annual meeting in three years. We recommitted to pursuing equity and excellence in general medicine and to meeting our professional and personal goals.

In this issue, Drs. Skandhan and Mohamed present an opportunity to use technology to continue networking and dissemination through a Twitter Poster competition. Dr. Patel offers an approach to meeting the needs of Generation Z learners for those of us steeped in the cultures common to other generations. Dr. LaVine and colleagues describe a national survey of ACLGIM members revealing that most physician leaders continue direct patient care as finding the ongoing patient care work central to their identity and leadership toolkit.

We hope you enjoy this issue of ACLGIM's *The Leadership Forum*.

Amith Skandhan

Waseem Mohamed

Technology in Medicine
Promoting Productivity: The Twitter Poster Competition

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The COVID-19 pandemic has caused many disruptions across different fields, and academic medicine was one of them. Balancing professional and personal responsibilities during the pandemic has further caused difficulty with the scholarly productivity of physicians and trainees. The reduced productivity disproportionately affected females and minority physicians. With the balance tipping towards clinical care, the academic yield has been affected, leading to the stress of not meeting deadlines and benchmarks for academic promotions. Additionally, social distancing guidelines, cancellation of educational events, inability to find daycare, and unexpected homeschooling responsibilities further contributed to the stress.[1]

One of the main aims of the Wiregrass Chapter of the Society of Hospital Medicine (SHM), based in Dothan, Alabama, is to promote ac-

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ademic medicine through our annual poster competitions. The chapter was established in 2014 and has grown significantly.

With the COVID-19 pandemic ongoing, and keeping with the social distancing guidelines, the chapter leadership proposed an innovative idea to use Twitter as the platform for the poster competition. As a result, the chapter was able to organize the poster competition for 2020 and 2021 using Twitter.

In 2021, we had 100 posters in six different categories. To encourage academic interaction, we had 25 judges from across the country belonging to various institutions. Using a streamlined process, we had an upload poster day, specific hashtags for each category, and poster judging spread over five days with specific times for judges to interact with the poster presenters. Additionally, we provided an option for the presenters to upload a short video describing their poster to upload along with their poster. The presenters were encouraged to retweet their posters and interact as well. Further, we had a set of rules and ethics to deal with Twitter conversations, monitored by the organizing committee.

2020
108 participants across 185 tweets used #SHMWiregrass.
The hashtag was seen 264,147 times.

2021
181 participants across 514 tweets used #SHMWiregrass.
The hashtag was seen 524,611 times.

In addition to the Twitter uploads, judges had access to an online directory of abstracts for the poster competition, later used for publication. Next, the judges filled out an online form that tabulated and sent the results to the organizing committee. Finally, we conducted a final meeting with the judges on zoom at a preselected time.

In addition to convenience, this poster competition created visibility for the academic work at an unprecedented scale, leading to improved networking and career growth opportunities. Furthermore, the presenter's family and friends had a chance to see and appreciate the work. Since we set specific times for the judge-presenter interaction, it made it easy for both parties to balance their responsibilities and participate in this experiment.

As a result, this project has highlighted an academic innovation while also considering the presenter's and judge's well-being. See the box for the Twitter analytic data for the last two year's poster competitions.

Traditional academic rigidity dictates scholarly activities like poster completion take place in person. However, the disruptions brought about by the COVID-19 pandemic have highlighted the need to develop innovative solutions. Merging social media like Twitter with academic medicine reveals data-driven broader visibility and interaction while balancing social distancing and accounting for the challenges faced by the participants. We feel this modality of academic experimentation should be utilized more.

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Medical Education
Meeting the Needs of Generation Z in Medical Education


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"Every generation imagines itself to be more intelligent than the one that went before it, and wiser than the one that comes after it." —George Orwell

As we navigate these unprecedented times through the COVID pandemic, economic uncertainty, and global instability, a new generation has entered the ranks of medical education—*Generation Z* (i.e., iGen, Gen Z) born between 1995-2012 are maturing in a vastly different world from previous generations.[1] Though generational characteristics are shaped by history, economics, and politics, no individual can be fully explained or understood in isolation of their unique lived experience and personal narrative through this broad lens alone. However, a few general tendencies and preferences do appear to typify this generation.

Having been raised in the shadows of September 11th, school shooter drills, the Great Recession, and a shift towards child-centered parenting styles, Gen Z tend to be "cautious and pragmatic" with lower rates of tolerance for risk and life experience typical of previous generations.[1, 2] Consequently, Gen Z may be less prepared for the rigors of independent living. As digital natives, they are more likely to spend time on social media in

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isolation than in face-to-face interactions. The lack of authentic connection with others can lead to worsening of mental health.[1] In a survey of medical students, 82% reported feelings of psychological distress.[3] However, Gen Z are more likely to seek mental health services and prioritize health and wellbeing compared to prior generations. Though volunteer and work experiences are more limited, Gen Z can utilize technology in creative ways to advance and address important issues such as social justice.[4]

Meeting the needs of Gen Z learners will require medical education not only to be intentional and thoughtful and but also to challenge the status quo. Curricula will need to be reimagined with a mix of face-to-face interactive education (TBL, PBL, flipped classrooms) and online supplementation with short, chunking of information in highly engaging ways.[1, 2] This will perhaps signal the long-awaited final death nil to the traditional lecture format. Incorporating student feedback on course content, design, and implementation will ensure an iterative process of co-creation. Educators will need to develop curricula around life skills, time management, and literary and communication skills to prepare learners for the professional world.[2] As the mental health support infrastructure for physicians and students has long been underdeveloped, medical schools will need to embrace far-reaching culture change and create robust programming, which is accessible, available, and convenient.[4] Furthermore, as Gen Z is the most diverse generation on the planet, educators will need to develop and nurture the skills needed to create brave spaces for rumbling with difficult and contentious issues in medicine, healthcare, and society.[2]

When each successive generation that enters medical school, educators will need to continue to evolve, stay humble and grow. Perhaps we should even thank them for nudging us towards courage and discomfort.

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Nancy LaVine | Jessica Hyla | Lauren Block

Clinical Care

Perspectives on the Balance of Clinical Care and Leadership in General Internal Medicine Leaders

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The COVID-19 pandemic demonstrated the importance of strong physician leadership within healthcare systems.[1] To support GIM leaders in times of crisis and times of calm, we must understand the challenges facing physician leaders.

As physicians assume leadership roles in administration, research, or education, time allotted to direct patient care can decrease. Balancing managerial and clinical roles is therefore challenging. Time constraints, financial pressures, clinical credibility, and job satisfaction may influence the decision to continue clinical care; some physician leaders give up direct patient care altogether.[2-4] Literature on physician leaders has not characterized the role direct patient care plays among leaders in academic general internal medicine (GIM).[2-4] We sought to determine whether GIM leaders continue to provide direct clinical care and why, in order to understand how GIM leaders view their role as a physician and leader.

We performed a national cross-sectional survey of ACLGIM (Association of Chiefs and Leaders of General Internal Medicine) physician leaders, a leadership organization within the Society of General Internal Medicine. A questionnaire was sent to the 232 active ACLGIM members in February 2018, including demographics; leadership role; time spent in administration, research, teaching, and patient care; and how patient care influences their leadership. Burnout was assessed using a single-item measure.[5] The survey was piloted for face and content validity with physician executives at Northwell Health. The project was deemed exempt by the Northwell Health Institutional Review Board.

The following is a list of what we discovered:

- 62 of 232 (27%) physicians responded to the survey; 55 (24%) completed the survey. Respondents were predominantly male (59%), white (80%), and middle-aged (age 45-64) 84%. 90% were employed by an academic medical center, with "Chief" being the title for the majority (67%). Most respondents reported holding a leadership role for less than 10 years (78.2%). On average, respondents spent 45% of time in administration, 19% of time in direct patient care, 14% of time supervising residents,

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12% of time in research, and 9% teaching.

- 86% of physician leaders reported currently providing direct patient care. Among these, 35% spent less than 10% of their time on direct patient care a week. Of the physician leaders currently providing direct patient care (N=47), 87.2% reported that they had to decrease their clinical activity to accommodate their leadership responsibilities.

Respondents ranked their role as a clinician as the highest in personal importance, but reported their administrative role was of highest importance to their organization. Top reasons for continuing to provide direct patient care included personal fulfillment, clinical credibility, and maintaining clinical skills/knowledge. Further, we discovered the following:

- 91.3% of respondents who provided direct patient care reported it enhanced their leadership role.
- 25% of respondents reported burnout (a score of >3). There was no significant correlation between burnout and time spent on direct patient care.

A majority of ACLGIM physician leaders continue to provide direct patient care. The reasons for continuing patient care included personal fulfilment, maintaining clinical credibility, and preserving clinical skills. This echoes previous literature that continuing direct patient care contributes to higher rates of satisfaction among physician leaders and enhances credibility among peers.[2,3]

GIM physician leaders also maintain a strong attachment to their identity as a clinician, despite progression into leadership roles with less time dedicated to patient care. Although physician leaders spend most time on administrative work and their role as an administrator is most valued by their organization, physician leaders place highest value on their role as clinicians.

Despite leadership roles, a burnout rate of 25% in this population were below the reported for average GIM physicians (38%); percent time spent in direct patient care did not correlate with burnout levels.[5]

Our data was self-reported and response rate was suboptimal, both limitations. As the survey was administered within a single leadership organization within a larger single specialty organization, results may not be generalizable. We have been careful to not make causal inferences from cross-sectional data, instead focusing on themes.

Most academic GIM physician leaders in this national sample reported continuing to provide direct patient care and believe that direct patient care enhances their leadership role. In this pivotal time in health care, supporting physician leaders by allotting time and resources towards their continued involvement in patient care is critical.

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