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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

We are pleased to share this December issue of ACLGIM's *Leadership Forum* with perspectives from colleagues across the country. As ACLGIM President, Mark Earnest shares his leadership journey, including how childhood lessons in advocacy and organization spurred professional success and leadership skills. In these challenging times of staffing shortages and pandemic fatigue, Lucille Torres-Deas and Abby Spencer write of culture change to prioritize connection and joy in medicine as a means to cultivating wellness and embracing diversity. Peter Cram compares health care from the perspective of patient and provider in Canada and the United States, highlighting benefits and drawbacks of each system. We hope these pieces motivate readers as they have inspired us. As the calendar year draws to a close, we invite all those who enjoy reading ACLGIM's *Leadership Forum* to consider joining us on the Editorial Board. An invitation to apply will be circulated widely this Fall and Winter.


Lucille M. Torres-Deas


Abby Spencer

Wellness
Wellbeing: Lead by Example

Lucille M. Torres-Deas, MD; Abby Spencer, MD, MS, FACP

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For too long, the culture of medicine has perpetuated the idea that physicians should sacrifice themselves during medical training and beyond—to show up when sick, to neglect their needs, and so forth—in order to learn the art of medicine. Without a doubt, the tragedies and loss in the wake of COVID-19 has brought to the forefront the need for a paradigm shift.

As leaders in medicine, if we are to improve the wellbeing of our medical trainees, we must rise to the challenge and lead by example. Our actions speak louder than our words. Medical trainees look to us to teach them about gathering histories, completing an appropriate physical exam, creating a differential diagnosis with a thoughtful plan, and managing challenging situations. As they look to us for this guidance and education, our trainees also feel the pressure of performing, making sound decisions

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with limited or limitless data, "doing no harm," and being evaluated. Our trainees take verbal cues from us, but more importantly, they learn the hidden curriculum from the consistent psychological and emotional cues we send as well. It's critical that as leaders and educators, we establish a safe and inclusive learning environment that nurtures the trainees, their professional identities, and their wellbeing. Our words and actions must represent the wellbeing and wellness culture to which we aspire.

What will our medical trainees think if their physician education leaders come in sick, avoid going to the doctors, and struggle with burnout and mental health without seeking help? Similarly, if we e-mail late at night, on the weekends and holidays, and expect a reply, what does this say about our respect for work-life boundaries? These actions may negate the statements that "your wellbeing is a priority" and reinforce the toxic hidden curriculum of the past. When we send mixed messages, our mixed feelings are heard loud and clear. If wellness is important, but not for us, and not if you have more work to do, trainees may not feel comfortable confiding in us that they are sick, exhausted, unsure, or dealing with a serious life event. They may suffer in silence, thereby failing to meet their potential, losing important relationships or opportunities, leaving medicine altogether, and possibly committing self-harm. It's alarming what we have seen across the country in medical schools, residency and fellowship programs, and the healthcare arena.

As we work to improve our healthcare systems, we must simultaneously improve our work culture to one that normalizes healthy boundaries, belonging, connection, joy, and fulfillment. It is crucial we share with our trainees how we connect to our meaning and purpose in medicine, recall what led us into medicine in the first place, and demonstrate setting the boundaries we all so desperately need. Recall the Japanese proverb of Ikigai—where passion, mission, profession, and vocation all align. When was the last time you connected with a trainee about what they most love to do? What they are good at? How they want to change the world? It's amazing the sense of belonging we can create when we invite our trainees to reflect on what they love and when they are at their best. Promoting wellbeing with our trainees also involves mitigating their imposter syndrome, advocating for diversity, equity, inclusion, and role-modeling a growth mindset. We must remind and demonstrate that we're in it for the long game—there is no race to the finish line here. While people admire our hard work, achievements, and awards, they may not always see the grit, sweat, tears, and failure along the way. Sharing these journeys with our trainees, opening to vulnerability, gives them permission to be human, too.

Adam Grant shares, "Resting is not a waste of time. It's an investment in well-being. Relaxing is not a sign of laziness, it's a source of energy. Breaks are not a distraction; they're a chance to refocus attention. Play is not a frivolous activity. It's a path to connection and creativity."[1]

So, physician education leaders, let's stand together as a united front to model that wellbeing is a priority. Let's ensure our actions speak louder than our words so the next generation can flourish and create a culture were medical trainee and physician wellbeing is a priority now and beyond.

References

1. Grant A. *Twitter.com/AdamGrant.* Posted August 17, 2021. Accessed October 18, 2022.

Peter Cram

Leadership Profile

Trade-offs and Compromises: Reflections on My Time as an Academic General Internist and Human Being in the United States and Canada

Peter Cram, MD, MBA

Dr. Cram (pecram@utmb.edu) is chair of the Department of Internal Medicine at the University of Texas Medical Branch (UTMB) in Galveston, TX, and previously director of the Division of General Internal Medicine and Geriatrics at Sinai Health System and University Health Network at the University of Toronto (2014-21).

In October 2013, our family bid goodbye to our beautiful home and dear friends in Iowa City. I resigned from my role as division chief for general internal medicine at the University of Iowa and the Iowa City VA. In January 2014, we began our new life as expats living in Toronto, Canada, where I was the division chief for general internal medicine and geriatrics at three large University of Toronto teaching hospitals. In April 2021, after seven tremendous years in Canada, I returned to the United States to become the chair of the Department of Medicine at the University of Texas, Galveston.

Our decision to move from Iowa to Toronto was well thought out—there were personal reasons, including exposing our children to a large, diverse, and very safe city in a nearby foreign country. There were professional reasons, including a chance to work in a top-tier university and simultaneously become an embedded researcher in a country with universal health insurance implemented using a national health insurance model. People often ask me to compare my experiences and impressions in these two adjacent and very different healthcare systems. I will offer a few observations, in no particular order:

- *Incentives truly matter.* The United States healthcare system, including both Medicare and private insurance, provides generous access to costly hospital-based tertiary and quaternary services so Americans get lots of these services. The Canadian system uses an array of policies to restrain access (and spending) so that Canadians get less of these services.
- *Trainees in Canada are given more autonomy than their United States peers.* In Toronto, it was commonplace for third-year medical students to manage 1-2 patients and fourth-year students to mange 4-5 patients largely autonomously. This practice is born of necessity, given patient volumes and house staff availability, and facilitated by a billing system and where this practice is generally accepted. While hospitalized patients in Canada are seen by the attending physician at the time of admission, they may not be seen again if doing well by the doctor (including at discharge).
- *Customer service in Canadian health care needs to be better.* The United States spends approximately 20% of gross domestic product on health care; Canada 12.7%. While much of the excess United States spending is likely waste (aka *low-value care*), some of this excess spending pays for valuable initiatives, such as the routine assessment of patient satisfaction and experience measures; in Canada, restrained spending means limited resources for routine capture of these sorts of data. There are few international comparisons of patient satisfaction and international comparisons are fraught with methodological challenges. Canadians tolerate poor service that most Americans would not accept.
- *The administrative complexity and waste resulting from the fragmented United States insurance system is real.* As a practicing hospitalist in Toronto, billing consisted of checking a box on an index card or a quick swipe on a smart-phone app. Although it seems quaint, clinical notes in Canada were primarily used to communicate treatment plans. Contrast this with the army of billing and coding staff layered on top of United States electronic health records to ensure that physicians and hospitals get paid. Moreover, as a physician I can count on one hand the number of times that insurance or payment was a concern in providing patient care (almost always for foreigners who became ill while visiting Toronto).
- *As best as we can tell, "outcomes" in the United States and Canada are similar.* The very concept of health outcomes is broad and covers multiple domains. While some research suggests potentially higher surgical complication rates in Canada than the United States, other research suggests lower post myocardial infarction mortality in Canada. Life expectancy, arguably the most all-encompassing outcome, is 1-2 years longer in Canada than in the United States.

In Canada, customer service may be less refined, hospitals and clinics more crowded, and access to tertiary and quaternary care more restricted. These drawbacks must be weighed against a system where insurance fades into the background of patient care and life expectancy and global measures of well-being seem to exceed the United States. I have come to believe that somewhere in between Canada's single payer and the United States' too many payers, the hybrid models employed by England, Australia, Israel, or Netherlands offer us a pathway forward.

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Mark Earnest

President's Column
My Journey to Leadership

Mark Earnest, MD, PhD

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My path to leadership arose from something very simple—there were things I wanted to see happen that I couldn't do alone.

In middle and high school, most of those things were primarily for fun: Boy Scout contests, an overnight basketball marathon to raise money for charity, changing an annual formal dance into a beach party ("The Beach Ball"). I don't remember embarking on any of those projects with much forethought. An idea would take hold of me and, as I persisted in sharing my excitement, a path forward would start to reveal itself as people joined me, adding their ideas and enthusiasm. As obstacles appeared, so would a set of solutions pointing to the permissions and resources that we needed to move forward. It was fun to do something that had never been done and even more fun to do it with a group of people who were as energized as I was. For me, it felt more like a pick-up game of sandlot football than anything I would have called leadership. People wanted to play, they just needed a nudge, and I was glad to provide it.

Medicine was not great for my confidence. Everyone around me had some talent or level of expertise that seemed well out of my reach. On a good day, I felt average. What kept me floating above the anxieties was the sense of purpose I felt in patient care. I was *good* at caring for people and my desire to do so helped me master what I needed to master to do it well. I always seemed to be able to get over the next hurdle and that was enough to keep me moving through medical school and training. I never imagined myself having the confidence or stature to hold a titled position of leadership, and frankly, never aspired to it.

I entered practice during a time of turmoil. The Clinton health plan had collapsed; subsequently, corporations and "managed care" were rapidly taking over health care across the country. Many of my patients lost access to care as hospitals and health systems cut back access to save money. In addition to my practice, I was working to develop myself as a teacher and had started a PhD to become a researcher. Suddenly, there were a lot of things I wanted to see happen. Looking at all the dysfunction and inequity in the health system, I wasn't sure what I could do. I was certain I needed to do something. I could not do any of it alone.

Moral distress slowly distilled into something more like purpose. I threw myself into the mix of advocates and policy-makers in the community and on campus and the dynamics I discovered in high school re-emerged. As I persisted in pursuit of a purpose, allies appeared, paths revealed themselves, and obstacles gave way to solutions. I found myself in a wonderful new place of possibility, bridging the resources of our campus with the rich, and diverse set of possibilities and people in the community. I gained sponsors on both sides and opportunities emerged to write grants, start initiatives and build programs. From an academic perspective, I was following completely non-traditional path, but it was working and felt incredibly rewarding.

Through years of iterations, of false starts and failures, as well as successful projects and programs, something happened. I began to feel confident. It was not an "I've got the answer" sort of confidence, but more of a "We got this" feeling when faced with a new opportunity or challenge. After 20 years of knocking on doors, probing the cracks, and, when necessary, picking a few locks (metaphorically, of course), I had a sense there was always a way to move a good idea forward and the confidence that I could work successfully with others to make that happen. I had started and led a few programs on and off campus and, through that, had learned my way around as well as the ins and outs of budgets, human resources, and the arcana of university administrative processes.

Eight years ago, I felt confident enough to say "yes" when my new chair asked if I would consider taking the newly vacated division head position as an interim. In the wake of that decision, a few things shifted—*my* purpose now is mostly helping other people actualize their own purpose. One thing hasn't changed; many days, it still feels like a good pick-up game. It's still fun to do something that's never been done, and even more fun to do it with people who are passionate and energized.