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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."


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Editorial Corner
From the Editors

Sunil Sahai, MD; Rita Lee, MD; Lauren Block, MD

In this summer's issue, we explore some themes about the future of medicine. The future of academic general internal medicine dominated the conversation at both the ACLGIM Winter Summit in December 2022 and the Hess Institute in May 2023. Topics included sustainability, recruitment, inclusivity, and adaptability and how we, as leaders, are tackling these challenges.

In this issue, we are rekindling the conversation about the future of our profession. Many of us were trained in rigid hierarchal organizations that failed to understand or adapt to transformative changes in our society. To this day, we still see the consequences of leadership designed to serve the "average white man" as Drs. Elizabeth Jacobs and Jeff Linder put it so succinctly at the 2022 ACLGIM Winter Summit. Dr. Amy Bonomi offers us a framework to analyze the inclusivity of our organizational culture and the questions we must ask ourselves as leaders across three domains. Dr. Pete Yunyongying dares to say what we all wish was not true: in the current system, health care, like food at a restaurant, is a commodity subject to the vagaries of the free market. It is up to us to decide what principles we need to compromise on and which values we hold sacrosanct that will differentiate us from others in the market. Finally, Dr. Mark Earnest ties together all the above themes by showcasing the work that was done at the Annual Hess Institute during the #SGIM23 in May 2023.

We hope that the June 2023 issue provides a basis for introspection for us as leaders in the field. In addition, we also hope that it provokes conversation within your institutions on how we may come together to face the challenges that await us and future leaders in academic general internal medicine.


Pete Yunyongying

Healthcare Economics
Like Food, Health Care Is a Commodity

Pete Yunyongying, MD, FACP

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Noma, the world's best restaurant, shocked everyone by announcing that it would close its doors; Executive Chef Rene Redzepi said that the fine dining industry could not sustain the balance between affordability, high-level quality, and a workforce treated fairly. This news came while nurses went on strike at Montefiore Medical Center and Mount Sinai Hospital. These are not just any hospitals, but long-standing health-

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Healthcare Economics

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care institutions with a reputation for quality. Mario Cilento, president of the New York State AFL-CIO, said nurses are forced to work in "unimaginable conditions."[1] Is this coincidence? Are these two industries that different? Or are they suffering from the same affliction?

The business model for the restaurant industry is based on commodity—something to be bought and sold. But for a place like Noma, it's not as simple as selling food. No one is going to pay $500 for just food and drink; instead, it is about marketing and selling a memorable experience where innovative food is served with impeccable service by a doting waitstaff in attractive surroundings. The closing of Noma highlights the conundrum for fine dining. To sustain a high-quality product at a price affordable to its customers, they must sacrifice fair working conditions and wages for their workforce. Quality, workforce, cost—Noma realized you can only have two of the three to survive. So, they decided to close and change their business model.

Many of us see this same conundrum in health care. Porter, et al, JGIM's article showed that it takes more than 26 hours a day to deliver the highest quality care to a typical outpatient primary care panel.[2] In other words, we are already sacrificing quality to meet other priorities. Nurses are striking in New York and physicians, nurses, and other healthcare staff are suffering from burnout at higher rates because we are sacrificing the workforce to meet other priorities. Despite any debate to think of health care as a human right, or any mission statement that says that quality health care is our *raison d'etre*, health care is managed as a commodity and run as business with cost (and budget, and margin, and profit) as the top priority.

Noma decided their untouchable priority was quality; but they realized that the sacrifices to the other priorities were unacceptable, so they decided to change the business model to find a different way to deliver the highest quality at an acceptable cost with a sustainable workforce. They closed their doors to the public to focus on research and development.

The signs are growing that the current business model for health care is just as unsustainable as Noma's. But what solutions lie ahead for us? Unlike Noma, hospital systems closing their doors to the public adversely impact the health and wellbeing of their communities, as is being seen in the rural health crisis we are facing presently. Do we, like Noma, decide that quality, and not cost, is the unassailable priority? And if so, how will we innovate? This, of course, is the premise that has led to the growth of concierge medicine, for example. Do we accept that health care is a commodity with cost as the top priority and continue to innovate along alternative payment models? Health care isn't facing just any challenge, it is facing an existential crisis, just like Noma.

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Amy Bonomi

Leadership

Inclusive Leadership: Probing Organizational Culture at Three Levels

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Today's most effective healthcare organizations and practices are led by inclusive leaders—those open to and supportive of diverse ideas, perspectives, and identities, and committed to continually improving their proficiency in inclusion concepts and skills to positively shape organizational culture.

Organizational culture can be thought of as "the patterns or systems of beliefs, values and behavioral norms that come to be taken for granted as basic assumptions".[3] What uniquely distinguishes inclusive leaders is their ongoing focus on signaling inclusivity at three levels of organizational culture:[3] Michael Landry, MD (Mentor):

1. **Visible artifacts and observed behaviors.** This ranges from the language, images, and accessibility indicators in the organization's marketing materials (e.g., does the organization's website and clinic materials include gender-neutral language?), email outreach, written policies, and practices, such as how job descriptions are written (e.g., are certain levels of education expected which may

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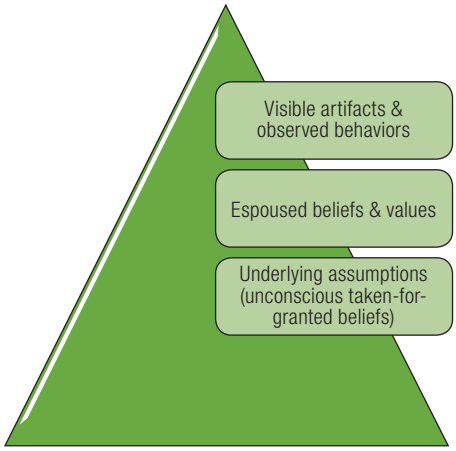

inadvertently exclude qualified candidates?). Inclusive leaders continually probe these areas, soliciting input from diverse stakeholders within and outside the organization to continually build awareness of areas they may or may not have considered.

2. **Espoused beliefs and values.** Espoused beliefs and values are what the organization says it stands for (e.g., inclusion, equity) that may or may not be congruent with behaviors in the organization. One strategy for checking alignment between the organization's values and behaviors is for leaders/members to create a table that lists the organization's espoused values. Next to the values, leaders/members define the value and then describe (from their vantage point) how behaviors in the organization align (or don't align) with the value. If we consider an organizational value like "inclusion," it is not uncommon for leaders/members to say that their organization does not always welcome/include diverse perspectives, that some level of assimilation and adherence to the status quo is expected. This becomes a launching point for leaders/members to explore how the organization can better align behaviors with values.

3. **Underlying assumptions, or unconscious taken-for-granted beliefs.** Underlying assumptions and beliefs constitute the most difficult level of organizational culture to influence because the thought and behavioral patterns which have developed since the beginning of the organization are now regarded as basic assumptions. Inclusive leaders continually examine underlying assumptions including how bias may be reflected in recruitment, evaluation, and promotion (or not) of members of minoritized groups (e.g., ability, age, gender, ethnicity, race, sexual orientation). This examination involves continually probing and broadening one's leadership network to ensure input from diverse stakeholders is consistently integrated into improvement efforts. To broaden leadership networks, leaders should reflect upon the three to five people they go to for advice and then to further reflect on the identities of those individuals. We tend to associate with those who look, sound, and act like us.[1,2] This reflection tool that can be used throughout leadership careers to continually expand networks and ideologies.

In closing, inclusive leadership involves a continual probing of three levels of organization culture. What aspects do or do not resonate with you? What are you doing in your own leadership practices to signal inclusion?

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Mark Earnest

ACLGIM
Attracting and Retaining Academic Generalists

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"I'm spending the majority of my efforts these days pursuing faculty recruitment…"

So began a GIM Connect message from Eric Rosenberg, (GIM Division Chief at the University of Florida) in November 2022—it described his struggle recruiting residents into their academic practice despite all things they had done to make practicing there easier and more attractive. Primary care recruitment, he noted, was more difficult than hospital medicine positions, especially now that they were competing with community practices where full-time work was now three days a week of patient care, "with no homework."

Eric's message opened the floodgates. Over the next week, dozens of people responded describing their own struggles to recruit as well as their anxieties about what this means for the future of academic GIM in general, and primary care especially. The responses were wide-ranging. Some people contributed steps they have taken in their divisions to increase their success at recruiting new faculty and retaining the ones they already have. Others spoke to root causes and offered theories about how we could reverse the slow decline

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of residents entering primary care. Sprinkled in between were numerous offers of empathy and various versions of "I feel your pain." Eric's message had clearly hit a nerve.

Fortunately, the conversation began just days before our annual summit in Arizona. While the meeting did not have time set aside for this topic, it surfaced frequently during and around the meeting. We devoted much of our ALGIM Executive Committee meeting to thinking through what we can and should do as an organization to address these widely shared concerns. I'm glad to say that we've settled on an answer.

Part of this year's Hess Institute focused on developing an action plan for addressing this growing crisis. We contracted with Civic Canopy, a Denver-based non-profit organization that specializes in facilitation, to help us develop such a plan. In the weeks leading up to Hess, the ACLGIM Executive Committee worked with Civic Canopy to lay the groundwork for the meeting itself. Surveys were sent to the ACLGIM membership in advance of the meeting to help guide our discussions—I thank those of you who filled them out. As this article goes to press, we are working to develop an action plan and toolkit to help us all with this shared struggle.

This is a challenge that requires a diverse set of perspectives. The usual broad mix of Hess attendees, current students, residents, new faculty, and those who have been doing this a long while, have put their experience and creativity to work to help us develop something impactful. In addition to the time devoted to the future of academic GIM described earlier, we had a terrific program, with several stimulating speakers and opportunities for networking and skills building.

Thanks to everyone who contributed to this work—those who attended Hess and the rest of you who offered your thoughts about the nature of our challenges and potential solutions. Stay tuned. I'm optimistic we will have an impactful set of actionable strategies to share with you soon.