Professionalism

1. A staff/faculty physician occasionally has outbursts, raising their voice and making aggressive comments against administrative staff, nurses, or trainees. “They yelled at me and called me incompetent for asking them to re-sign a credentialing document when the original could not be found,” said an administrator. “They asked me what I’m going to do for a career since I have no future as an ophthalmologist,” said a trainee. The outbursts are rare, and this is a highly valued and productive physician with unique skills that would be difficult to replicate.

2. A year ago, you landed an awesome new faculty member, recruiting her away from a well-known program. She was thoughtful, erudite, a good teacher, and a highly engaged faculty member. But, it wasn’t long before things started to fall apart. It was reported that she was keeping alcohol in her office mini fridge, and performance in the clinic began to unravel. Clinical procedure safety protocols were being ignored, and behavior with staff and patients alike began to be more antagonistic. You met with her on several occasions to address the concerns, but little progress was apparent. Particularly worrisome was her apparent inability to adhere to standardized protocols for in-office procedures. What should be your next step?

3. A division director — a clinically excellent, deeply committed faculty member — has a pattern of firing off emails in the heat of frustration. When a scheduling snafu causes clinic disruptions, they send a sharply worded message to, for example, the surgery center director, copying hospital administration, questioning their competence. When a new institutional policy adds documentation burden, they email the CMO calling the policy “absurd” and “designed by people who don’t see patients.” Each email lands like a small grenade, and me, the chair, finds myself repeatedly in damage-control mode — calling recipients to smooth things over, reassuring institutional partners that your department values the relationship, and protecting your faculty member’s reputation from the trail they are leaving behind. Your division director’s frustrations are often legitimate. They are a talented physician, an effective teacher, and someone who cares deeply about the department. But their reactive emails are eroding trust with institutional partners, undermining my department’s credibility, and creating a perception that my group is difficult to work with. Leading to my need to address the behavior without demoralizing a key faculty member.

4. One of my senior administrators is, in many ways, my department's backbone. They have deep institutional knowledge — procurement rules, HR policies, credentialing processes, compliance requirements — the kind of expertise that takes years to accumulate and is impossible to replace quickly. In a small department where the administrative team wears many hats, they are indispensable. But they have a persistent blind spot: they cannot acknowledge mistakes. When an error surfaces — almost always something minor and easily fixable — they deflect, reframe, or quietly corrects it without acknowledgment. On one occasion, you texted them during a trip to let them know your hotel confirmation was missing from the travel app. They responded that it was there. Within moments, it appeared — because they had just added it. Rather than saying, "Sorry, I missed that — it's in there now," they presented it as though the error had never occurred.

5. The hospital has a requirement that all notes be signed and charges submitted within 7 days of a visit. However, one faculty member is consistently behind in their notes and charges. This results in confusion among others providing care for individual patients; ("Did the medications change?" "What is the follow-up plan?"). The charges are sometimes so late that bills are not paid by insurance due to "lack of timely filing." The doctor consistently receives the highest possible scores on patient surveys and is revered by staff and colleagues.

Conflict Management

1. While preparing for an external inspection, hospital administrators discover that bottles of eyedrops are not being kept in a locked cabinet between use. On further review of manufacturer packaging, they note that topical proparacaine bottles are not being placed in a locked refrigerator between patients during the day. They issue a new requirement that all exam rooms with eyedrops must be equipped with a locked cabinet for storage between patients, and, further that the proparacaine drops must be continually kept in a locked refrigerator between patients. Then, on even closer review, they discover that all bottles of eyedrops currently used in the clinic are labeled as "single use" by the manufacturer. They therefore demand that fresh, unopened bottles of dilating drops be used for every unique patient for every visit to the eye clinic.

2. You are the PD. You get a safety report where a resident states the attending faculty abandoned them in the OR during a case leaving the patient at risk. You reach out to the resident who reports that the attending asked them to close the conjunctiva and they said that they didn't know how. The attending drew on the board the running

suture closure and left the room. The faculty explains that 1) the trainee has completed 8 of the 10 weeks on rotation and has seen and done this procedure multiple times, 2) the faculty member is confident that this resident's surgical skills are excellent and they can handle closing on their own, 3) it is June 18 and this resident is graduating and being pushed out into the world in 2 weeks.

Time Management

1. As the newly appointed leader of your department or division, you quickly discover that one of your greatest challenges is time management. In addition to continuing patient care demands, you now have several additional responsibilities. Several new administrative meetings have been added to your calendar each week. Your email inbox has exploded with requests for decisions on items such as research space, hiring, or call-schedule conflicts. In addition, you are now copied on many more emails regarding issues of which you need to be aware. You feel a responsibility to be immediately responsive to your colleagues you are leading, and you find that you are spending evenings and weekends catching up on tasks. You regret that you don't have the time you need to work on issues that require your thoughtful, focused attention, such as budget reviews, annual assessment and goal setting, and long-term programmatic planning.

Team Building

1. You assume a new leadership position (e.g., department chair, division chief, children's hospital ophthalmologist-in-chief) in a health system where you have never worked, and in a city you have never lived. From your first day, you find yourself navigating a group with low morale, fragmented teams, and high staff turnover, all while meeting faculty members or colleagues who are looking to you for stability even though you're a newcomer. Some of your divisions have been depleted by recent departures, and those who remain are feeling overwhelmed. Incidentally, some of your new colleagues (and direct reports) had been candidates for the position you now hold. Institutional leadership is eager for rapid improvement in faculty and staff engagement and retention, volume of clinic visits and surgeries, and financial parameters.

2. A year after you arrive as Chair, it becomes apparent that you need to develop a compensation plan. Under the previous Chair, each faculty member had negotiated their terms and salary individually with the Chair. You needed a new plan to level the playing field because salaries, incentives, and required clinical sessions were all over the place. Your new plan standardized salaries, set session targets, and added upside bonuses and downside salary decreases based on productivity. There were "winners" and "losers" and within 6 months, 25% of the faculty had resigned and moved to other Departments in town or joined a private practice. You had prepared

yourself for challenges before you took the job as Chair. But now, many of the remaining faculty are questioning your leadership and your wisdom, and Hospital and University Senior Management are asking questions too. What should you do?

Negotiation and Consensus Building

1. The PMR department houses one residency and four fellowships. Two of the four fellowships (Brain Injury Medicine and Spinal Cord Injury Medicine) go unfilled 50% or more of the time (fill once every 3 years) and have similar match statistics nationwide (22 total applicants last year for spinal cord injury). The hospital wants to reallocate the FTE to other, more competitive programs. The program faculty see the fellowship is a pathway to faculty recruitment, want to remain engaged in teaching and want to promote their specialties.

Stakeholder Analysis:

- Hospital: faces their own financial hardships and would like to reallocate FTE from poorly recruiting programs into programs that fill so that there are not staffing gaps
- Department Chair: faces a Departmental financial deficit and growing pressure from the school to reduce deficits. Program director and coordinator costs are fixed filled or unfilled. Notes with regard to recruitment that fellowship not required for brain or spinal cord injury practice as it is a key component of PMR residency. Only emphasized for academic positions. Considering closing one fellowship to save money. Not sure how to choose. Concerned about recruitment.
- GME office: Published an analysis that shows that program efficiency (cost to train per FTE trained) is unsustainable for programs <4 trainees per year (these are 1 fellow each)
- Department Faculty: disappointed. See the failure of the Department to support the fellowships (despite clear financial hardship) a value judgment. Worry about future faculty recruitment efforts. Pitting SCI against BI faculty.
- Affiliate residency program director sees potential value add with program closure. Resident experience more robust on years no fellow matches because residents have more elective opportunities.

RESOURCES

1. *The Truth about Leadership* —James Kouzes and Barry Posner
2. *Influence, the Psychology of Persuasion* — Robert Cialdini
3. *Drive - The Surprising Truth About What Motivates Us* — Daniel Pink
4. *Getting Things Done* — David Allen
5. *How to Start a Movement* — Derek Sivers (2010) https://www.youtube.com/watch?v=V74AxCqOTvg
6. *How to Win Friends and Influence People* — Dale Carnegie (1936)
7. *Thinking, Fast and Slow* — Daniel Kahneman (2011)
8. *Give and Take* — Adam Grant (2013)
9. *Originals* — Adam Grant (2016)
10. *Good to Great* — Jim Collins (2001)
11. *Quiet: The Power of Introverts in a World That Can't Stop Talking* — Susan Cain (2012)
12. *Athena Rising: How and Why Men Should Mentor Women* — W. Brad Johnson & David G. Smith (2016)
13. *Lean In: Women, Work, and the Will to Lead* — Sheryl Sandberg (2013)
14. *A More Beautiful Question: The Power of Inquiry to Spark Breakthrough Ideas* — Warren Berger (2014)
15. *Leadership: In Turbulent Times* — Doris Kearns Goodwin (2018)
16. *Thanks for the Feedback: The Science and Art of Receiving Feedback Well* — Douglas Stone & Sheila Heen (2014)
17. *Built to Last* — Jim Collins (1994)
18. *Outliers* — Malcolm Gladwell (2008)
19. *The Tipping Point* — Malcolm Gladwell (2000)
20. *Radical Candor: Be a Kick-Ass Boss Without Losing Your Humanity* — Kim Scott
21. *Leaders Eat Last: Why Some Teams Pull Together and Others Don't* — Simon Sinek
22. *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World* — Heifetz, Grashow, Linsky
23. *Getting to Yes: Negotiating Agreement Without Giving In* https://a.co/d/06b6rmm4
24. *The Anatomy of Peace (Fifth Edition): Resolving the Heart of Conflict* https://a.co/d/07sc8NPE