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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."


Maureen Lyons


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Editorial Corner
From the Editors

Maureen Lyons, MD; David Margolius, MD; Lauren Block, MD

As this issue goes to press, the Annual SGIM Meeting is fully underway with a packed schedule of diverse and interesting topics. A fully virtual experience, the conference offers a blend of large group sessions with live Q&A, prerecorded sessions with the unique opportunity to return and view at a later time, and posters that can be perused at your leisure with a live Q&A at designated poster session times. We hope you were able to take time to attend the conference, rejuvenate, and connect with colleagues both old and new.

In this issue, we highlight a few of the workshops and offerings of the annual meeting: workshops on empathy, political advocacy, and promoting talent with high-yield summaries and key takeaways. These topics are evergreen in the world of leadership, but particularly salient with the ongoing public health crises of COVID and racism. Each article provides an overview of the topic and concrete steps forward. We also highlight our incoming ACLGIM president, Dr. Anu Paranjape, and she shares her reflections on this past year with a particular focus on the challenges and successes of the vaccine rollout.

We hope you enjoy the articles and wish you a very happy summer!


Anuradha Paranjape

President's Corner

Anuradha Paranjape, MD, MPH, FACP

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December 14, 2020. A date to remember. That was the day the first non-trial COVID-19 vaccine was administered. That was also the day that the electoral college certified the 2020 election, signaling the next step towards a Biden-Harris administration. I remember feeling as if a weight had lifted off my shoulders even though COVID-19 case counts were high and we were under partial lockdown again. Because both those events signaled hope.

Since the first two COVID vaccines to receive emergency authorization for use are different from known existing vaccines, we all knew there would be questions once they were rolled out. First are questions about vaccine safety and efficacy, especially given how quickly they were produced, and the technology is new. The lack of trust in the medical system among the very same communities which were ravaged by the first wave of COVID-19 last spring was of concern among physicians. One of my nurses had reported on misinformation that was spread in her neighborhood, such as the vaccine would change one's DNA, that it would embed 5G technology. And

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President's Corner

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those were the believable myths. Turns out, there was little hesitancy. When we began our rollout in my institution to our patients, some had no hesitation what so ever, others just needed their questions answered. Indeed, it was vaccine deliberation -and not hesitancy - and lack of access that were interfering with vaccination.[1] Patients would come in with concern over the vaccine contrasted with the hope of safety from the virus and a chance to see their grandchildren. Once we were able to share the CDC recommendation that fully vaccinated people could see unvaccinated family members, it was easier for patients to make a decision to get vaccinated.

Unfortunately, initial roll out in the City and across the country was not uniform. From news reports, it appears that there was little coordinated effort to get the vaccines to the states. I do think as a country we can do far better to ensure equitable distribution. This past year, the pandemic shone a very bright light on what happens when partisan politics get in the way of the health of the country. Even before vaccine rollout, those patients who could get telehealth via video visits safely were more likely to be able to work from home and not risk COVID exposure. The same is true for vaccines. The people at the top of the priority list have had the least access and have had to rely on friends and neighbors spread the word about appointment availability and setting them up with online appointments. There were unfortunate reports of "line jumping" all across the world.[2] Today is April 28, the 99th day of the Biden administration; they have more than delivered on their promise of "a 100 shots in a 100 days" and has secured enough supply to vaccinate every adult. With FEMAs support, mass vaccination sites have helped to reduce the inequity and improve access to vaccine for all. My hope for the Biden presidency is that we can codify a mechanism to deal with public health crises that will not fall prey to politics.

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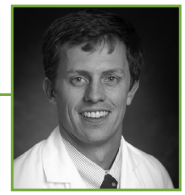

Starr Steinhilber Deepa Bhatnagar Winter Williams

SGIM Workshop
Promoting Talent in 2021: Beyond Mentoring, Consider Sponsoring

Starr Steinhilber, MD, MPH, FACP; Deepa Bhatnagar, MD; Winter Williams, MD, FACP

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Although we are surrounded by talent within General Internal Medicine, how do we effectively and equitably promote it? Junior faculty often struggles to promote themselves, and senior faculty may recognize talent but not know how to advance it fairly. In this column, we provide advice for both situations.

Much has been written about the importance of mentorship; however, sponsorship is increasingly recognized as a separate but vital component of faculty success.[1] Both the mentor/mentee and sponsor/sponsee relationships represent a mutually beneficial pairing, typically of junior and senior individuals, though peer and near-peer models can also be effective. Mentorship is often longitudinal, helping decide where to go and which opportunities to pursue or avoid over time, while sponsorship is more discrete and episodic, such as nominating a colleague for a specific role or opportunity. The differences are summarized well by the phrase: a coach talks *to* you, a mentor talks *with* you, and a sponsor talks *about* you.

Estrada, et al., previously detailed challenges and strategies for promoting talent.[2] Here, we build from those and offer several actions specific to career level.

Junior faculty should look for opportunities and rise to the task. Identify your interests and tell your boss, an action that serves as a means of "branding" and helps others think of you for opportunities. If a sponsor nominates you for something, follow through. Don't let

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yourself and your sponsor down. If offered an opportunity for which you don't have the interest or bandwidth, use that opportunity to sponsor a peer. Finally, promote yourself! If you are a good candidate for a role or award, don't be afraid to ask someone to nominate you. Help senior leaders and peers recognize your talent and promote it.

Senior leaders should consider sponsoring diversely. For every position available, remain intentional to encourage a variety of talent—one woman and one man, one junior and one senior, as well as diverse applicants. An additional step would be creating a Request for Applications (RFA) for open positions to ensure sponsorship is not favoritism. Don't let an award nomination cross your desk without nominating someone, or, if too burdensome, create a committee to do the work as a group (sponsorship!). Consider promotion of others a vital part of your job and a testament of your own success. When your sponsee gets the position, check in with them. Although the sponsorship act was episodic, see how they are doing and whether it was a good match. Use this as feedback for future sponsorship.

Whether early or late in your career, you must continue to refine and pursue your career sweet spot, or "Ikigai," a Japanese concept meaning *a reason for being*. To know which steps to take next, we all must know where we are going. Through effective mentorship and sponsorship, this sweet spot can be achieved within General Internal Medicine.

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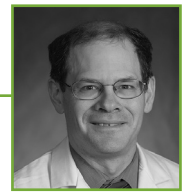
Hannah Lichtsinn


Sire Sow


Nancy Connolly


Jeffrey Jaeger

SGIM Workshop

Doctors in Politics: Demystifying the Process of Running for and Serving in Elected Office for Physicians

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Physicians positively influence the health of their patients and communities through work in multiple spheres of influence—an influence that starts with clinical care and expands to health system quality improvement, community health engagement, and state and federal policy. As this sphere expands from the clinic outward, fewer physicians engage at each level. While an increasing number of physicians participate in health policy advocacy at the state and federal level, far too few take the step of political involvement by serving in elected roles.

Physicians constituted 4.6% of members of congress during the first hundred years of the US Congress. Since then, direct physician engagement in politics decreased consistently through the latter half of the 20th century. During the past decade, however, there has been an increase in the numbers of doctors running for and serving in political office. Currently 17, or 3.2%, of all US members of congress are physicians: 14 republicans and 3 democrats. As respected community members and experts in healthcare delivery, physicians add an important voice to the work of creating and implementing policy on federal, state, and local platforms.

Physicians are uniquely suited for a role in governance. We are bound to a moral imperative of prioritizing health. As scientists, we are expert synthesizers of complex information who do not shy away from following whichever path data and information lead us towards, regardless of the politics. We, especially those of us in primary care fields, are gifted in making personal connections with people and in sharing deep empathy with those we care for. We value honesty, integrity, and transparency. By the nature of our work, we are skilled in bridging competing opinions and worldviews.

The dearth of physician involvement in the political process, despite our well-suited qualities, can be attributed to several challenges. In addition to unfamiliarity with the process, engaging with activities that fall outside the comfort zone of most physicians can feel daunting. Furthermore, the significant time commitment of managing a campaign can seem insurmountable for physicians wanting to continue their clinical practice.

Despite these challenges, physicians should consider serving in elected office. There are examples of physicians serving in nearly every level of government in elected office, from school boards to US congress. Depending on their role, physicians will be able to maintain varying levels of clinical practice while serving in government. With adequate support from seasoned campaign organizers and fundraisers, physicians can extend their sphere of influence outside of the exam room and into the halls of government.

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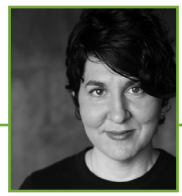

Maura Minsky | Colleen Gillespie | Jennifer Adams

SGIM Workshop
Empathy in Medicine: The New Normal

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Empathy is the practice of authentically working toward understanding another person's experience through engaged curiosity. This practice has been shown to decrease bias, to improve patients' outcomes, and to increase collective and individual wellness. A teachable and measurable skill, empathy is a core tenant for successful interpersonal relationships.

Leadership is about the collective—it requires an understanding of one's position and power and an openness to others' experiences and perspectives. At The Empathy Project, we propose broadening the definition of leadership to include the cornerstones of empathy: curiosity, vulnerability, and humility. These may seem like attributes a leader may want to repress. In fact, the opposite is true. What leads to better communication and stronger leadership?—dialing into the needs of others by asking questions, listening deeply, reflecting back what you've heard, and sharing your heart. Empathy builds connection and authentic connection is hard, not hard-wired. We are not born with empathy and cannot choose to be empathetic. Empathy is a learned skill and it is a cognitive skill that must be practiced and applied, like tying a knot. Practicing empathy builds muscle memory, which is necessary because when empathy is needed most is when it is hardest to access.

Research confirms that empathy reflects the following:

- Is a *learned and measurable skill* that can improve with education and practice making the best doctors even better[1]
- Empowers *students* to *identify as life-long learners* by embracing challenges, learning from feedback, aiming for mastery, and committing to a growth mindset
- Creates *meaningful connections* between students, colleagues, and care teams who rely on one another for their well-being
- Buoys *physician wellness* by increasing satisfaction with their work, decreasing stress, strengthening connection to patients and colleagues[2]
- Results in more *favorable health outcomes* by improving patient satisfaction and increasing adherence to treatment[3]
- Contributes to *reducing bias* by breaking down barriers created by social norms and stereotyping[4]
- Builds *resilience in the presence of burnout and the recovery of trauma*, magnified by the societal and personal impact of COVID.

In our workshop, The Empathy Project, in partnership with Narrative 4 (an organization whose goal is to create radical empathy) presented our innovative, narrative-based empathy curriculum, which can be implemented in person or virtually at home institutions.

Outcomes reflect the following:

- Understand empathy as a vital human competency that is mutable, measurable, and teachable
- Learn how employing empathy benefits the patient and the clinician
- Experience novel strategies for teaching empathy that use narrative
- Articulate how empathy training can be implemented in your work community

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