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SELAM News

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Joanne M. Conroy, MD
President

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Due date for inclusion in next newsletter: May 1, 2002

FROM THE PRESIDENT

I hope all of you have had a productive, relaxing year and are ready for another. Mark your calendars for the 4th Annual Spring SELAM CE Meeting in Philadelphia, April 26-27, 2002.

SELAM hosted its now annual reception, November 3, 2001, during the annual AAMC reception in Washington, DC. We gratefully acknowledge the financial contributions of Eastern Virginia Medical School, Georgetown University School of Medicine, Michigan State University, University of Maryland School of Medicine, and University of Texas Medical Branch – Galveston. At the reception we recognized two individuals for their commitment to advancing the careers of women in academic medicine and dentistry. The SELAM Award for the Promotion of Women in Academic Health Centers was presented to Dr. Jeanne Sinkford and Dr. John Stobo. Dr. Sinkford accepts her award at the spring dental education meeting. Dr. Stobo accepted his award in person. Read about them in the announcement on p. 10.

Janet Bickel, Associate Vice President, Division of Medical School Affairs, AAMC, received a SELAM pin for her work in increasing women's leadership and development in academic medicine. This was timely, since AAMC presented special Women in Medicine 25th Anniversary Awards on November 4, 2001. Norma E. Wagoner, PhD, received the Special Recognition Award as the leader of the original group instrumental in establishing AAMC's Women in Medicine Program. History Maker Awardees were Christine K. Cassel, MD, now Dean of Oregon Health Sciences University SOM; Carola Eisenberg, MD, Lecturer in Social Medicine at Harvard Medical School; Anna Cherrie Epps, PhD, Dean of Meharry Medical College SOM; Nancy E. Gary, MD, President Emerita and Special Assistant to the President of ECFMG; Ruth L. Kirschstein, MD, Acting Director of NIH; Vivian W. Pinn, MD, Director of the Office of Research on Women's Health, NIH; and Eleanor G. Shore, MD, MPH, Dean for Faculty Affairs at Harvard Medical School.

I had a very *interesting* summer starting a new job. I now straddle the worlds of academic and not-for-profit system-based medicine. I became Chief Medical Officer of the Western Region of Atlantic Health System (AHS) in northern New Jersey at the end of May 2001. We have four hospitals, and 250 residents and medical students rotating from UMDNJ. The system has over 100,000 admissions per year and over 2,000 medical staff, both voluntary and employed. Summer was filled with the normal joys, stresses and strains of moving…and a few extraordinary ones! We had a fire in our rental condo two weeks after moving in. We spent eight weeks in the lovely Summerfield Suites in downtown Florham Park, NJ. I now appreciate the phenomenon of stress with compounding interest and know that *attitude is everything*. I also discovered the New Jersey attitude. On the front page of the *Post & Courier* in Charleston, SC, was a survey that said most Americans do not perceive New Jersey as a wonderful place to live, yet *most citizens of New Jersey couldn't care less*!

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Despite the stresses, this was a wonderful move. There is nothing more energizing than getting out of your comfort zone, into an environment where you have to prove yourself all over again. I had to establish new networks of contacts and gain an understanding of how decisions are made in an organization that is culturally and organizationally very different from the one I left. I work very hard, but I am on the best part…the steep part…of the learning curve. A few things I've learned in the transition:

1. A mystique exists among private practitioners about academic medicine. They give a not so subtle deference to academicians. We never really appreciate this.
2. Health systems are very focused on quality and service. AHS uses measurable goals for customer service, quality, system growth, cost control, and employee development as the basis for incentive compensation for senior management. At a two-day workshop all directors, managers, and senior leadership focused on customer service. Seeing their commitment and enthusiasm throughout the ranks was fascinating. Clearly, successful initiatives start at the top. The 100% commitment of the CEO and President of AHS to improving and maintaining quality, service and growth, makes them as important to everyone else within the organization. I was so impressed that I forwarded the workshop materials to my peers in South Carolina. In academic medicine our current problems so distract us that we don't realize service, growth and quality can actually provide solutions.
3. Many *more* similarities than differences exist between private practitioners and academicians. Both want to be involved in corporate decision making, and are thirsty for substantive leadership development. As I look at our hospitals' medical staff, I notice that the fluorishing hospitals are those with young active staff. The hospitals with problems are ones with aging staff unable to attract or unwilling to share practices with those just out of training programs. This is applicable to academic medicine. One of my foci is to analyze our medical staff demographics and identify whom we need to actively recruit in the next five years. Both academic and private practice medicine struggle with aging facilities, burgeoning patient populations and growing numbers of uninsured patients. Both have departments "on the ropes" (often the same departments) that need internal reviews and get-well plans. Conflict in both environments exists over ancillaries, who controls them, hospital- vs. practitioner-based interests, and credentialing as differences between subspecialties blur, e.g., interventional and vascular procedures and nuclear medicine.

In spite of the personal challenges my husband and I faced, I feel very fortunate to be in a position where the challenges excite me. Working with people you respect and enjoy working with is an added benefit. My ELAM experience and SELAM contacts made me a more competitive candidate. They allow me to be a more successful contributor to AHS. I encourage all of you to stay active and recruit your peers to participate in SELAM for both personal and professional development.

See you at the SELAM CE meeting. Have a great spring.

Joanne M. Conroy, MD
Chief Medical Officer
Western Region
Atlantic Health System

EDITOR'S CORNER

Did you miss the newsletter? Well, it's back, better than ever, but only twice a year (and still late – sorry. Life's teacher presented me with a few speed bumps in the past seven months). This academic year is a succession of new challenges to my time management skills. I added "part-time grad student" to my full-time job *(see page 20)*, squeezing in arthroscopic knee surgery 11 days before classes started.

In February 2002 I was Nancy Hardt's first dinner guest in her new Memphis condo overlooking the Mississippi. Establishing an Institute for Women's Health is her second job (she's commuting to Gainesville to work Fridays – and ride on the weekends). Nancy is a great addition to our faculty. At long last I have a fellow ELUM within arm's reach.

You'll enjoy catching up on our colleagues' accomplishments in the wonderfully lengthy *Updates on Members (see page 3)*. Roz Richman keeps us posted on ELAM news *(see page 7)*. We are on the move! Marijo Tamburrino interviews Carolyn Robinowitz as our *SELAM Mentor (see page 10)*. Carolyn talks about her career and provides a wealth of advice for leaders, women leaders in particular.

David Bachrach and Page Morahan continue to contribute outstanding columns. David writes about promoting responsible change, that inevitable fact of life *(see page 13)*. Page continues the theme by describing career transitions *(see page 15)*. Combine them with Janette Collins' salary survey of academic administrative positions in *Issues in the Workplace (see page 17)*, and you've got a great game plan to map out a potential transition.

Issues in the Workplace also includes Linda Adkison and Marie Dent's article on building effective teams. Joanne Conroy shares insights on customer service. Check out the book reviews *(see page 22)*. When you read something you like, send me a review for the newsletter.

We recognize two individuals who promote women in academic health careers *(see page 10)*, and donors who help SELAM promote its mission *(see page 9)*. At the upcoming annual CE meeting, you can help by donating and bidding on auction items *(see page 9)*. Of course, you can always donate all or part of that honorarium, raise, or bonus to SELAM!

Keep up that achievement in whatever aspect of your life you choose, you powerful SELAM members!

Kris Lohr

UPDATE ON MEMBERS

SOM: School of Medicine
SOD: School of Dentistry
COM: College of Medicine
COD: College of Dentistry

Promotions & New Positions

1995-96 Fellows

PonJola Coney, MD, Chair, Department of Obstetrics and Gynecology, Southern Illinois University SOM, has been appointed Senior Vice President for Health Affairs, Meharry Medical College, and Dean of its medical school, effective July 1, 2002. She will join Meharry ELUMs Pamela Williams and Cherae Farmer-Dixon, and will be close to Vanderbilt ELUMs Debbie German, Ellen Clayton, Lynn Matrisian, and current ELAM fellow Connie Graves. "[I] will work enthusiastically with the Meharry-Vanderbilt Alliance, a unique partnership of Nashville's two medical schools that aims to strengthen medical education, research and patient services at both institutions."

Clair A. Francomano, MD, Johns Hopkins University SOM (and formerly Chief, Medical Genetics Branch, National Human Genome Research Institute), has a new NIH position as Senior Investigator, Laboratory of Genetics, National Institute on Aging.

Nancy Sisson Hardt, MD, has been appointed Director of the Institute for Women's Health and the Methodist Endowed Chair in Women's Health, University of Tennessee Health Science Center (UTHSC) in Memphis, effective February 2002. She will be a Professor in the Department of Preventive Medicine. The Institute for Women's Health was recently created to engage the University of Memphis, the Methodist Hospital System, and the Community in a joint effort with UTHSC to enhance the lives and health of women of all ages through partnerships in research, education, and clinical services. The objective of the Institute is to build a model for improving the health of women in Greater Memphis, implementing interventions and measuring the outcomes related to them, and applying the most successful aspects of the model to a wider geographic area.

Stephanie V. Seremetis, MD, has a new position as Medical Director, BioPharmaceuticals, NovoNordisk Pharmaceuticals Inc. She writes, "I'd be happy to tell you more about this change, if it would be of interest to you and to other ELUMS. It is very interesting out here in terms of the issue of responsibility and authority actually being linked. Amazing!"

Elizabeth F. Sherertz, MD, MBA, has moved from Wake Forest University SOM to private practice at The Skin Surgery Center, Winston-Salem, NC (May 2001).

Angelina L. Trujillo, MD, has moved from South Dakota to Connecticut and taken a position as Deputy Director, Bayer Corporation/Pharmaceutical Division. She writes, "Being in the pharmaceutical industry is a challenge, and I'm very happy to be here."

Wendy J. Wolf, MD, MPH, has been appointed Executive Director of The Maine Health Access Foundation, Inc. of Augusta, Maine. According to Wendy, "This new health care foundation was created from the sale of Blue Cross and Blue Shield of Maine (nonprofit) to Anthem Blue Cross and Blue Shield (profit). The foundation has a $90 million portfolio that will be used to provide grant funding to improve health care access in Maine. Needless to say, this is a great opportunity to continue my work on behalf of low-income children and families."

1996-97 Fellows

Lisa A. Tedesco, PhD, The University of Michigan, has been named Interim Provost and Executive Vice President for Academic Affairs (September 2001). As provost, she will be the chief academic and budget officer for the University.

1998-99 Fellows

Linda S. Austin, MD, has moved to Maine and assumed several new roles – Professor of Psychiatry, Acadia Hospital, and Director of Medical Media, Eastern Maine Medical Center – while continuing to host her live call-in program, "What's on Your Mind?" on Maine's NPR Radio (most Thursdays at 1 p.m.).

Ann S. Chinnis, MD, MSHA, West Virginia University SOM, has been appointed permanent Chair, Department of Emergency Medicine.

Lydia P. Howell, PhD, UC-Davis SOM, has been appointed Associate Dean for Academic Affairs and Faculty Development (December 2001). She wrote, "By the way, my project during ELAM was developing a mission-based reporting system and I'm proud to say it is going to be published [*Acad Med* 2002; 77: 130-8]!! ELAM has paid off in more ways than one!"

Katherine A. Loveland, PhD, University of Texas-Houston Medical School, has been appointed Assistant Dean for Faculty Affairs (December 2001).

1999-2000 Fellows

Kathryn A. Cunningham, PhD, University of Texas Medical Branch in Galveston, was appointed Vice-Chairman of the Department of Pharmacology and Toxicology (October 2001). In her new role, she will assist the Chairman, Dr. James Halpert, in the development and implementation of the strategic research vision of the department and provide additional leadership focus in matters relating to research. She will promote departmental research programs and collaboration, and will serve as faculty point of contact and liaison on issues related to pharmacology and toxicology research. Dr. Cunningham was also awarded the 2001 Distinguished Faculty Research Award at UTMB.

Eva L. Feldman, MD, PhD, University of Michigan Medical School, was promoted to full Professor.

Lisa G. Kaplowitz, MD, Virginia Commonwealth University (VCU) SOM, became the Medical Director of Ambulatory Care for the VCU Health System, a position she advocated for with her Dean as a result of ELAM. She is still the Director of the VCU HIV/AIDS Center 50% of the time. She also is enrolled in the Executive Master's in Health Administration Program in the Department of Health Administration at VCU.

Mary E. Martin, DDS, MEd, was promoted to Professor (July 1, 2001). "Many kudos to Page for the time spent with me at ELAM!" She also was nominated anonymously for the "Best of the Best" Women in Oklahoma Award given September 20, 2001, at the Governor's Conference on Women in Business. Mary finished in the Sweet Sixteen from a pool of 140 nominations.

Kathy B. Porter, MD, currently Chair of Obstetrics and Gynecology at Texas Tech University Health Sciences Center SOM, will become Chair of Obstetrics and Gynecology at the University of South Alabama, where Mary Townsley, PhD, also 1999-2000 ELUM, is located.

Janet M. Williams, MD, West Virginia University SOM, was promoted to full Professor with tenure in the Department of Emergency Medicine and appointed interim Director, WV Center on Aging (July 2001). She also was awarded the Outstanding Teaching Faculty Award by emergency medicine residents at WVU.

2000-01 Fellows

Jane C.K. Fitch, MD, was appointed John L. Plewes Chair and Professor, Department of Anesthesiology, University of Oklahoma SOM. She wrote, "ELAM worked for me!!! I just accepted the Anesthesiology Chair position at the University of Oklahoma – and it was all because of ELAM! I met their Dean, Jerry Vannatta, MD (who was at ELAM with his new Pathology Chair, Ann Thor, MD) at our Spring Session. He invited me to interview for his Anesthesiology Chair position – I did – and the rest is history! Now Jerry has

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two ELAM Chairs, and an ELAM fellow for 2001-2002. Needless to say, he's a big ELAM supporter. The knowledge and skills that I learned at ELAM have served me well. I have no doubt that they will continue to serve me well in the future. But as my example demonstrates, perhaps one of the most valuable aspects that we get from ELAM is the networking. Many thanks to both of you [Page and Roz] for all of the heart and soul that you put into the ELAM program. You are absolutely helping to advance the role of women in medicine and for that I am forever grateful. Thank you!"

Maria K. Hordinsky, MD, University of Minnesota Medical School, has been appointed Chair, Department of Dermatology (December 2001).

Sharon Jean Kaminer, MD, FACC, accepted a position with Sibley Heart Center in Atlanta, GA. She wrote, "My primary responsibility is as director of the medical/surgical ward at Children's Healthcare of Atlanta, Egleston. I will also have an appointment as faculty at Emory University."

Marilyn Marx, MD, MBA, University of Texas Medical Branch at Galveston, was appointed Senior Associate Dean for Faculty Practice and Physician Chief Executive of the Faculty Practice, effective January 1, 2002. According to the announcement by Dean Stanley Lemon, "Dr. Marx, who is trained as a general surgeon and who has previously practiced in the community, currently serves as Chief Medical Director of the Faculty Practice and Assistant Dean for Faculty Practice. As Senior Associate Dean for Faculty Practice, Dr. Marx will oversee all aspects of the medical school faculty practice, with a strong focus on strategic planning and the future development of the practice. She brings a wealth of experience and formal training in practice management to this position."

Ardythe L. Morrow, PhD, was appointed Professor and Director, Center for Epidemiology and Biostatistics Children's Hospital Medical Center/ University of Cincinnati COM (September 2001).

Maria L. Soto-Greene, MD, UMDNJ-New Jersey Medical School, was appointed Senior Associate Dean for Education (July 2001).

Ann E. Thompson, MD, FACCM, University of Pittsburgh SOM, has accepted a position as half-time Associate Dean for Faculty Affairs (July 2001).

Nanci S. Tofsky, DDS, UMDNJ-New Jersey Dental School, has been promoted to Full Professor and writes, "I am quite certain that ELAM had a little something to do with that. Hope all is well at The Gatehouse."

Faculty/Other

Robert F. Jones, PhD, was promoted to Vice President, Faculty and Institutional Studies, Association of American Medical Colleges (July 2001).

Winifred (Winnie) Lanoix, EdD, has been appointed Senior Vice President, Manchester, Wayne, PA. Manchester is a major multidiscipline Human Capital Management consulting firm specializing in career management/transition, performance improvement, assessment, coaching, organization effectiveness, and education and training, with more than 130 locations in 25 countries worldwide.

Sharon A. McDade, EdD, was promoted to Director, Center for Educational Leadership and Transformation, Graduate School of Education and Human Development, The George Washington University.

Jeannette E. South-Paul, MD, was appointed Professor and Chair, Department of Family Medicine, University of Pittsburgh SOM (July 2001).

News of Note

1995-96 Fellows

Deborah C. German, MD, was selected for the YWCA Academy for Women of Achievement (AWA) award and was honored in October 2001. She was an invited Speaker at the Harvard Medical Alumni Symposium in Summer 2001. She gave the Keynote Address for the opening of school on September 7, 2001, at Boston University SOM. Dr. German was recently selected by the University of Rochester to be featured in the Alumni Magazine as one of several outstanding alumni. In December 2001, Debbie ran the Honolulu marathon for the Arthritis Foundation and raised about $10,000. She wrote, "I finished the race and came in the top 8% in my age group and top half of all runners. My time was 5 hr 35 min and 12 sec! I wasn't sure I would be able to finish, as this was my first marathon. I did well by my standards."

Suzanne E. Landis, MD, University of North Carolina SOM: "On May 19th, I started riding my bicycle with about 1,500 others from Spartanburg and rode to Marion, stopped for a rest and to refuel. Then I started climbing up to the parkway on Route 80 and then up the parkway to the top of Mt. Mitchell, 102 miles in all, with 12,000 total feet of climbing. The last mile I was in a hail/rain storm, but I finished intact and without any orthopedic injuries. It was the most physically challenging activity I have ever done." (May 2001).

1996-97 Fellows

Linda P. Fried, MD, MPH, Professor of Medicine, Epidemiology, and Health Policy; Director, Center on Aging and Health; and Deputy Director, Clinical Epidemiology and Health Services Research, Department of Medicine, Johns Hopkins University SOM, was elected to the Institute of Medicine (2001).

Lois Margaret Nora, MD, JD, University of Kentucky COM, was awarded an American Association of University Women University Research Scholar-in-Residence award. "Over the next two years, … we [will] endeavor to improve the learning environment for women and men and contribute to positive social change through enhancing knowledge of gender discrimination and sexual harassment issues." (July 2001).

Lisa A. Tedesco, PhD, was honored by the Academic Women's Caucus of the University of Michigan with a Sarah Goddard Power Award, for "her commitment to scholarship, and her contributions to the betterment of women" (February 12, 2002). [Last year, the Caucus selected as a recipient of the award SELAM member Jayne Thorson, Assistant Dean for Faculty Affairs in Michigan's Medical School.]

1997-98 Fellows

Kristine M. Lohr, MD, University of Tennessee Health Science Center COM, was accepted to the university's Master of Science in Health Administration (focusing on Health Policy) program. On a sad note, Kris lost her mother, Lucille E. Lohr, on December 24, 2001.

1998-99 Fellows

Catherine DeVries, MD, FACS, FAAP, University of Utah SOM: "This year I am President of the Society of Women in Urology (all 185 of us!!!). We are having trouble attracting and retaining women in academics in urology as in other fields. As President, it is my agenda to support career development of the members, but my not-so-private agenda is to encourage women to consider academics and to support them especially toward leadership positions" (July 2001).

Rose Goldstein, MD, CM, FACP, University of Ottawa Faculty of Medicine, led the First Ottawa Academic Health Sciences Leadership Program.

Renee R. Jenkins, MD, Professor and Chair, Department of Pediatrics and Child Health, COM, Howard University, was elected to the Institute of Medicine (2001).

Laura Schweitzer, PhD, was featured in the Fall/Winter issue of *Medicine*, University of Louisville's semiannual publication. The article, "New Era: Laura Schweitzer leads school's campaign to boost the number of women leaders in academic medicine," highlighted her efforts to promote women and improve the environment and system so that women can thrive. The article cited Leah Dickstein and ELUM Barbara McLaughlin as other women holding key leadership positions at Louisville. Elsewhere in the magazine was a photo of 2001-02 ELAM Fellow Susan Galandiuk, MD.

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Rebecca S. Twersky, MD, SUNY Downstate Medical Center COM, was featured in *Anesthesiology*, a periodical distributed to all US Anesthesiologists ["Rebecca S. Twersky, MD, Balances Professional, Personal Life]. The editors decided to run a series on Women in Anesthesia, in an effort to laud the efforts of women in the specialty and encourage young medical students and residents. [Women thus far featured included Virgina Apgar, (of Apgar fame), and Gertie Marx (an 80+ retired anesthesiologist who laid the foundation for obstetrical anesthesia), and now featured is none other than an ELAM grad, Rebecca Twersky. http://www.anesthesiologynews.com (June 2001).]

1999-2000 Fellows

Linda R. Adkison, PhD, Mercer University SOM, sent us an update: "I have continued my CEE (continued ELUM training) and completed about seven more books/books on tape this fall. *Yes or No* by Spenser Jonson and *Managing by Values* by Ken Blanchard are the most recent. I listen to them on tape and then either re-listen and take notes or buy the book to highlight and take notes. *HBR [Harvard Business Review]* has a special issue on Leadership articles this month (January 2002). I've noticed most of the books and articles say many of the same things over and over, just in different scenarios."

Valerie A. Arkoosh, MD, MCP Hahnemann University SOM, was elected President of the Society for Obstetric Anesthesia and Perinatology (May 2001). In October 2001, Valerie was named as one of the recipients of a $15,000 competitive research grant that was awarded during Discovery 2001: A Celebration of Biomedical Research annual research day. Valerie gave birth to twins (Olivia, 5 lb.10 oz., and Trevor, 5 lb.11 oz., both 18.5 inches) on January 29, 2002. (Valerie was the first, and so far only, Fellow to give birth – to her son Ian—between Fall and Spring ELAM sessions). The Arkoosh-Harbison family photo album is online at www.arkoosh.com.

Kathryn A. Cunningham, PhD, University of Texas Medical Branch in Galveston, was named Vice-Chairman for Research on October 1, 2001. She says, "I am very pleased with the promotion and the associated responsibilities!"

Simin Dadparvar, MD, MCP Hahnemann University SOM, organized a class project to benefit ELAM: the creation of an "ELAM scarf." Two scarf designs were unveiled at the 2001 AAMC annual meeting. Those who purchase the scarf receive a booklet on how to tie it and another of "scarf stories." Says Valerie Arkoosh, who helped with the project:, "The idea for the stories came from Marla Gold at one of our monthly [MCPHU] ELAM lunches. I did the ground work and Simin put the brochure together. Teamwork at its best!"

Eva L. Feldman, MD, PhD, University of Michigan Medical School, was named a finalist for the 2002 Marion Spencer Fay Award by the National Board for Women in Medicine.

Noni MacDonald, MD, University of Dalhousie Faculty of Medicine, writes, "I am indeed still surviving as Dean (now in year 3) and still smiling. Hardest job I have ever done!"

Marilyn Telen, MD, Duke University SOM, received an endowed professorship (The Wellcome Clinical Professor of Medicine) in July 2001.

Kathleen Weatherstone, MD, University of Kansas SOM, filled her Division as of July 1, 2001. Some may remember recruitment as one of her biggest goals and challenges when going through ELAM. Second, Kathleen went to Uganda in October 2001 on a medical mission.

2000-01 Fellows

Donna M. Murasko, PhD, MCP Hahnemann University SOM, received a Drexel University Synergy grant and was inducted into the university's "106 Club" (June 2001).

Multiple Classes, Faculty/Other

Allen S. Lichter, MD, Professor of Radiation Oncology and Dean, Medical School, University of Michigan (a Dean who's been very supportive of ELAM) was elected to the Institute of Medicine (2001).

Page Morahan, PhD, Co-Director of ELAM, joined Vanderbilt ELUMs Ellen Clayton, MD, 1999-2000, Deborah C. German, MD, 1995-96, and Lynn Matrisian, PhD, 1997-98; ELAM Fellow Cornelia (Connie) Graves, MD, 2001-02; Meharry ELUMs Cherae Farmer-Dixon, DDS, 2000-01, and Pamela Williams, MD, 2000-01; and East Tennessee State University COM ELUM Theresa Lura, MD, 2000-01, for an ELAM/ELUM Fellows dinner on January 23, 2002, in Nashville TN.

Address Changes

1995-96 Fellows

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1996-97 Fellows

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1998-99 Fellows

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1999-2000 Fellows

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2000-01 Fellows

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NOTABLE

On the cover of the February 2002 issue of *Academic Medicine,* the second of four headlines reads "Wasted Potential of Women in the Professions." The National Policy Perspectives article (pp. 110-112) is titled "Capitalizing on Women's Intellectual Capital in the Professions" by Page Morahan, PhD, and Janet Bickel, MA. They describe the need to redefine the "ideal worker" in the context of the increased percentage of women in the labor force, and both male and female workers seeking "work situations that allow for a high-quality personal life outside work without decades of deferred gratification." Providing five examples of interest, they then describe ways to proceed to improve return on investment in women.

In the *Washington Post* (1/13/02) Ann Gerhart cites Air Force pilot Lieutenant Colonel Martha McSally as a success story for the modern military. She then describes McSally's suit of Defense Secretary Donald Rumsfeld over the unconstitutionality of the abaya policy: all female personnel must wear the head-to-toe gown (abaya) and matching head scarf, can not drive, must ride in the back seat and must always be escorted. State Department female employees and wives of military personnel, however, are not subject to the abaya policy, and male military personnel are forbidden from wearing traditional Saudi garb.

In the December 2001 issue of *AAMC Reporter,* Janet Bickel writes, "What does it mean to be a pioneer today...? Being 'first' always carries with it 'surplus visibility' – any mistakes appear more notable and memorable. Isolation is likewise a greater risk for women pioneers, who are much less likely to be married than their male peers. Women leaders face other challenges men do not, including resistance reporting to them; they also experience a narrower band of acceptable assertive behavior that constrains their decision-making. And women still have more difficulty gaining the floor at meetings and making their voices heard."

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ELAM Update

The ELAM Program office has been extremely busy. We're delighted to share with you some of our accomplishments and activities.

The Robert Wood Johnson Foundation Grant: Our biggest news of all — a 5-year grant awarded September 2001 (through August 2006), "Evaluation of Effectiveness and Long-term Impact of the ELAM Program and Theory Building about Leadership Development of Women." This study will seek to compare leadership attitudes and career progression of ELAM graduates with a national comparison group of women academics created through a stratified, random design from the AAMC medical school faculty database. The project will assess not only how ELAM affects the participants' leadership and career development but also how the presence of Fellows affects their medical or dental school climate regarding women's issues. In addition to the generous grant from RWJ Foundation, we are very pleased to acknowledge our funding partners on this project: Mayo Medical School at Mayo Clinic, Rochester, MN; University of Michigan Medical School; Vanderbilt University School of Medicine; and Wright State University School of Medicine. All alumnae will be receiving information and a request for their participation this spring. We hope that ELUMs will read the 3-page consent form and join us in this unique research!

ELAM database: With considerable expertise from an MCPHU colleague, we now have a unified database that includes information on all ELAM constituencies, from applicants through alumnae, as well as faculty and friends. With this new database, we will be able to provide considerable support to SELAM. Of course, it's up to *you* to let us know your latest information…new address, phone, e-mail…new title, promotion, honor…etc.

ELAM website: Ed Brown, whom many of you from the first three classes may remember, has modified the website, updating many of the pages. Using information from our new database, he added some new features. Click on "Alumnae": you will find two new directories, in addition to an overview of the classes to date and links to listings of Fellows by class year. One is an alphabetical listing of all Fellows; the other shows Fellows by state and institution. We hope that this will make it easier to find and connect with ELAM alumnae. Of course, there's a link to the SELAM website as well!

New ELAM and SELAM e-mail addresses: To make it easier for you to contact the ELAM office and SELAM International, we've set up two e-mail accounts – **elam@drexel.edu** and **selam@drexel.edu**. Now, there's no excuse for not staying in touch!

ELAM flowcharts: Jean Kilian has completed about half of this very large project. Our goal is to flowchart our major processes, to identify how we can be more effective and efficient. One improvement this year was to hold teleconferences with the new Fellows to explain the Benchmarks 360º process (and thereby save numerous phone calls and time-wasting follow-ups that were typical of previous years!).

ELAM office staff: Tori Odhner (her real name is Victoria, but everyone calls her Tori!) joined us in early June. We're delighted that she has accepted a permanent position in our office as Program Coordinator (as of December 2001). She's applied her high tech talents and experience to our new database, our website, and the Blackboard e-learning platform that we've been using since last year. Tori has also updated our ELAM Book List. You'll meet Tori at the 2002 SELAM CE meeting in April.

2001-02 ELAM news: We've made several program changes to enhance ELAM, including the addition of Core Faculty and Faculty Advisers.

- ***Core Faculty*** oversee and coordinate specific curricular units – Ann Chinnis (ELAM 1998-99) and Nancy Hardt (ELAM 1995-96) are responsible for the finance unit; Judith Katz is managing the personal professional topic area; and Nancy Gary is heading up our special programs (Meet the Leaders, etc) as well as our Faculty Advisers.
- ***Faculty Advisers*** are former or current Deans: Barbara Atkinson, MD; Amira Gohara, MD; John Hutton, MD; Allen Neims, MD, PhD; and Carolyn Robinowitz, MD. Each Learning Community (8-10 Fellows…formerly called "Learning Lab Group") works with one of these seasoned advisers, particularly with their intersession assignments. Several groups met with their Faculty Advisers during the AAMC meeting in Washington last November. All of the Faculty Advisers will attend the Spring Session.
- ***Technology***: We are using eCollege online evaluation services to gather and compile course and program evaluations, and Blackboard e-learning platform to share information, hold online discussions through its Discussion Board and Virtual Classroom features and enhance/expand overall intersession connectivity among Fellows and their Learning Communities. Incidentally, more than half of the Fellows submitted their photos and bio-sketches by e-mail this year!

2002-03 ELAM applications: We received a record number of applications for the eighth class, including from 15 medical and 3 dental schools that have never had an ELAM Fellow. Thanks to everyone for helping to market the ELAM Program to their colleagues at these and other schools!

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The 2001-02 Fellows (the seventh ELAM class) gathered at the Gregg Conference Center for the Fall Session. Up to September 11, the session was going quite well…after that day's events, the session, like the world, was very different. The Fellows were very anxious to get home to their loved ones; they also discussed traveling to New York or Washington to offer their professional services during the crisis. Of course, travel for the next few days was impossible, so Fellows made the best of their time. They displayed remarkable courage, fortitude and resilience under tremendous stress, focusing as best as they could on Power and Systems and Tom Gilmore's Strategic Planning sessions. And, largely through Tori's assistance, we helped to arrange alternative travel plans for the Fellows. Most returned home via carpool caravans — to Iowa, Oklahoma and Texas, to Alabama and Florida, to Boston. Those from the West Coast were able to fly home on Friday or Saturday. And apparently, some of the carpooling Fellows are planning to repeat their experiences when they travel back for the Spring Session!

So we look forward to our 2002 Spring Session, to the returning 2001-02 Fellows and to greeting many ELUMs (including the 1996-97 class, celebrating its 5th year reunion) at the 2002 SELAM Continuing Education program that takes place concurrent with the ELAM session. See you in April!!!

Rosalyn C. Richman, MA

SAVE THE DATES!

WOMEN LEADERS AS CHANGE AGENTS

Philadelphia Courtyard Downtown
Philadelphia PA
4th Annual Spring CE Meeting, April 26-27, 2002.

Discounted registration fee before March 15, 2002.
Discounted room rate if reservations made by April 1, 2002.
Visit the OCME website at www.cme.louisville.edu

Friday, April 26, 2002

Panel Discussion: The Role of Search Firms
Barbara Atkinson, MD, Nancy L. Cook, Jan Greenwood
Changes Needed at Your Institution
Laura Schweitzer, PhD

Saturday, April 27, 2002

Keynote Address: Campaigns as a Strategy for Change
Tom Gilmore, AB, MArch
Two Case Studies from Academic Medicine:
1. Curriculum Revision: Lindsey Henson, MD
2. Governance Documents: Laura Schweitzer, PhD

Leading from the Middle
Valeri Parisi, MD
Keynote Address: Tempered Radicals: How People Use Differences to Inspire Change at Work [Book Review p. 22]
Debra Meyerson, PhD
Breakout Sessions:
1. Taking Interim Positions: Theola Douglas, DDS, MBA, Betty Drees, MD, Alice Speer, MD
2. Interviewing Skills: David Bachrach, MBA, Judith Katz EdD
3. Non-Traditional Medical/Dental Roles: Yolanda Bonta, DMD, MS, Clair Francomano, MD, Angelina Trujillo, MD
4. Second in Command: Claudia Adkison, JD, PhD, Miki Rifkin, PhD, Karen West, DMD, MPH

SELAM RECEPTION AT ANNUAL DENTAL EDUCATION MEETING

SELAM International will hold a reception at the annual meeting of the American Dental Education Association in San Diego, CA, 7:00-8:30 p.m. on Saturday, March 2, 2002. The reception will be located in the Cunningham Room – Manchester Grand Hyatt San Diego, One Market Place. The Schools of Dentistry at Meharry Medical College, University of Kentucky, University of Medicine and Dentistry of New Jersey, Oregon Health Sciences University, University of Texas Health Science Center at Houston and West Virginia University are the generous financial sponsors. Dr. Jeanne Sinkford of the ADEA will receive her SELAM award that evening for her contributions to the advancement of women in the health professions.

Karen Pierce West, DMD, MPH
Assistant Dean for Academic Affairs
University of Kentucky College of Dentistry

SELAM SCARF

The ELAM Class of 1999-2000 announces their Class gift: donation of designs for the SELAM scarves. Thirty senior students at Philadelphia University (formerly College of Textiles) designed the scarves through competition; three Professors chose the most outstanding designs. Designs are based on the mythical three-winged bird, the symbol of a "chaotic world."

These silk scarves come in two rich, vibrant color combinations, red/gold (designed by Ms. Kathleen Remsa) and purple/silver (designed by Ms. Kathie Eckert). The scarves (12-3/8 in. wide X 48 in. long) were first available for sale at the 2001 AAMC Meeting.

The price is $75.00 plus 7% tax and a $5.00 shipping and handling fee. Make checks payable to SELAM, Intl. For further information or to place an order, please contact:

Dr. Simin Dadparvar
250 Maple Hill Road, Gladwyne, PA. 19035.
Tel: (215) 762-7678, Fax: (215) 246-5926
E-mail: SDadparvar@aol.com

FROM THE TREASURER

Since receiving its tax-exempt status, SELAM International has received numerous donations from its supporters. These have taken the form of items donated to our silent auctions, proceeds from sales of the SELAM pin, gifts in kind from annual CE meeting faculty, support of specific programs, cash donations, etc. As a consequence, SELAM is in excellent financial condition for such a young organization. Our goals of tangibly supporting the ELAM mission are starting to look like they will become a reality one of these days!

If you like to buy stuff on-line, go to your favorite e-catalogue through igive.com and select "Society for Executive Leadership in Academic Medicine" as your "cause." SELAM will receive a donation from igive.com for every purchase. Most big "stores" are available through this route. Even a dollar at a time adds up!

Please keep those donations coming. We cannot do it without you!

Donor Recognition
Beginning with this issue, we wish to acknowledge major donors to SELAM. The Board of Directors has set the following categories:

Donor	$ <250
Bronze Patron	$ 250-499
Silver Patron	$ 500 - 999
Gold Patron	$ 1000 - 4999
President's Circle	$ 5000 and above

We gratefully recognize the following individuals for their support:

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- Dr. Kristine Lohr
- Dr. Sharon Turner
- Merck
- Rush Medical College

President's Circle
- Drs. Roberta and Victor Sonnino

Roberta E. Sonnino, MD

SELAM Fundraising Auction

The annual auction at the SELAM CE meeting will be held at 6:00 pm on Saturday, April 27, 2002, during the Wine and Cheese Reception. **Our fundraising goal this year is $10,000. The proceeds will be used to benefit SELAM projects.** Please contribute items for auction. To meet our goal, donation of intangible items, such as dinners, use of vacation homes and timeshare weeks, frequent flyer tickets, etc., and more expensive items (e.g., fine win; designer scarves, jewelry, clothing and accessories; stained glass window; handmade quilt) are welcome. Let your imagination run wild. **Your donation will be tax deductible since SELAM is a 501(c)(3) corporation, and you will receive a receipt.**

Either bring your items to the meeting or, if unable to attend, mail in advance to Rosalyn C. Richman, MA, The ELAM Program, MCP Hahnemann University, The Gatehouse, 3300 Henry Avenue, Philadelphia PA 19129-1191.

There is no end that is not a beginning.

Henrietta Szold

The whole art of life is knowing the right time to say things.

Maeve Binchy

When one door of happiness closes, another opens; but often we look so long at the closed door that we do not see the one which has been opened for us.

Helen Keller

Nothing will ever be attempted, if all possible objections must first be overcome.

Samuel Johnson

The important thing is this: to be able at any moment to sacrifice what we are for what we could become.

Charles Du Bos

SELAM AWARDS

The Society for Executive Leadership in Academic Medicine (SELAM) congratulates Dr. Jeanne C. Sinkford and Dr. John Stobo as recipients of the 2001 Award for the Promotion of Women in Academic Health Centers. This award is given to those who best demonstrate excellence in their commitment to the advancement and promotion of women in academic health professions. SELAM, a national organization committed to the advancement and promotion of women to executive positions in academic health professions, believes Dr. Sinkford and Dr. Stobo demonstrate the best attributes of leadership in promoting women's careers in academic health centers.

Dr. Sinkford is Associate Executive Director and Director, Center for Equity and Diversity, American Dental Education Association (ADEA), and Professor and Dean Emeritus, Howard University College of Dentistry. Dr. Sinkford received her DDS degree from Howard University College of Dentistry in 1958, specialty training in prosthodontics and a PhD in physiology from Northwestern University. She served as Chair of Prosthodontics and Associate Dean at Howard University College of Dentistry. Her tenure as Dean at Howard lasted from 1975-1991. Following early retirement, she joined ADEA as special assistant to the executive director and was charged with developing and implementing policy on issues involving gender and minorities in dentistry.

Dr. Sinkford's leadership in gender equity is unsurpassed. She is responsible for supporting and implementing strategies to promote women's careers in academic dentistry. Her initiative led to the development of the Enid Neidle fellowship program for women in dentistry who wish to pursue a gender-related academic issue. Dr. Sinkford helped raise the number of women in leadership programs. This has led to a significant increase in the number of women holding administrative positions in dental education. Under her guidance, women's liaison organizations in each dental school were established to create a network of female dental academicians across the country. Additionally, she planned and organized the International Women's Leadership Conferences, which brought women's leadership issues to the forefront of dental education.

As a national leader in academic dentistry, Dr. Sinkford is a role model for female students, faculty and administrators. Her continued support and sponsorship of women's careers in dentistry is unrivaled. She is a dedicated, warm and sincere individual whose concern for gender equality has moved the dental profession forward and enhanced its excellence and effectiveness.

As Chair of the Department of Medicine at Johns Hopkins University, Dr. Stobo actively sponsored, supported and implemented strategies and program activities developed in partnership with women faculty in his department. He created the departmental Task Force on Women's Academic Careers in Medicine as a standing committee. His legacy continues in its work. This initiative has had a number of successes and led to progressive learning about the complex challenge of both structural and cultural change. Its interventions successfully advanced women to a higher rank by 550%, improved their satisfaction ratings by up to 60% and increased by 183% the number of women in the Department of Medicine who felt they would stay in academic medicine. He also mandated training of the entire faculty and led education sessions about the challenges and barriers that face women in their career success and satisfaction.

As President of the University of Texas Medical Branch in Galveston, Dr. Stobo continues his commitment to the advancement of women in academic medicine. He works actively with the Core Committee on the Status of Women Faculty and Administrators. He sponsors such essential initiatives as faculty satisfaction and salary equity surveys and emphasizes a comprehensive approach to faculty development led by its top leaders. Dr. Stobo strongly and actively supports endeavors of UTMB's Schools of Medicine, Nursing, and Allied Health Sciences and Graduate School of Biomedical Sciences that support and promote women. As a national leader in academic medicine, he is a role model for his continued, enlightened, authentic support of women's careers and membership in academic health centers. His approach is principled, pragmatic and courageous – an approach urgently needed in academic medicine today in order to sustain and enhance its excellence and effectiveness.

SELAM MENTOR

Carolyn Robinowitz, MD

Carolyn Robinowitz, MD

Carolyn Robinowitz, MD, is currently a consultant to medical and educational organizations and institutions. She holds professorial appointments at The George Washington University School of Medicine and the Uniformed Services University of the Health Sciences. She also serves as an ELAM Faculty Adviser to one of the five Learning Communities of the 2001-02 ELAM Class. Marijo Tamburrino, MD, ELAM 1997-98, interviewed Carolyn for this issue.

As I ponder your questions, I find myself in the dilemma of distinguishing between what I have done and experienced and what I recommend. My own career has been less carefully planned, in part because women were not very visible in medical leadership, and I was not all that aware of opportunities. Additionally, my early work life was spent adapting to the academic schedule and moves of a spouse, as well as juggling the time demands of motherhood in a less than supportive work environment. Support and partnership from my husband, as well as colleagues, has been key throughout. Part of my success has come from enjoying challenge and change, finding, creating, and responding to opportunities,

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as well as being willing to take risks. Some of my most successful and enjoyable work situations came from unplanned or unanticipated offers. When I joined the American Psychiatric Association (APA) in 1976, it was with the anticipation of a five-year (at the most) commitment. I stayed for 18 years, constantly molding and enriching the nature of my position. Having a vision as well as the energy and optimism to go after it has been my pattern for success.

1. What is your leadership style?

Inclusive, eclectic and pragmatic are the best descriptors of my leadership style. I tend to think of myself as plain vanilla and non-charismatic, but learned to recognize the enormous importance that is vested with authority and position. Enthusiasm, energy, and optimism in addressing challenges, as well as a strong knowledge base, characterize attractive and highly motivating leaders. The leader has the responsibility to develop and share a vision consistent with the mission of the organization. The team can contribute much to shaping and effecting this vision. Good leaders identify and recruit the best team members, help them develop their skills, and then get out of the way, providing appropriate resources, support, and encouragement. Some would see that as a quasi-parental approach – helping others grow, develop their potential, and succeed. Certainly understanding development (and particularly of adolescents and young adults) has been helpful. Over the years, I have learned the usefulness of curbing my impatience and recognizing that I don't have the only answers, while assisting others to be creative, learn skills, take risks and do things in a different manner. The give and take of the team is very enriching. I have always encouraged others to analyze and question; I value team players, but don't need "yes" men or women. Of course, there is a need to find a balance between group input, delegation and ultimate responsibility and accountability – to know when to intervene and when to hold back. All in all, I hope that one of my best contributions has been the development of the next generation of leaders.

2. Do you adapt your negotiating approach to account for diversity, i.e., what adjustments do you make in consideration of differences in gender, culture, personality, etc.?

I have worked to tailor my approaches to the needs and styles of my colleagues – addressing variables such as culture, gender, personality and style. It is useful to determine what is important to each member of the team, how to motivate and encourage, and how to deal with problems. As a psychiatrist, I am attuned to non-verbal behavior, and to others' moods, feelings, and unspoken responses. While I try not to fall into the trap of analyzing or "psychologizing" others with whom I interact, awareness of emotion and feelings is helpful in finding the most positive interactions and outcome. I tend to look for the "win win" – the negotiation that will bring the most positive outcome to all, without sacrificing integrity of the mission. This approach has had its difficulties. A few colleagues, generally male, view the authority of leaders as a power struggle, feel that negotiation and compromise are weaknesses, and want someone (else) to lose. Still others are happier being told what to do, without discussion. Yet the best colleagues have risen to the challenges and welcomed the opportunity to contribute to vision, mission, and implementation.

3. What advice or tips can you give on how to enhance one's time management?

Time is the most precious commodity, and often the one over which we think we have the least control. The standard approaches really do work: organizing, prioritizing, realistic scheduling, delegating, and multitasking. Good planning and discipline are key. Setting priorities, with a daily "to do" task list, with reasonable allocations of time only works if the schedule is followed. Making adjustments for delays is vital, not only to compensate for unforeseen glitches, but to recognize that others may not be as deadline driven, do not see the task as a high priority, or don't have the requisite information or skills to fulfill it.

One approach that has been particularly helpful for me has been to set aside some specific protected time each day for unforeseen problems – meetings running over, tasks taking longer than anticipated, interruptions, urgent requests and other unexpected events. Having this time leaves me less frazzled and more productive, and when there is no problem to be addressed, the time can be used for all sorts of enrichment. I also have found that scheduling blocks of uninterrupted time for planning or writing allows me to address more complex issues thoughtfully. Working from home one morning a week was one way to ensure such a block. When my children were young, I woke early, doing some of my most productive work when I was rested and before the day's fast-paced action began. Having a good place to work and appropriate office equipment at home – computer and printer, Internet access, fax – improves effectiveness and promotes flexibility. Having a designated time for telephone availability helps avoid time-wasting phone tag. Flexibility helps – as does building in time for play. And of course, having an organized and competent assistant who is empowered and effective in managing your time (as I did at APA) is a godsend.

4. What are some of the most effective coping strategies for work-related stress that you have discovered or that you have heard from colleagues?

Exercise is a top priority; it relieves stress, improves mood, and helps offset "nervous nibbling." But paradoxically, when we need it the most may be when we find we "don't have the time." I walk most mornings, because if I don't do it then, the excuses proliferate and I find I am too tired later in the day. The carrot is watching videos while I walk, generally of movies I have missed – seeing them as serials over two or three mornings – looking forward to the next installment. I also enjoy the repetitious mindlessness of swimming, and frequently discover that during my laps, I have addressed some difficult issue without realizing it. During the day, I use a number of relaxation techniques including visualization, that take only a

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few minutes and can be done at my desk. I have found managing by walking around was helpful as well.

One of the most difficult tasks is to *leave it in the office.* When I am home, I want to enjoy home, and not be troubled by work. I often use the drive home to leave stress or frustration behind. The radio is a distraction which helps define the boundary between work and home. As I leave the office, I sometimes visualize putting a stressful situation in a folder, and leaving the folder on a special shelf, to be returned to at another time, but not interfering with my next activity.

Humor is an essential aspect of my stress management. Putting issues in perspective or just having a good laugh works well for me, minimizes the over-importance given to some problems, and defuses some tough situations.

Leaders often are limited in their informal contacts and office friendships, so it becomes even more important to maintain a network of friends and colleagues, including some from other locales and professions. My friends provide much support, as well as alert me to pitfalls. Families too provide support and underscore what is really important. As colleagues have looked back on their life work, I have never heard anyone say, "Gosh, I wish I had spent more time in the office!" Recreation and non-work interests such as music provide balance and refreshment as well as enrichment.

5. What are some of the biggest challenges in academic medicine today? What do you see as potential solutions?

Academic medicine is facing many challenges. Financial issues usually lead everyone's list. While I agree that managing the financial strains of academic medical centers is key to survival, a major challenge is how to maintain quality and integrity – both of the institution and of one's own values. Fiscal difficulties bring out the best in few. While supportive of academic health centers and medical research, the public has concerns about our ethics and honesty. How do we protect our patients? How do we avoid the inherent conflicts of interest that come with certain partnerships? How do academic leaders assist faculty and staff in doing good work, not losing sight of the mission of the institution and its commitment to quality, in spite of uncertainties? Change is a constant, as the old ways no longer work, and we can not be bound by the pearls of the past when planning for the future. Clearly, leaders have to set the tone and encourage constant review of performance and values, avoiding "spin," whitewashing, or managing results to suit our purposes. We need to set the model and demonstrate, not just preach. Our faculty and trainees model themselves after our behavior. At the same time we must be pragmatic activists, addressing the tough financial issues while working to inform policy makers of the problems and needs, and speaking on behalf of our patients and our professions.

6. Imagine that you are starting over as a junior faculty member. Describe what you would ideally like to experience from your mentor, and how you would like to be mentored.

I have had many wonderful mentors, most of whom were men. As caretakers, they encouraged and supported, suggested, helped find resources, brought me in to projects as partners, not just technicians, demonstrated skills, and were wonderfully constructive critics. They genuinely wanted me to be successful, helped connect me with people and programs, enlightened me about the politics of leadership, were easily accessible, and alerted me when I was potentially getting in to trouble. They encouraged me to reach beyond the length of my arms or even my vision. They taught by questioning as well as by example.

My first mentors were women, wonderful religious (nuns) who emphasized ethics, integrity, compassion and commitment to others, while making it clear that women could do or be anything they wanted, as long as they worked hard enough. Time and politics probably tempered that final phrase, but the inspiration of these wonderful women has set a tone for my work throughout my career.

7. For someone who aspires to be in a leadership role similar to yours, how do you advise her to apportion her time among the four traditional areas of teaching, patient care, research and administration?

Academic institutions still value the so-called triple threat – the researcher who teaches and provides clinical care, while devaluing administration – but the realities demand a different set of actual priorities. Increasingly, more faculty are spending more time in clinical work with less remuneration, and less time and energy for scholarship or education. At the same time, the value system calls for research productivity as measured by grants and publications. Education is regarded with ambivalence, as it is time- and labor-intensive. In many institutions, chairs and other leaders are chosen without regard for their administrative knowledge or experience, even though the tasks require these kinds of skills. And it is sad when excellent researchers leave their research endeavors to become chairs or deans and do not do well in their new roles, while no longer being productive scientists. No one can be all things to all people.

My own career path has not been the traditional progress seen in academic medical centers. Rather, after five years in academia, I spent two decades in a medical specialty organization, designing, implementing and evaluating education programs, and eventually taking a leadership role in health policy design and implementation, as well as serving as chief operating officer. It was a wonderful experience. When I returned to the university, it was to an administrative position, although I also continued to provide direct clinical care and taught students and residents. Going from a dean for students to the medical school dean is also an unusual move, but reflected my experiences in education as well as broader administration.

My specific advice would depend on the skills and interests of the individual faculty member. No one can or should do everything. Yet it is expected that leaders will be good clinicians, effective teachers, and have an area of scholarly proficiency. To lead in an area, we must have some understanding of its contents and particular demands. Regardless of balance or anything else, anyone aspiring to be a leader in an academic medical center *must have an identifiable medical/scientific area of expertise*. Scholarship is important as well.

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In addition to the more traditional bench and clinical research, faculty can engage in such areas as evidence-based medicine, quality improvement, critical pathways, outcome assessment, quality of life, ethics, economics and other areas related to health care policy.

As an educator, I am torn between encouraging faculty to place much effort into teaching (why are we in medical schools anyhow?) and recognizing that so many institutions put little value on high quality teaching. Yet educators have such an influence on future generations. Developing a course, evaluating the impact of educational programs, and improving patient outcomes through improved physician performance are some examples.

Protecting time is important, but developing an awareness of medical center/university function through participation on a *few* select committees is very instructive. Be careful, though; sometimes women are chosen to balance committee membership, and it is easy to become over-committed.

Learning administrative skills is a plus – and many opt for a formal degree program (e.g., MBA, MPA or MPH) either full or part-time. Information management and financial understanding are two areas in which physicians often are deficient. Strengths in those areas are highly valued. Good interactive/communicative people skills are another plus. Increasingly, leadership is needed in the clinical arena, managing hospital and ambulatory care settings. Understanding research operations including funding, infrastructure, patient support, and ethics requires an integrated knowledge of science and administration; that too is an area of need.

It is important to use opportunities that come your way – to analyze experiences, to propose solutions for problems, new directions or approaches, and to communicate these through the literature as well as verbally to colleagues. Don't be afraid to be self-promoting; let others know of your successes and accomplishments. Volunteer (in moderation) to use your skills.

Use mentors to get advice and assistance in setting and maintaining priorities as well as skill development, and determining the best proportion of time devoted to each area, based on your particular skills.

Of course, it is essential to have a vision.

8. What changes in academic leadership roles for women have you seen in the past five years, and what changes do you anticipate in the future?

The past five years have brought more visible successes for women, but disappointingly at a rate slower than anticipated. While women are more accepted in leadership positions, they are frequently relegated to traditional roles (e.g., student affairs) or placed in invisible but relatively unimportant positions. They and their more junior colleagues still experience institutionalized and covert sexism, encounter glass ceilings and brick walls, meet with open and passive resistance and are evaluated by different and often contradictory standards. In fact, junior women, who constitute a less threatening group, may face less of the difficulties that affect their more senior sisters.

What will make a difference? It is not just in jest that colleagues have stated that there will be greater change when the daughters of our male leaders face these obstacles. We need: a critical mass of women in each institution complemented by networking; intra-institutional organizations of women faculty devoted to professional development, mentoring and support; intra-specialty organizations or functions to support women; educational efforts aimed at deans and other academic leaders; policy efforts, such as flexibility in terms of work schedule, promotions and tenure; and of course, national efforts such as ELAM, SELAM, and those of the AAMC.

Marijo Tamburrino, MD
ELAM 1997-98

The Physician's Executive Coach on Promoting Responsible Change

… If your time to you
Is worth savin'
Then you better start swimmin'
Or you'll sink like a stone
For the times they are a-changin'
Bob Dylan

Who's Driving Your Organization?

This is truly about leadership in the purest sense of the word. Creating a vision of the future and communicating that vision broadly to those who can make it happen and who are impacted by its execution.

Change is inevitable, of that we are certain. While there are factors outside of our control, there is much within our control … and even more within our influence. If you follow the principle of 'negotiation jujitsu,' you can take those things that come your way that are neither controllable nor 'influenceable' and either dodge them or work them to your advantage (or accept their impact and move on).

Are YOU setting the direction for your organization (or your unit within your organization)? Is someone else? Is no one? Are you driving your organization toward its vision (Hands on the wheel? Foot on the accelerator? Eye on the road? A clear destination in mind?)? Or, are you drifting toward your goal (afloat with no sail, no tiller, no compass and no map)?

Why Change?

If change is inevitable, and we can guide to a great degree where we are going, how we will get there and how we will be impacted along the way, then maybe we ought to confront change on our terms. Why change? Here are some reasons given not to change:

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- Let well enough alone.
- Is where we are really so bad?
- Isn't this good enough for government work?
- We are comfortable with what we have and what we know.
- Don't rock the boat.
- Let's not change just for change's sake.

Or,

- Are we really as good as we can be?
- If we're not moving forward, we are losing ground because there is no such thing as standing still.
- If we don't know where we're going, any road will get us there.
- When we come to a fork in the road, we'll take it.

But if change is inevitable, and we want to influence our destiny, then let's assume that we will drive our change. What do we need to know?

Types of Change

There are many types of change but we'll present a few here:

- Incremental Change
  Modest adjustments in direction, breadth and/or scope of activity. Pace of change may range from glacial to slow. Outcomes may be difficult to measure, let alone perceive.
- Quantum Change
  Dramatic shift in direction, breadth and/or scope of activity. One can look back on the year and see a difference … movement is perceptible, impact is palpable.
- BHAG (Big, Hairy, Audacious Goal)
  A stretch effort beyond quantum change that fundamentally moves the organization to a new level, often beyond and above its peer group. In the big scheme of things, movement is not only perceptible, but also felt, like a 'breath of fresh air' or a trembler through one's body.

The Capacity for Change

Change for change's sake is not what we're talking about. This is not Emeril who just wants to 'Kick it up a bit' to excite the taste buds of those in his audience. This is about advancing the organization towards its vision and fulfillment of its mission. It is also not about frequent shifts in direction, the so-called 'Idea of the Month' approach.

People do have a capacity to deal with change, although there are limits. The proper approach and effective execution enhance capacity. Properly alerted to WHAT is to occur, WHY it is to occur, and WHEN it is to occur (and HOW it will impact them), most people can deal well with a quantum shift. Proper preparation, training, and the testing of systems before 'going live,' all help to ease anxieties and make people more comfortable about change. In fact, a common reaction to a well-executed change process often sounds like this:

- "Finally, somebody's doing something about that problem that we (operating in the trenches) have been concerned about for so long."
- "I am glad they have those of us on the front line proposing and implementing solutions rather than the folks in the Ivory Tower guessing what will and won't work."
- "This is good; we can see a difference already. I am ready to take some risk and get involved in the process."
- "I like the recognition we are now getting for a job well done, and the money (increase in salary) isn't bad either."

Inadequate preparation will likely result in resistance. This can range from mild to outright sabotage of the plan at one extreme, to misaligned efforts that result in sub-optimal accomplishment or outright failure at the other.

The Mandate for Change

If you are driving toward change then a clearly worded, well-articulated and repeatedly communicated Mandate for Change is in order. The Mandate for Change states:

- **WHAT** - We are going to significantly improve performance in the Operating Rooms by reducing our resource utilization by one-third, increasing our throughput by 15%, and improving patient/employee/physician satisfaction as measured by our objective instrument by 20%/25%/50% respectively.
- **WHY**- Our margins are eroding and we won't have resources to invest in current or new programs in the future, or money to remain salary-competitive for our staff. Patients/employees/physicians continue to express their longstanding frustration with our unsuccessful efforts to improve this area over the past 5 years, despite our incremental efforts. The impact of not doing something successful will be felt at many levels.
- **WHEN** - We will prepare and begin implementation the first of the year … we expect that full implementation will take 18 months.
- **HOW** - We will adopt a 'Best Practices' approach to OR utilization and apply the principles of 'Kaizen' and 'Rapid Process Improvement.' We'll pilot our plan in the West Wing operating rooms first, assess our performance and adjust as necessary before rolling it out to the main ORs.

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The Power of a Clearly Articulated and Well Communicated Vision

What makes quantum change, let alone the accomplishment of a BHAG possible? It becomes possible when one assembles the ingredients for success:

- A focused approach.
- A well-articulated and communicated Vision, in support of a broadly held Mission.
- A well thought-out process carried out by a properly staffed team of individuals, adequately trained and equipped.
- Well-defined **Expectations**, principles of **Accountability** and the application of timely **Consequences** for compliance/non-compliance.

The 'E' Word -Expectations

We have expectations of one another. We count on certain outcomes. If our expectations aren't fulfilled and we don't get the desired outcomes, we lose trust and confidence in the process and in one another.

Expectations are sometimes referred to as 'The Compact.' It is the understanding that we have with one another. They are the rules by which we operate and the outcomes we come to expect when everyone is doing their part.

The 'A' Word - Accountability

We assign Roles and we set Goals … and we hold people accountable to do what is assigned to them and what is expected of them. With greater frequency than one can imagine, people in positions of responsibility do the first part and then fail to follow through on the second part … they do not hold people accountable for fulfilling their part of The Compact.

The 'C' Word - Consequences

Not only do we too frequently not hold people accountable, but too often there are not clear consequences for their behavior. While many are motivated by the satisfaction of a job well done, it is often best to show near-immediate recognition for fulfillment of one's portion of the Compact … and make that recognition public… celebrate success! While we don't often publicly announce great failures (unless there is an important lesson to be learned that will help others avoid the same mistakes … and then only if doing so is 'safe' and a part of the culture), it is important that the response for failing to fulfill the Compact is dealt with in just as swift a manner.

Conclusion

"Make no little plans. They have no magic to stir (Wo)men's blood and probably themselves will not be realized"

- Daniel Burnham, Chicago architect and planner

Moving through life adrift and subject to the whims of others, or of no one for that matter, seems like a pretty bleak existence. Most people want to be led. Most people relish working with others toward a shared Vision in support of a noble Mission. Most people thrive on clarity of purpose and direction. They like the feeling they get from accomplishing measurable goals. They enjoy the rewards, both tangible and otherwise that come from shared success.

You are among the leaders of academic medicine … what role are you playing within your organization to advance the Vision and realize the Mission? Are you driving, or are you drifting?

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Strategic Career Planning: Traversing Career Transitions – Moving from Coping to Thriving

We estimate that more than half of the ELAM alumnae have made at least one career transition – ranging from a part-time new administrative position within the same institution, to a similar position at a new institution, to a completely new career in a new organization inside or outside academic medicine/dentistry.

Some have made transitions gradually, after having a growing sense of lack of professional advancement or fulfillment or general unhappiness, and after completing a carefully thought out career decision process. Others have made changes abruptly – either by choice or from factors outside their control. Sometimes this is necessary – you may not make the transition smoothly, *and* you can be catapulted into a healthier situation. However, it is optimum to be pro-active and to do the groundwork for a change on your terms and time frame. This can minimize the possibility of "jumping from the frying pan into the fire."

How can one best make career transitions, so that you "thrive" rather than merely "cope or survive" such changes? I propose four general steps.

1. *Recognize when you are ready for a change, and that such a state is a normal phase in any job or career*. Your career is your own; you do *not* need to stay in a position because others would like you to stay there! It's OK to say, I've been there and done that, and I'm ready to move on!

In any job, you go through an initial steep learning curve, then an up and down period as you continue to learn, and eventually arrive at a plateau. One clue to recognizing that your interests

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are changing is to notice what professional reading you voluntarily pick up. Do you let your scientific disciplinary journals pile up, yet find time to read other topics? At this point, it is useful to ask yourself honestly, "Have I learned all I can with this job? Is there anything my successor would do in the first three months that I have been putting off? Is this knowledge or a skill that I'd like (or know would be good for my career) to learn?" If there is, this is the time to do that learning, whether it is a scientific or clinical technique, or an interpersonal issue.

What you want to avoid in this job plateau phase is to "hang in" there in the job, feeling burnt out and cynical. You may decide for good reasons to stay with the job (e.g., family is well settled, benefits are good, retirement is near). This needs to be a conscious decision, being comfortable with yourself that you will continue to perform the job well, *and* will shift your focus to get your love of learning and recognition from other places. For example, you might decide to become more active in your national and international disciplinary societies. Or you may decide to become more active in local organizations, such as boards of non-profit institutions.

2. *Identify your passions, professional and personal.* Any of these choices requires you to identify your passions. Sometimes we get into tunnel vision and lose sight of our real passions. There are numerous books and reflective exercises that you can use to help you identify what you really want to spend your life energy on. Some of my favorites are:

- Think of a day, at the end of which you may be physically tired, yet are psychically energized. What were you doing that day? And now, think of a day, at the end of which you may be physically tired, and *also* psychically drained. What were you doing that day? What was different about the two?
- Describe what you are doing when you completely lose track of time. For me, that often means getting absorbed in analyzing data – data of any kind!
- Describe professional and personal achievements in your life. What themes emerge regarding your transferable skills? Which do you like to do best? This analysis gives you important clues as to the functions you want to focus on in your future career.
- Describe in full Technicolor detail, a day 5 years from now that would be an ideal day in your career. What are you doing from morning to night? What are you wearing? Where is your office, lab, or clinic located (or do you have them) and what is in it? What people do you interact with during the day? Whom do you have lunch with? How far away is your work from your home?
- What professional legacy would you like to leave? For me, I once thought it was assisting the development of the field of biologic response modifiers – now I believe it has been the opportunity to develop the ELAM program and to work with a tremendous group of talented women across the U.S. and Canada!
- What would you do if you won the 10 million dollar lottery?

3. *Investigate the career possibilities generated by these passions*. A major approach involves using scientific investigative skills – researching various options through informational interviews, identifying transferable skills, outlining the big picture of what you want in your professional and personal life, and assessing your current job risk (e.g., is the organization stable, are you keeping up with the skills needed, are you staying aligned with organizational goals?). It is also useful to explore undefined roles. More than half the job titles today did not exist five years ago! And often, you can create a job that 'fits you' *and* meets a vital need of your current or a new organization. It is essential that you do your *due diligence* in investigating possibilities. This includes: defining the job, title, responsibility, authority, to whom you report, and how and when you'll be evaluated. A good question to ask is, "If at the end of a year, I had made you look outstanding through my performance in this job, what would I have achieved for you?" Also, investigate how "do-able" the job is, is it funded sufficiently, how stable is it (and this tends to be less with new job titles with undefined responsibilities), and what termites are likely to be found in the woodpile. Finally, will the job make you stronger – more skilled and marketable in the future? Sometimes a strategic lateral move may fill in some important gap in your experience that you know you will need for a subsequent position.

4. *Understand that career transition involves an emotional roller coaster, and identify the support you need to go through it and thrive*. This is a critical aspect of change to new jobs that is often neglected. Even in good changes, expect to go through the roller coaster with its grieving periods. Honor them – respect them. You are likely to first have *uninformed optimism*, which will change quickly to *informed pessimism* when the "termites in the woodpile" surface. It is easy to check out at this stage, unless you build in support to help you stay on the roller coaster ride until you reach *hopeful realism* and eventually *informed realism*. This includes paying special attention to your physical, emotional and spiritual health – right at a time when you're likely to say you're too busy and will get back to exercise and sleeping your optimum hours later. This is the time to nurture yourself (massages or bubble baths, anyone?!), stay connected with helpful friends, keep up your spiritual practices, etc. If any of you have any special methods you have found helpful as you have traversed change, post it to the ELUM listserv and maybe we can develop a book of transition tips!

Wishing everyone who is considering or traversing a job or career change – have a joyous, thriving time of it!

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ISSUES IN THE WORKPLACE

Building Effective Teams through Leadership

Effective leaders are those who become adept at getting things done through others. For many with scientific backgrounds, this is a learned rather than a natural process. Leading through teams is an essential skill. An inability to recognize and develop teams can lead to failures in establishing change within an institution or program. Therefore, skills in team development are important for success of the team and programs effected by team activities. Lessons related to developing team leaders have corollaries in developing executives.

Kotter[1] suggests that teams be composed of compatible members. He also recommends avoiding at all costs "snakes and egos" - those people who create enough mistrust to kill teamwork. To create effective teams, Bossidy[2] recommends selecting individuals who have the ability to execute, and have both perspective and multiple experiences. Realistically, however, the team leader must develop an effective team from a variety of individuals who may not meet all of these criteria. Effective teamwork is a complex behavior requiring high energy and does not always correlate positively with talent.

Druskat and Wolff[3] discuss the skills involved in building emotional intelligence within teams or groups to increase performance. Group emotional intelligence extends the definition of personal emotional intelligence described by Daniel Goleman. According to Goleman, *personal competence*, or awareness of and regulating one's own emotions, and *social competence*, or awareness and regulation of other's emotions, are the chief characteristics of emotional intelligence. Group emotional intelligence requires that the group, or team, be *aware of emotions* both within and outside of the group. Furthermore, the group should possess the *ability to regulate those emotions*.

Group emotional intelligence supports three conditions essential to group effectiveness: trust among group members, a sense of group identity, and a sense of group efficacy. The goal of team emotional intelligence is a balance between team cohesion and each team member's individuality. While differing somewhat from institutional leaders, team leaders still require some of the same qualities to insure that the team actually functions with the leader. In particular, leaders must be able to impart their own humanity and approachability, empathize with the team members, rely on intuition, and capture the uniqueness of ideas for the team's task. Team leaders should seek an interpersonal understanding of the team members and be sensitive to opinions, even those representing a minority opinion. By asking for the minority opinion perspective, the leader is seen as making an effort to understand other team members. This creates trust, leading to better group participation and better group efficacy. Both interpersonal understanding and perspective taking develop the awareness necessary for emotional intelligence.

Regulating the emotions of the team requires creating an attitude of responding to challenges within the team that can then be applied to challenges from outside the team. These attitudes include developing a vocabulary for addressing negativity within the group, developing a can-do attitude, and encouraging proactive problem solving. The latter is extremely powerful and underscores a refusal by the team to feel powerless. The attitudes also energize an eagerness to take charge of the problem. Displaying appreciation and respect for group members builds trust and group identity and facilitates positive regulation of team emotions. Combining confrontation skills, caring skills, and awareness skills leads to strong team emotional intelligence and increased productivity.

Teams may develop high levels of emotional intelligence and still face difficulty from groups outside of the team when interacting with other groups. The internal strength of the team will prevail and a higher degree of emotional intelligence can be developed with outside groups when the group builds trust and regulates emotions, by confronting negativity and appreciating and respecting the contributions offered by outside groups. While a team may be successful within its own boundaries, failure to translate emotional skills beyond team boundaries to other groups eventually may seriously limit the team's effectiveness. Successful leaders effectively channel emotions at three levels: the individual team members, the team as a unit, and those outside of the team. In demonstrating these, the leader acknowledges the role of the individuals and their interaction. Both Kotter[1] and Bossidy[2] recognize this as important to the functioning of the team as a unit. Druskat and Wolff[3] also address the equally important need for leaders to acknowledge the role of those not on the committee to the ultimate success of the team's task.

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Related Reading

1. Kotter JP, *Leading Change.* Harvard Business School Press, (c) 1996.
2. Bossidy L "The Job No CEO Should Delegate" *HBR* Mar. 2001, pp. 47-49.
3. Druskat VU, and Wolff SB, "Building the Emotional Intelligence of Groups" *HBR* Mar. 2001, pp. 80-90.
4. Goffee R, and Jones G, "Why Should Anyone Be Led by You?" *HBR* Sept/Oct 2000 pp. 63-70.

Boss: "Profits are down. Our senior management blames the weak economy."

Dilbert: "So they're saying that profits went *up* because of great management and *down* because of a weak economy?"

Boss: "These meetings will go faster if you stop putting things in context."

Dilbert: "Sorry."

Dilbert by Scott Adams

When nothing is sure, everything is possible.
Margaret Drabble

Salaries of Assistant/Associate Dean and Other Academic Medical Administrative Positions

On 6/29/01, I posed the following question to the ELUM listserve (ELUM-l@drexel.edu): "I am negotiating to move from a 25% Assistant Dean of Graduate Medical Education (GME) position to a 50% Associate Dean of GME position. There is very little benchmarking data regarding compensation for these positions. I would like to be compensated at market value for a full-time equivalent (FTE) clinician in my discipline, with half coming from my department and half from the hospital (paying my Associate Dean salary). Do any of you have similar administrative roles, and if so, can you tell me how your salary is apportioned? Do you earn less because you have an administrative role? Does your department subsidize your salary in order for you to have non-clinical time for your administrative role?"

I received 18 responses. As the Table shows, 15 (88%) of 17 responses described situations where there was no loss in clinical salary for taking on administrative responsibilities. One response was excluded from the Table to honor a request for confidentiality. The respondents represented a variety of clinical specialties associated with a broad range of clinical income.

Physicians in administrative positions in academic medical centers are unique. In general, physicians maintain an appointment within a clinical department and have clinical duties. Clinical responsibilities and compensation for clinical productivity vary among clinical specialties. Conversely, administrative responsibilities for a given title do not change according to the clinical specialty of the physician-administrator. How should administrative salaries be determined? Should they be based on an arbitrary administrative salary scale, or on the physician's clinical market value? Generally, clinical salaries are based on the latter. There are good benchmarking data for physician clinical salaries, but not for physician-administrator salaries. Even if there were benchmark data, it would reflect a skewed balance of physician-administrator clinical specialties. Without good benchmarking data, institutions may offer compensation for administrative positions at a lower level than a physician's clinical market value. In some cases, a physician in a lower paying specialty may assume a salary increase when taking an administrative position. Should a physician accept an administrative salary that is substantially below his/her clinical market value? If the answer is no, only physicians representing lower paying clinical specialties will accept administrative positions. Accepting a promotion at a substantial decrease in salary may seem counter-intuitive, especially if at the same institution other physician-administrators representing lower-paying specialties realize a salary increase for accepting an administrative position.

Chairperson salaries represent a precedent for paying physician-administrators based on clinical market value. Chairs of clinical departments generally have fewer clinical responsibilities than other faculty in the department, and in some cases may not have any clinical responsibilities. Yet, the Association of American Medical Colleges (AAMC) benchmark data show that chairs earn higher salaries than their non-chair colleagues do. In the case of a chair, taking an administrative position results in a salary increase, which in some cases can be substantial. Salary for other positions, such as president or chief executive officer of a faculty practice group, may be based on the physician-administrator's clinical market value. Should it be any different for an assistant or associate dean position?

A physician-administrator can bring recognition and prestige to a clinical department through his/her administrative position. There may be other benefits for the clinical department, such as access to information and other resources. Should a clinical department subsidize the salary of one of their physicians who assumes an administrative role? If so, what is a reasonable amount of subsidization? There are potential drawbacks to departmental subsidization. If a physician-administrator's time is split 50-50 between administrative and clinical responsibilities, and the institution does not contribute 50% of the physician-administrator's total clinical salary, regularly granting 50% non-clinical time from the department for the physician administrator may be difficult.

Generally, salaries are determined based on job responsibilities, benchmark salary data, and the candidate's qualifications. Accurate benchmark data are essential. As an example, would it be appropriate to lump together the salary of an Associate Dean/ Neurosurgeon with the salary of an Associate Dean/Pediatrician in determining benchmark data? Or would it be appropriate to lump all Associate Dean/Neurosurgeons in one group and all Associate Dean/Pediatricians in another? The problem with the latter is the small number in each group. But because the group is small, can we ignore the fact that the group is unique? How big does a group have to be to be considered "big enough?" Is the group "Associate Deans of Faculty Affairs," as an example, big enough for benchmark purposes? If the answer is "no, but it's the best we have," then the same can be said for a group of two Associate Dean/Neurosurgeons. Most ELUM physicians who responded to my query were able to preserve their total clinical salary when accepting a part-time administrative position. I thank all the ELUMs who provided responses to my listserve query.

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Table. Determination of salaries for physician-administrators at different institutions.

Title	Clinical Specialty	Salary Sources & Amount
15 Examples of no loss in clinical salary for administrative responsibilities		
Director of Cancer Center	Surgery	• No loss of salary for administrative role. • Dean pays for loss of one OR day (straight salary for administrative job and part of practice plan for clinical work).
Associate or Assistant Dean	Specialty not determined	• Paid more than clinical FTE. • Paid at baseline departmental salary + administrative differential from College.
0.75 Associate Dean	Internal Medicine	• Assuming role in Dean's office did not result in salary cut. • Dean matches discipline salary, even though it may be higher than what the previous Associate Dean was paid.
Associate Dean of GME	Internal Medicine	• Parity with others in home clinical department. • Department does not subsidize time for administrative role.
Associate Deans	Previous or present: Internal Medicine, OB/GYN, Pediatrics, Ophthalmology and Surgery.	• All paid based on department of origin, split by department and central administration according to FTE.
0.5 FTE Medical Director of Ambulatory Care	Internal Medicine	• No change in total salary when taking on administrative role. • Receives 50% of salary (based on 1 clinical FTE in specialty) from Health System.
All administrative roles	All specialties	• When assuming administrative roles, salaries remain unchanged, except for some leadership positions (department and division chairs, and a few others), which carry a modest salary increase. • Positions with responsibilities of Assistant/Associate Dean retain base salary or receive very modest increase. • Salary adjustment for leadership positions continues after one leaves the position, so no one tries to hang on to a chairmanship, deanship, etc. just for $$. • Philosophy is that salary should be neither an incentive nor disincentive to be in leadership. All physicians are fully salaried based on credentials, department, and market value for physician in that field.
0.2 FTE Chair of Credentials	Radiology	• Total salary remains at parity with other clinicians in that discipline at institution. • Medical center pays department pro-rated percent of salary for administrative role.
0.5 FTE Associate Dean	Psychiatry	• Preserves full clinical salary and receives additional $10,000 Administrative Salary. • Dean makes up difference for any decrease in clinical revenue due to fewer clinical hours worked.
Associate Dean	Psychiatry	• Paid at same rate as if practicing in clinical specialty.
Associate Dean	Surgery	• Paid at same rate as if practicing in clinical specialty.
1.0 FTE Associate Dean	Surgery	• Salary as Associate Dean based on clinical salary before taking position.
0.5 FTE Associate Dean of GME	Radiology	• Salary as Associate Dean same as clinical salary. • Department pays 50%, Dean's office 50%.
0.5 FTE Associate Dean	Pathology	• Salary at 80th percentile AAMC for rank and department (divided between Dean and department) in addition to $25,000 administrative supplement from Dean.
0.5 FTE Associate Dean for Curriculum	Pediatrics	• Salary based on clinical duties, with prorated percent coming from Dean's office and department. Dean's office and department split all raises (including academic promotion).
• **2 Examples where clinicians may have lower salaries for administrative responsibilities**		
Associate Dean for Faculty Affairs	Clinical specialty not determined	• Physicians in Dean's office receive FTE percentage of a (low) standard physician's salary of $150,000. For 50% Associate Dean position, department gets $75,000 from Dean's office to use at their discretion and Associate Dean receives $75,000 plus "extra pay" (usually about $10,000) from Dean's office.
0.5 FTE Associate Dean for Faculty Affairs	Anesthesiology	• Initial offer was for 50% administrative time instead of clinical role (based on much lower salary common to other full time administrators in Dean's office). This was a difference of about $80,000 base salary. Negotiated increasing it – to split difference, putting clinician on higher scale than others.
Note: some respondents provided information on their administrative roles; others provided information about the administrative roles of others in their institution.		

Customer Service at Pike's Place Fish Market: What Does It Have to Do with Medical Care?

Our organization, Atlantic Health System, recently embarked on a two-day retreat for all managers, directors, senior management and medical staff leadership, to focus on customer service. Over 400 people participated in the five workshops that were held over a period of two months. Many concepts were presented. The most intriguing one was a customer service philosophy, called *The Fish Philosophy*.

The Fish Philosophy was developed at the Pike's Place Fish Market in Seattle, WA. Our introduction consisted of two very engaging videos about the history of the market and the use of the customer service philosophy in other areas. In the first video they presented "the problem." When the Pike's Place Fish Market was purchased over 10 years ago, the new owner with the 12 workers challenged themselves to figure out how to improve the business. The market had not been doing well. It was a simple fish market with long hours and harsh working conditions. The job was exhausting for the young men who worked there, and it showed in how they interacted with customers. *The Fish Philosophy* began as a practical joke on a co-worker. When he muttered the order, they all started yelling it loudly and sequentially to each other. They all laughed and then realized that perhaps they were onto something. They began to brainstorm about how to recreate and keep that good energy. The product that resulted was the Pike's Place Fish Market mentality, which is characterized by playfully engaging the customers, being friendly, and working as a team. Now, when a customer places an order, they yell it out in rapid fire one to another and actually fling the fish over 20 feet to the "catcher" who then filets and packages the fish. Legions of people every year gather around the Fish Market, not just to buy fish, but to observe this group working together and having a great time.

The Fish Philosophy consists of four very simple tenants.

1. **Work should be fun.** To make work fun, you need to encourage spontaneity in the workplace.
2. **Be there.** When you are interacting with a customer or coworker, don't become distracted with other issues. Distraction results in giving their needs only part of your attention. You should be 150% present, using active listening, so you can be sure you understand exactly what they are trying to communicate.
3. **Make someone's day.** Go out of your way once a day to do something extraordinary for someone else. Not only will you make that person's day, but you will make your own day as well.
4. **Choose your attitude.** This is probably the most important rule. We all have external issues that make everyday life challenging, but it is essentially up to us to decide if we are going to be in a good mood or a bad mood when we go to work. The truth is that it is a lot easier to be happy than grumpy, and certainly easier on the people around you. Your attitude is your personal choice….so choose a positive one.

How effective is this? The philosophy is very simple, but not simplistic. The success is obvious when you watch the video of everyday activity in the Fish Market.

How does this apply to medical care? A number of medical centers have adopted the Fish Philosophy. Who can argue with having fun at work, being present, making someone's day or having good attitude? In fact, most of the complaints I handle as CMO arise from interactions where we don't pay attention to these things. I encourage any of you who are interested to check out the website www.fishphilosophy.com, to see if this is something you would like to bring back to your division or organization. Making our environment positive for both our patients and our co-workers is needed in medicine now more than ever. I would be happy to answer any questions. I am an avid email reader.

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On Being a Student...Again

For three years I toyed with the idea of getting a master's degree in health administration, but I didn't relish the thought of long-distance learning and even minimal commuting trips. I watched a friend live through the local full-time-only Executive MBA program and knew that wasn't for me. Then, miraculously, my own university created a master's of science in health administration (focus: health policy) program. I thought, "Bingo!" as I applied and then entered as a part-time student in Fall 2001. Raises have been scarce or non-existent in academia, so I thought I'd retool, exercise my brain, benefit from tuition deferment, and return to the classroom nearly three decades after medical school. I've never worked harder for a raise in my life!

A friend and one of my current professors assures me it's the right choice. She coaches me through every speed bump and crisis, liberally sprinkling her support and advice with stories from her PhD studies while working full-time. Her most frequent reminder: "You've been on the other side of the desk for decades. Now that you're a student again, you'll find it hard to be back in the subservient role." What?! After decades of professional growth "in spite of," you don't mention the word "subservient" to a professional woman. Another friend, now retired, remarked, "I can't believe I'm having lunch with a friend who's running off to do homework!" In fact, my study partner for statistics is a former resident for whom I was faculty advisor and now serve as her mentor.

Registration was a maze of forms collected from and delivered to three different offices. I thought I was on top of it till, halfway through the first semester of statistics, I learned I wasn't on the official roster. During orientation I visited displays to gather signatures from colleagues and staff in student services who knew me in my Professor and Course Director roles. I fielded comments

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like, "You're kidding!…. What are *you* doing here?… You're doing *what*?" They were incredulous but quickly supportive. I even had to pose for a mug shot, complete with name and SSN on a placard, for the class roster. Now in my second semester, I feel compelled to share my insights and observations.

In Memphis the academic year starts in mid-August. Still, I was seized with the urge to buy and wear a plaid dress on Day 1. The stores carried only wool blends. So I broke my remembered tradition and bought a few summer frocks on sale for my "Back to School" wardrobe. Not one was plaid. One of my fall classes was offered 7:10-10:10 p.m. Tuesdays at the University of Memphis (another public higher education institution in Memphis). This of course interfered with my bedtime. I quickly learned that "business casual" still made me stick out. I just don't own ragged T-shirts and cut-offs, and I lack tattoos and multiple pierced body parts. But I loved wearing jeans to class!

Classmates at my home institution are a diverse bunch, from grad students right out of college to other faculty and administrators (mostly junior). I just might be the oldest, but all of us working full-time question repetitively the sanity of our decision as we slog through two semesters of biostatistics. Yes, I have statistics phobia. One day I stood up after a particularly bewildering class, feeling like a deer in the headlights. I looked around and recognized that same look in my 30 classmates. (That was comforting!) I'm convinced statistics is a 10-letter synonym for masochism. Homework to hand in? Three open-book take-home exams per semester? Struggling with the SAS computer program and complicated calculations on a handheld calculator? Deduction of 10 points for each data entry error?

Students in my health economics class at U of M were diverse: a junior hospital administrator, a FedEx employee working three jobs, a single mother of three and home health nurse, and a woman who rocked to and fro. An undergraduate economics majors declared smoking cessation as cost-ineffective, despite evidence to the contrary. During the break I passed him smoking in the designated area. Another undergrad was a silent, mild-mannered, earringed football player who strolled in and out of class, in marked contrast to my Type A attendance. However, we looked at him differently when we learned how difficult it was to pull him off an opposing player during a fight. The professor insisted on student team presentations. We came to judge their utility and quality by the number of times he didn't interrupt to take over. Another midterm and final closed-book exam, and (gasp!) a term paper (I learned the hard way about changes in data reporting that occurred in a 10-year database).

I developed a new appreciation for medical students' feedback. First, volume of material. "We don't have time to go over everything in class, so you'll have to cover it yourself." One-quarter of the textbook?!? "Please pull 100 pages [font size 8] off these websites and read them by next week." But I'm bifocally challenged! "Sign up for these 10 essential daily e-mail newsletters and read them." Second, required attendance. Adult and team-based learning is labor-intensive. We work hard for our one-credit seminar – two team presentations a semester, automatic grade drop if you miss more than a designated number of sessions, grade dependent on how the entire team does *and* how much you participate in discussions. The professor makes a check each time you open your mouth. I feel like I'm entering stage left each time I walk into the room. Third, "errors" on exams. "I didn't like the way you said it." When I questioned the statistical definition of range, "That's the problem with clinicians." Hmmm, I'm beginning to understand the concept of subservience and how to accept and adapt to a teacher's style and expectations.

A few more pearls:

- Yes, get advice from your faculty advisor. Then quickly get the practical advice from other working, older grad students who know the ropes. I naively signed up for seven credits the first semester. I planned to do the two-year program in three years. That plan is under revision.
- Caffeine is my friend, albeit a fickle one. I can drink more tea and cola now with no problem falling asleep. However, around statistics exam time, I wake up with incredible solutions to the problems. "For power and sample size, all I have to do is divide by Avogadro's number." I wondered where I'd find that number decades after chemistry class. After the first sip of tea, I suddenly realized there was absolutely no connection. An alternate definition of "statistical nightmare."
- Weight-bearing exercise helps prevent osteoporosis. How many texts, paper-filled binders and laptop computers can you carry in how many tote bags and still make it to your car without shortness of breath?
- At work: delegate, delegate, delegate. Practice the "broken record technique" when asked to do something, "No, thank you, I'm not interested." Of course, be wise in the process. Prioritize.
- Remember to add the tea leaves before you pour the hot water into the teacup. It tastes better. And has much more caffeine.
- An electric tabletop grill timer runs without electricity. However, meat cooks better if you plug the grill in.

Yes, my stress level has increased. I read fewer novels, I hug my dogs more often, I sometimes skip riding my horse in inclement weather. I still have season tickets to two concert series. I've become much choosier about how I spend my "free time." I've already become more flexible. My habit was to wait and brew tea when I got to work, but this year's 8:00 a.m. classes forced a change. Despite my statistics phobia, I used my neophyte knowledge twice so far in meetings – and watched my colleagues roll their eyes as the guest consultant waxed vociferously over my suggestions.

Mary Lou Cook said, "Creativity is inventing, experimenting, growing, taking risks, breaking rules, making mistakes, and having fun." I'm doing all seven, especially if one defines "fun" as getting the correct F statistic and p value. But I guarantee – statistics can't be over fast enough!

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ELAM 1997-98

BOOK REVIEWS

Tempered Radicals – How People Use Difference to Inspire Change at Work. Debra Meyerson. Boston; Harvard Business School Press, 2001.

This is a MUST READ!! I've been waiting for months for this to come out – it finally arrived, and I've been reading it almost non-stop. Meyerson (visiting professor at Stanford and at Simmons Schools of Business) gives a name to what many of us are: "people who want to succeed in their organizations yet want to live by their values or identities, even if they are somehow at odds with the dominant culture of their organizations. They want to rock the boat, and they want to stay in it." And they're tempered, toughened like iron to steel, as they perform leadership.

Meyerson's thesis, well documented by research, is that most major, lasting culture change in organizations is performed by tempered radicals. She shows how these acts represent a crucial form of leadership that she calls "everyday leadership." This is what I have called being a "leader from wherever you are." Tempered radicals are distinct from those employees who choose to stay and completely assimilate into the culture, or those who leave either through resignation that they will never fit in or through flaming out in untempered radicalism.

Meyerson describes three general types of tempered radicals: (1) those who perceive they have different social identities from the majority, and see these as setting them apart and excluding them from the mainstream. Her research found that almost all African Americans and gay and lesbian employees viewed themselves in this group, as did about half the women and Latinos. (2) those who also perceive different social identities, but see those differences as merely cultural and stylistic. This group comprised most of the Asian Americans, and half the women and Latinos. In contrast to the first group, the second group views problems as a personal dilemma, so they tend to expend their energy looking for ways to fit in, and do not work towards changing the predominant culture or seek out natural allies for support. (3) those who perceive their differences are not cultural but philosophical (social consciousness, environmental, etc.). Their response is more like the first group of tempered radicals than the second. Most acts toward cultural change derive from the first and third type of tempered radical.

Tempered radicalism can lead to change that no one can identify how it came about. For example, Meyerson tells the story of a woman who quietly modified (without a formal organizational policy) work schedules to be more flexible. When Meyerson interviewed the chief HR officer several years later, she explained that the culture had shifted dramatically to be more hospitable to working parents – that whereas a 5:30 p.m. meeting would have been the norm, now it would be seen as completely inappropriate. The change was due, she felt, because many employees pushed back on the old expectations (supported by quiet tempered radicals) and set examples for other employees.

Meyerson describes a range of activities of tempered radicals, beginning with quiet acts that may go undetected or not linked to the person. An African American executive, on her own, sent notices of entry level employment to predominantly minority colleges (while HR was recruiting from the Ivy League), and thereby increased the number of minority entry level employees. A slightly riskier activity is described as "turning threats into learning opportunities." A tempered radical pointed out that an organizational practice (e.g., making travel plans on short notice) penalized valuable employees who could not pick up and go at the last minute, and suggested the desirability of advance notice. At the end of the spectrum of tempered radical acts is strategic leveraging of small wins and organizing collective action. Practical examples of each activity are given. These give many useful ideas for tempered radicals to consider in the context of changing culture in academic health centers.

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Who Moved My Cheese? An A-Mazing Way to Deal with Change in Your Work and in Your Life. Spencer Johnson, MD. New York; GP Putnam's Sons, 1998.

If you are reading this newsletter, odds are you are somehow involved in academic medicine, presumably in a leadership role, i.e., you are part of an "organization." If so, this book is for you. This tiny book (hardcover has 94 pages with large type) can be read in under one hour (perfect for a short flight). It is a parable that reminds us of some of the quirks of "organizational" life that we have certainly heard before, but somehow we need to hear again and again.

It is the story of two mice, Sniff and Scurry, and two "little people," Hem and Haw, the size of mice, who live in a maze. The maze represents the organization they live and work in. They each have "their cheese," a metaphor for what they really want in life, what keeps them happy. The main point of the story is how they each deal with unexpected change, i.e., when their cheese gets moved. The story evolves by following the experience of one who has successfully dealt with the changes and found "his" cheese. As he proceeds through the maze, he writes messages on the wall, based on his experience. Thus, the "Handwriting on the Wall" assumes a very real connotation.

The author summarizes the entire book in the seven points of "Handwriting on the Wall:"

- Change happens (They keep moving the cheese)
- Anticipate change (Get ready for the cheese to move)
- Monitor change (Smell the cheese often so you know when it is getting old)
- Adapt to change quickly (The quicker you let go of old cheese, the sooner you can enjoy New Cheese)
- Change (Move with the cheese)
- Enjoy change! (Savor the adventure and enjoy the taste of New Cheese)

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- Be ready to change quickly and enjoy it again and again (They keep moving the cheese)

The message is not earth shattering, and the characters will sound familiar. It is very easy to identify with one or more of them (most of us have probably reacted like all of them at some time in our lives). Yet this simple story drives the point home very effectively. It is quick and pleasant to read, and a refreshing reminder that in this time of constant turmoil and change, learning to move with the cheese is a skill we all need.

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Who Cooked the Last Supper? The Women's History of the World. Rosalind Miles. New York; Three Rivers Press, 2001.

Walking through the bookstore in Oxford MS, the title caught my eye. I was mortified. I'd never even thought of the question. Born in England, the author writes both fiction and non-fiction. This book, previously published as *The Women's History of the World (1988)*, has been translated into many languages. This reissue is the first text in the original form (i.e., with humor intact) to appear in the US. Basically, she describes the repetitive nature of women's struggle from prehistoric time to now. Her observation is that "women make progress in times of social change," e.g., wars and the American frontier. (Hmmm, here's our chance in health care.) Her message: "Every gain, every success for women is taken to mean that men are being cheated and denigrated… While women were straining every muscle, nerve and bone for the last 30 years, while they labored to remake themselves, their lives and the world, what were 20th century men doing all this time? And how long will it take them to join in and support us?"

The first chapters describe the matriarchy till the "fall of woman" led to patriarchy and developed dependence of women upon men. Some of her hypotheses seem a stretch, but descriptions of discrimination and attacks on female sexuality ring true. Woman's work became husband and family, and support of her husband in his demanding work. But there are stories of female heroes, e.g., 15th century tradeswomen, medieval physicians, French revolutionaries, Annie Blance Sokalski (the real-life Calamity Jane), suffragettes, abolitionists, and reproductive rights activists, that bring the history to life. Her final chapter describes the new strength of woman, "recognition of the oldest truth [that] only the people who care enough about us to work consistently for our liberation is us." She's right – our history has no ending, and has only just begun.

We never do learn who cooked the Last Supper. Her recounting provides a pleasant relief from the usual telling of history.

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The Women Who Broke All the Rules. How the Choices of a Generation Changed Our Lives. Susan B. Evans, EdD, Joan P. Avis, PhD. Napierville IL; Sourcebooks, Inc., 1999.

These researchers interviewed scores of women from the Torchbearer generation, using a standard interview format published in the appendix. These are "women who were in their teens and early twenties during the period of historically unprecedented social change that began in America in the late 1960s," born between 1945 and 1955. I didn't expect to find myself in these pages, or to think of myself as a Torchbearer or "accidental pioneer" – but I saw myself in many of the interviewees and identified with their discomforts. Chapter titles aptly describe the themes, e.g., "By the time I got to college, they changed all the rules," "I've made lifestyle choices that surprised even me," "I've grown, what's his problem?" and "I'm blessed to have women friends who are the backbone of my life." Each chapter is filled with Old and New Rules, and Old and New Truths, fleshed out with stories and quotations from the women interviewed.

In the final chapter, "Keep walking and remember to pass the torch," they list "12 incredibly smart pieces of advice for young women." Among them, "Do not accept mediocrity. You may be able to do it all, but you sure as hell can't do it all at once. Your first career is not your only career. Don't be in a hurry or you'll miss out on the little things along the way."

This book is not the easiest read. However, thinking of myself as a Torchbearer is fortifying.

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QUOTABLE

Be not afraid of growing slowly; be afraid only of standing still.

-Chinese proverb

Leadership is the art of appearing calm while everyone else is running around madly.

-Anonymous

Aerodynamically a bumblebee shouldn't be able to fly, but the bumblebee doesn't know that so it goes on flying anyway.

-Mary Kay Ash

There is not the slightest doubt that women belong to the people of God and the human race as much as men and are not another species of dissimilar race.

-Christine de Pizan
The Book of the City of Ladies, 1405

Common sense is the knack of seeing things as they are, and doing things as they ought to be done.

-Harriet Beecher Stowe

REMEMBER!

- To let us hear about anything you want to share with all.
- To send in your nomination & questions for the next SELAM Mentor.
- To send in book reviews for SELAM News. (You are reading in your spare time, aren't you?)
- To write or send in a topic for Issues in the Workplace.
- To recruit a colleague (or more – unofficial contest to get the most members!) to join SELAM Intl. Prospective members do not have to be ELAMs or ELUMs.
- To nominate a woman for the ELAM program. Send names to Rosalyn Richman.
- Due date for next newsletter is *May 1, 2002*

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SELAM International is committed to the advancement and promotion of women to executive positions in academic health professions through programs that enhance professional development and provide networking and mentoring opportunities.

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