Association of University Professors of Neurology

Difficult Conversations

Sunday, October 13th, 2019

Description:

As Neurology Chairs, we frequently need to tell a faculty member, trainee, or staff member that their work is inadequate, that they have done something wrong, or that their services are no longer needed. We are called on to investigate real or imagined infractions, or mediate between conflicting personnel. These interactions are collectively known as "Difficult Conversations." Despite years of medical and research training, we get no training in how to do manage these interactions effectively. This session will provide guidance from Dr. Henry Kaminski, a senior Neurology chair who will share what he has learned about how to approach a difficult or contentious topic, how to mediate between warring parties, when to take sides, how to fire an employee, and other challenging topics.

Learning Objectives:

1. Discuss strategies for conveying unpleasant information without injuring the person or the relationship.
2. List several approaches to diffuse contentious situations, and describe why it is important to listen to all sides of an argument before making a judgment.
3. Discuss why honesty and integrity are the most important things you bring to a difficult conversation.

Speaker:

Henry Kaminski, MD, Meta A. Neumann Professor and Chair of Neurology, George Washington University

Moderator:

L. John Greenfield, MD, PhD, UConn Health

Learning Objectives: The learner will have a framework for having difficult conversations, and can educate others on key features of what makes a difficult conversation easier.

Paradox: On a daily basis, we have difficult conversations with our *patients*…but we are not prepared to have such with our colleagues or trainees…the skill sets do differ.

Levels of difficult conversations can vary in severity (from perspective of the chair). These may range from minor discomfort with discussions such as feedback to trainees, an annual report with a faculty member, or giving bad news to faculty (related to financial, operations issues, departing as Chair, etc.).

More difficult conversation may involve corrective action with faculty member (for minor to moderate problems), such as chronic tardiness to clinic, poor productivity, a single episode of impoliteness, salary issues, tardy documentation, timely billing submission, discharge summary completion, space allocation, or other resources.

The most difficult conversations could include an initial discussion which could lead to termination or actual termination discussion (which has significant potential for legal actions).

There are many rationalizations for delaying difficult conversations including: fear/discomfort/anxiety, the reluctance to upset another human being, concerns about compromising existing relationships, and the negative impact that could result from the conversation. Faculty or staff may leave, which could result in loss of revenue, compromise in work flows, and call coverage problems. You may avoid having a difficult conversation due to misplaced loyalty to a faculty or staff

member who no longer deserves it, as well as fear of the the Unknown, inexperience in handling fraught situations, and uncertainty about what needs to be said and done.

It is important to appreciate the power dynamic. You cannot underestimate the anxiety/discomfort/concern individuals have when interacting with you as Chair. This should wain over time, but may not disappear, as you get to be known by your faculty and staff …unless you are a bad chair. You can appreciate the perspective to some degree when the roles are reversed and your Dean or CEO is meeting you for a difficult conversation.

Preparation is important. Take sufficient time to get your data together, but do not delay having the meeting. Clearly consider the point you want to communicate. Don't over think. Stay calm, and be positive.

Why even have these conversations? It is your job as a leader. Moreover, because there are obvious benefits to difficult conversations. These include information gathering, correction of misperceptions or false assumptions, improved behavior, improved departmental processes, better relationships, and respect. Having a first difficult conversation makes the next one easier.

The most important difficult conversations involve physician incompetence, fraud, and emotional, physical, or sexual abuse. Remember, if you think you need to call your legal department, then you do.

Those who aspire to be department chairs should try to practice this skill when the situation arises. Mentorship can be extremely helpful, and it pays to seek out advice when you expect to have a difficult conversation. Also, the professionals at your Human Resources Department are your friends and can tell you what needs to be done and how things should be handled if you are unsure.

Disclaimer: I am an old white guy born and raised in the United States. I cannot comment on the dynamic between a Chair who is a woman, a minority, raised in non-US cultural, and some combination of all and the person they are having a conversation.

A number of articles in the ***Harvard Business Review*** address these issues:

Hahn M, Molinsky A. Having a Difficult Conversation with Someone from a Different Culture, March 25, 2016.
Gallo A. How to Mentally Prepare for a Difficult Conversation. April 4, 2016.
Rowland D. What's Worse than a Difficult Conversation? Avoiding One. April 8, 2016.
Seppala E, Stevenson J. In a Difficult Conversation, Listen More Than you Talk, February 9, 2017.
Valcour M. 8 Ways to Get a Difficult Conversation Back on Track. May 22, 2017
Garfinkle J. How to Have Difficult Conversations When You Don't Like Conflict. May 24, 2017.
Bernardo D. You Just Had a Difficult Conversation at Work. Here's What to Do Next. May 29, 2017
Galo A. How to Control Your Emotions During a Difficulty Conversation. December 1, 2017.

The following books are also recommended reading: "Difficult Conversations" by Douglas Stone, Bruce Patton, and Sheila Heen, and "Crucial Conversations" by Kerry Patterson et al. Another surprising source of wisdom is "How to talk so teens will listen and how to listen so teens will talk" by Adele Faber and Elaine Mazlish.

"Labor to keep alive in your breast that little spark of celestial fire called conscience."
-George Washington

Immigration Law for Neurology Chairs

Monday, October 14th, 2019

Description:

Our Neurology workforce depends heavily on the recruitment and retention of physicians from outside the continental US, who train in our residency programs and join our faculties under the auspices of a variety of visa programs. Understanding how these programs work is vitally important to Chairs who need to navigate the legal, social and financial issues raised by immigration. Dr. Erica Schuyler, residency program Director at the UConn/Hartford Healthcare program and President-elect of the Consortium of Program Directors, will provide an overview of how the various visa programs, Conrad waivers, and other immigration mechanisms can be used to facilitate recruitment and retention of residents and faculty from abroad. She will also discuss some of the problems that trainees and new faculty face when integrating into medical and social systems that are often significantly different than the ones in which they were born and raised.

Learning Objectives:

1. Describe the features of J1, H1B, O1, Conrad waiver, and permanent resident ("Green card") visas.
2. Discuss some of the problems faced by foreign physicians as they integrate into the US medical system and society.

Speakers:

Erica Schuyler, MD, UConn Health , Associate Chief of Neurology for Education, Hartford Hospital
Chair, AAN Consortium of Neurology Program Directors

Moderator:

L. John Greenfield, MD, PhD, Chair, UConn Health

Disclosures: I have no relevant disclosures.

DISCLAIMER: Please consult with an attorney early and often. I am not an immigration specialist and cannot guarantee the complete accuracy of this content. Always seek good legal counsel!!

Why is this topic important? International Medical Graduate (IMG) physicians make up a significant part of our physician and neurology workforce. As physician leaders, we need to understand what the process is for international physicians to come to the US to train and work. We need to to understand the needs of our international trainees and colleagues so that we can support them and provide a welcoming training and working environment.

Why do international physicians want to train in the US? There are many possible reasons including: resource constraints in their home country, limits on the types of care or training positions that may not be available in their home country, research and academic opportunities.

There is a shortage of physicians in the US that is worsening, with projected shortfall of up to 100,000 or more by 2030. This is due to the production of new physicians by US training programs not keeping up with the aging workforce and expanding population. US medical schools are expected to increase total enrollment by 30% in the next decade. There is a 59% increase in enrollment in US MD and DO medical schools between 2002 and 2021, due both to increased class size and to the increased number of accredited medical schools from 125 to 145 over the past 10 years. However, this is insufficient to meet the need.

IMGs serve to mitigate that shortfall. IMGs contribute approximately a quarter of practicing physicians and residents in the US; IMGs represented 24.5% of practicing physicians and 24.9 % of residents in 2016. For some specialties (IM, FM, Psychiatry) there is a higher proportion of IMGs (more than 50% for Geriatrics, about 47% for Nephrology, 44% for interventional cardiology, about 41% for critical care medicine. Neurology

is about 31% IMGs. The lowest percentage of IMGs are in Dermatology and Orthopedic Surgery (about 5%). Some states have a larger proportion of IMGs practicing including New Jersey, New York and Florida. Physicians in training have similar percentages with a few exceptions: Pulmonary Disease fellows are 90% IMGs, Nephrology fellows about 65% IMGs, Geriatric fellows 57% IMGs, while Neurology Residents are about 36% IMGs.

For IMGs to obtain a medical license and practice in the US, they must undergo US residency training in most cases, usually with a 3 year minimum requirement. They need a visa to enter and remain in the US for their training. The most common visa for GME is the J-1 for cultural and educational exchange, but some IMGs come to the US with H1B intended for specialized workers. Other possibilities include the F1 visa with Optional Practical Training (primarily students), or TPS (temporary protected status) for those coming from endangered countries or situations.

Rarely, someone who completed all training in another country bypasses repeating residency, does 3 year "clinical fellowship", and then petitions the state medical board for licensure. These physicians are usually from countries with the highest standards of medical training (e.g. England), and have often already achieved prominence in their discipline.

For IMGs to train in the US, they must past a standardized test administered by the Educational Commission for Foreign Medical Graduates (ECFMG). This is a not-for-profit non-governmental agency. ECFMG is the only sponsor for physician J-1 exchange visitor visas for IMGs pursuing US Graduate Medical Education. The ECFMG verifies that IMGs meet eligibility requirements and then issues a Form DS-2019, a certificate of eligibility for exchange visitor status.

An IMG is defined as any physician who received his/her basic medical degree from a medical school outside of the United States or Canada, regardless of country of citizenship. This includes US citizens who attended off-shore or foreign medical schools (who do not need a visa) and non-US citizens who do need a visa.

ECFMG Certification Requirements include Medical Education Credentials, i.e. completion of a medical school curriculum of at least 4 years. Applicants for ECFMG Certification must graduate from a medical school that has been "appropriately accredited," and the accrediting agency must be "recognized." As of 2023, the School and graduation year must be listed in the World Directory of Medical Schools (World Directory or WDMS, www.wdoms.org). ECFMG also performes primary-source verification of the medical diploma & transcript(s). Resident candidates must also complete the U.S. Medical Licensing Examinations (USMLE, www.usmle.org), which consists of 3 "Steps": Step 1 Basic Science, Step 2 Clinical Knowledge (CK), and Step 2 Clinical Skills (CS). The 3rd Step exam is typically taken after starting residency, but may be taken in advance.

Of more than 20,000 candidates who apply for ECFMG certification annually, about 10,000 are certified, about 12,200 participate in the match process, and about 6,600 match into residency programs. The timetable begins

In 2018, match rates for U.S. citizen and non-U.S. citizen IMGs was the highest in 25 years. There were 5,075 US IMG participants, of whom 57% (2900) matched, and 7067 non-US IMG participants of whom 56.1% (3,962) matched. In Neurology in 2017, there were 94 programs offering 492 PGY1 positions, with 8 programs not filling. 451 of the 1062 applicants were US medical seniors, of whom 249 matched, accounting for 50.6% of positions. The number of ranked positions was 3010 for US seniors and 5242 total. 58 programs offered 294 PGY2 positions, with 7 unfilled programs. There were 394 US senior applicants of a total of 819, of whom 185 matched, filling 62.9% of positions. At UConn, there were 712 applicants in 2018 for 7 PGY1 positions, of which 414 were from non-US IMGs.

The most common non-immigrant visa for U.S. GME is the J-1 Exchange Visitor Physician (sponsored by ECFMG), with about 12,000 granted in 2018. The second most common is the H-1B Specialty Occupation Worker (with the teaching hospital as Employer). Less Common options include the **F**-1 Student with Optional

Practical Training (OPT), J-2 Dependent with Employment Authorization Document (EAD), or O-1 Individuals with Extraordinary Ability or Achievement. Each visa classification is tied to federal regulations that define the purpose, eligibility requirements, restrictions, timelines, reporting / monitoring, procedures, fees etc.

The requirements for J1 and H1B visas are slightly different. H1B visas are not sponsored by the ECFMG but by the employing hospital, which puts obligations on the institution (such as returning the employee to their native country if they are fired). H1B visas require completion of Step 3 and medical licensure, while the J1 requires only completion of Step 2 CK and CS. J1 visas are valid for up to 7 years while H1B can be used up to 6 years. J-1 visas require a "Statement of Need" from the Ministry of Health of the home country and generally require return to the home country after training for 2 years before the trainee can apply to the US for permanent resident status. H1B visas do not have a return home requirement. Spouses or dependents of J1 holders (on J2 visas) may seek work authorization, and there is limited work authorization for H1B dependents on H-4 visas. The fees for J-1 visas are paid by the J-1 physician, while H1B visa fees are paid by the employer (hospital).

Training program liaisons (TPL) have specific reporting responsibilities regarding J-1 physicians, including notification of new J-1 arrivals and of any visa delays or denials, Completion of required forms for leave of absence, off-site rotations, dismissals or resignations. Contract ammendmnets (start date, training level, etc.) and any serious incidents or allegations involving J-1 physicians.

ECFMG-FAIMER provides support for IMGs in U.S. GME (*https://www.ecfmg.org/news/)*. It monitors and reports on immigration developments with direct e-mails and website resources for IMGs and U.S. Programs. It also collaborates closely with the U.S. academic medical community, including stakeholder engagements, sharing resources, data, and research, collaborates on Clinician Well-Being & Resilience initiative of National Academy of Medicine, and including new diversity language in ACGME Common Program Requirements. It also educates on the importance of IMGs to U.S. GME and health care.

Since 2016, immigration reform has been a much discussed topic. Much of the discussion is related to border security, closing loopholes in immigration policy, and restricting illegal entry and performing extreme vetting of entry of non-citizens from countries that may pose a terrorist threat. Between January and December 2017, there were two presidential executive orders that restricted travel from certain countries related to a perceived terrorist threat. Ultimately in December 2017, the Supreme Court upheld some of the travel restrictions which included new J visa restrictions from 8 countries. These restrictions, which were modified several times, caused a lot of confusion around the time of the 2018 match in terms of who may be restricted entry to the US for training.

How did/does this affect the neurology match? In Spring of 2017, the AAN Program Director (PD) survey asked whether PDs altered their rank lists due to the executive order. Several PDs commented that they moved ALL of their IMG applicants down or off their rank lists because they didn't know what the restrictions would be. How did this affect the match? The ECFMG Designated Institutional Official (DIO) Program Survey asked this question in September 2017. There were 127 of 400 DIOs (32%) responding. Of these, 78% agreed that the January 2017 executive order affected their February rank list. When asked how likely are your programs to interview/rank future non-US citizens, 34% said very likely, 37% likely, 19% neutral, 10% unlikely. How did the changes in US immigration policy impact your training programs? 49% said little to no impact, 10% increased stress and anxiety among J-1 physicians, 10% travel issues or concerns, 10% affected applicant selection.

The executive order appears to have caused a decrease in total number of physicians from affected countries submitting application for ECFMG certification and submitting new J-1 applications. J-1 arrival data did not demonstrate significant increase in total arrival rate or on-time arrival rate as a whole. The EO/proclamation only affects new J-1 applications from the EO countries. There has been a mild decrease in the total number of non-US IMG applicants, but the match rate has not changed. PD and DIO survey results regarding changing their rank order list due to travel restrictions may be partially attributable to not understanding the restrictions.

Another major issue for IMG physicians on training visas is the ability to remain in the US to work after graduation. There are several major programs that allow graduates to waive the 2 year home return requirement. These provide work visas for physicians and pathways to permanent residency.

Many IMGs stay in the US after training. As noted above, IMGs make up approximately 25% of the physician workforce. They are a vital part of primary care and subspecialty care in rural/underserved areas. Patient outcomes are at least equivalent, if not better, for persons treated by IMGs. Physician concordance based on ethnicity, language, and demographic variables improves access to care for underserved minorities supporting a more diverse provider workforce. (Pinsky, W. The Importance of International Medical Graduates in the United States. *Ann Intern Med.* 2017;166(11):840-841.)

The majority of IMG residents and fellows are on J1 visas (approximately 75%), which is valid for training but not for employment as a physician. For this reason, trainees on J1 visas are not permitted to moonlight. J1 visas require returning to the home country for at least 2 years prior to returning to the US for work. J1 physicians can not apply for H1-B status or permanent residency. They either need to return to their home country for the required period OR get a waiver of the requirement.

According to immigration attorney Michael L. Kim from Hall, Render, Killian, Heath & Lyman, P.C. (@hallrender on Twitter) Indianapolis (phone interview on 10/11/19), there are several programs to waive the 2 year home residence requirement. The most common is the "Conrad 30" which will be discussed in more detail below. Others include HHS waivers, which are only for certain facilities, DRA (Delta Regional Authority) for institutions in a specific geographic areas to sponsor a primary care or specialist, ARC (Appalacian Regional Commission), also specific to a geographic region, for both specialists and primary care, and VA waivers, which cover only VA facilities.

The Conrad 30 J-1 Waiver Program The J-1 medical doctor must agree to be employed full-time in H-1B nonimmigrant status at a health care facility located in an area designated by the U.S. Department of Health and Human Services (HHS) as a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP). He/she must obtain a contract from the health care facility located in an area designated by HHS as a HPSA, MUA, or MUP, and obtain a "no objection" letter from his or her home country if the home government funded his or her exchange program. The grantee must agree to begin employment at the health care facility within 90 days of receipt of the waiver, not the date his or her J-1 visa expires. (See US Department of Homeland Security, US Citizenship and Immigration Services. https://www.uscis.gov/working-united-states/students-and-exchange-visitors/conrad-30-waiver-program#Background)

The J-1 Waiver Program (Conrad 30) allows J-1 medical doctors to apply for a waiver for the 2-year residence requirement upon completion of the J-1 exchange visitor program. (See section 214(l) of the Immigration Nationality Act (INA)). The program addresses the shortage of qualified doctors in medically underserved areas. If USCIS grants the waiver, the J-1 medical doctor must practice medicine for at least three years in an area designated by HHS as a HPSA, MUA, or MUP. Once the Conrad 30 waiver recipient has fulfilled all of the terms and conditions imposed on the waiver, including the 3-year period of employment with the health care facility, he or she (and his or her spouse and/or child) will become eligible to apply for an immigrant visa, Permanent residence, or H or L nonimmigrant visa

J-1 Waiver Program Requirements: The applicant must have an offer of full-time employment at a health care facility in a designated health care professional shortage area or at a health care facility which serves patients from such a designated area; must agree to begin employment at that facility within 90 days of receiving a waiver; and must sign a contract to continue working at that health care facility for a total of 40 hours per week and for not less than three years.

Health Care Facility Requirements: The employer must provide evidence that efforts to recruit an American physician have failed (i.e. copies of advertisements for vacant positions); document that a minimum of 30% of the applicant physician's patients reside in an area designated by the United States Secretary of Health and Human Services as having a shortage of health care professionals; provide a description of why the physician's services are required and how the applicant physician's work will benefit the indigent and medically underserved; and provide letters of community support from at least three (3) community agencies stating that the J-1 placement is critical and will help alleviate health care access problems for the underserved population of the community.

Conrad 30 is a state run program that follows federal guidelines. States vary in how they prioritize and select the 30 spots. Each state can reserve up to 10 flex spots (which can be used for institutions that are not in underserved areas but serve a proportion of underserved patients, or for physicians who provide a needed subspecialty that is underserved in the region). Some states offer 5 slots but never approve them. Regulations vary by threshold but the MSPA typically between 30-50%. There is a LOT of variation between states. More information can be found here: https://www.resolve.net/education/j-1-update-flex-10-slots

For FLEX spots, the Institution needs to document that although even though the facility is not in a MSPA, that care is provided to underserved residents. On the employer side, example with a large institution with a hospital, need data collection to prove that 30% (in some states up to 50%) lives in MUA areas. For these calculations, you can't use zip codes. For 10000 visits per year, you have to use the addresses. No one is routinely saving this data.

Some states have a "first come first served" application process. Most prioritize primary care unless they use a lottery. Most states have websites to explain their program. They don't typically say how many applications they receive or what specialties receive the waivers. For example:

Indiana favors primary care, 1st come/first serve. From 9/1-12/31 only process primary care. After 1/1 will process specialist. Usually 15 spots or less are left for specialists.

Michigan by preference/priority. They take all applications then prioritize by specialty.

NY and Illinois give priority to primary care MD.

Washington DC typically has not filled their spots.

Connecticut's process for submitting a waiver application has changed three times since 2016.

Canadian citizens have more flexibility. They are visa exempt, and don't have to apply to US embassy. They can file an H1-B application. If they petition approval from USCIS, they can present to port of entry/customs who look at their approval notice, and can be admitted for H1-B visas without getting a waiver first. However, this is a short term solution, and doesn't waive the 2 year home requirement.

If you are successful in obtaining the waiver, the processing time is 4-7 months. The application is waiving the 2 year home requirement. This clears the way to change visa status to H1-B. They must file an H1-B application before their training is completed. They can't have a gap between graduation and ther start date, though there is a 30 day grace period. They need a permanent medical license. There must be sufficient time for appropriate hospital credentialing.

If the applicant is NOT successful in obtaining the waiver, the applicant needs to either obtain waiver in another state or return to their home country. An O1 visa can be an option in this case. The only time an O1 visa comes up when there is no waiver job or if the H1-B time has been used up. The O1 application must

document extraordinary ability and that candidate is at the top of their field of endeavor. USCIS needs to think that is the applicant is at the top of profession. This can be very difficult to do for someone just completing training and is by no means a guarantee.

The O-1 visa for Extraordinary Ability is exempt from USMLE (1,2,& 3) & English proficiency requirements. It does require extensive documentation to establish sustained national or international acclaim, and a demonstrated record of extraordinary achievement. The candidate must demonstrate extraordinary ability; should be within the top 5% of their field. They must be coming to the U.S. to work in their field of expertise on a special project. The First criteria is a Nobel Prize! If no Nobel, other criteria include other prizes/awards, scholarly publications or textbooks, teaching orjudging the work of others (e.g., grant or manuscript reviews), memberships in prestigious organizations, and having been written about in the media/literature.

When filing an O1 appliccation, be honest with the beneficiary and his department – not everyone can be outstanding. Do a Google scholar search and a regular Google search - you never know what you will find! Use resources available through your institution's library, such as ISI Web of Science Journal Citation Reports, Scopus, Thomson-Reuters Web of Science, etc. Review all the evidence provided carefully; present your strongest evidence first (patents, newspaper articles, invited lectures, major awards). Read the peer review letters carefully; if they mention "fellow" or "resident" or "young" ask for a revision. These are red flags for USCIS. **Do not include the CVs of the referees**; USCIS likes to compare and may deny saying that the beneficiary is not a peer of his reviewers. Provide detailed information on your institution and its contributions; explain in detail how important beneficiary and his/her work is to this renowned institution. If the candidate has received awards: find out about previous winners; where they work, what they did, why they received the award; how many awards were given? What was the selection pool and criteria for the award? For memberships: Who are the other members? How were they selected? Contract and special project requirements – make sure your contract language complies with O1 specifications.

Advice for hiring institutions: Be familiar with your state's options and requirements. Be upfront with candidates regarding the process in your state so they can determine if it is worth the risk. Get the contract processed early to be one of the first and best put-together applications that will give an advantage. Getting an Conrad waiver or O1 visa is not impossible—if well prepared and start early, have well informed counsel, good chance it will work (even in states with a lottery).

Advice for negotiating with candidates: Offer to sponsor PR. Cover premium processing fee for H1b $1410. Offer to cover their dependents expenses. For H4 dependents, there is one filing fee (even if multiple dependents) costing $1000-1500 total.

Applying for permanent residency (green card): Most institutions with H1-B physicians will sponsor application after 6 months probationary period. This is a 3 step process—the first two occur during the first 3 year contract. The third step can be initiated after completion of the 3 years. For most countries of origin, the turnaround time is 1-2 years. However, China is 5-6 years, and India is around 12 years. The H1-B can be renewed for up to 6 years but can be approved for eligibility beyond 6 years.

Travel while on waiver: Travel outside US is NOT recommended during the waiver period. It is possible that this could put the 2 year home return requirement at risk for resetting. It is felt to be typically OK to travel to US territories and other places that don't require a visa.

In summary, the physician workforce, healthcare disparities, access, and immigration are all complex and constantly changing. Immigration policies, for the most part, are not significantly limiting the entry of non-US trained physicians for GME. Understanding the current policies for our non-US IMG colleagues will help us to continue to recruit and train the best and brightest physicians into our training programs—both from the US and abroad.

The majority of Neurology trainees are on an ECFMG sponsored J1 training visa which requires 2 year home return after graduation. Waiver options are complex and rules vary from state to state, but this may be the best option to fill needed positions, especially in underserved areas. With advance preparation and legal support, a J1 waiver is a viable option for many institutions.

Association of University Professors of Neurology

Philanthropy – Lessons Learned

Tuesday, October 15th, 2019

Description:
Our Neurology Departments are increasingly dependent on alternative sources of revenue to support research, education and other "unfunded missions." For many, philanthropy plays an increasingly important role in providing such support. This session will tap the collective wisdom of department chairs who have been successful in obtaining support for their programs through private or public donations. This session will take a "data blitz" approach to address a variety of questions. How do you identify patients who might have the resources to give to your department? How have you approached donors, and what strategies do you find successful? Do you have "war stories" of what has or has not worked? How do you use philanthropic contributions to subsidize your clinical, education or research programs? Do you find that your foundation officers are helpful or do they poach prospective donors for other projects?

Learning Objectives:

1. Describe successful approaches to identifying and obtaining philanthropic contributions.
2. Discuss how to utilize philanthropic donations to protect faculty effort, fund research or education, or other goals.
3. Describe ways that recruiting donations can improve a department's involvement in the community.

Speakers:
S. Thomas Carmichael, M.D., Ph.D., UCLA
David M. Holtzman, MD, Washington University School of Medicine
David G Standaert, MD, PhD, University of Alabama at Birmingham

Moderator:
L. John Greenfield, MD, PhD, UConn Health

Dr. Carmichael declined to offer his presentation for summary due to proprietary information from UCLA.
Dr. Holtzman spoke without Powerpoint notes, and no record of his talk is available.

Using philanthropy to support career development

David G. Standaert, MD, PhD, John N. Whitaker Professor and Chair of Neurology
University of Alabama at Birmingham

Disclosures: Dr. Standaert has served as a paid consultant to these companies within the last 12 months:
Abbvie Inc., Sanofi-Aventis Research and Development, RTI Consulting, Censa Pharmaceuticals, Grey Matter Technologies, Cerevance, Inc., Theravance, Inc, AVROBio. No off-label use of medications will be presented.

Dr. Francis Schumann (1914 – 2013) was in the Harvard College class of 1935 and went to U Penn Medical School. He was a Flight Surgeon in the US Army. He met Heide Jenisch in Berlin, and they married after the war. He was a surgeon at Philadephia General Hospital, and then retired to Machias, ME. He established the Francis and Heidi Ingeborg Schumann fellowship in Parkinson disease, which supports fellows for two years of specialized training in PD research and/or treatment. This has been used for both MD and PhD fellows. The structure is flexible, and can be combined with other sources of funding. The only fixed requirement is that the fellow has to travel to Maine to visit the Schumanns.

There have been 15 Schumann Fellows, who have received $1,500,000 in fellowship support.

The Parkinson Association of Alabama provides funding for a Pre-doctoral Scholar, which is funded by an annual cocktail event. It supports a graduate student stipend and tuition for one year ($35,000). More than 10 students have been supported so far.

Alzheimers of Central Alabama also supports a Predoctoral Scholar. This provides funding to support a graduate student position, and is tied to the T32 selection process. It is currently in the first of a two year commitment.

The idea of supporting an identifiable person, rather than a project or equipment, is a powerful draw for some potential donors. A key part of building these relationships is letting the donors meet and get to know the individuals they are supporting. "Supporting a young scientist/physician is like planting a tree, it will continue to return benefits far into the future."

Feedback from Audience:

Type of Session	Title	Date	Session Rating	Speaker Rating
Chair Level	Difficult Conversations	10/13/2019 7:30	4.64	Henry Kaminski MD - 5
Chair Level	Immigration Law	10/14/2019 7:00	4	Erica Schuyler MD
Chair Level	Philanthropy - Lessons Learned	10/15/2019 7:00	4.8	S. Thomas Carmichael MD, PhD David Standaert MD, PhD David Holtzman MD

Comments:
Difficult Conversations:

*Difficult conversations, can always learn new techniques.
*Very effective case study. Lots of discussion with audience.
*Good topic but there was too much random discussion. The mini-play was well done. Subsequent discussion ducked the issue of generational change in relation to the perceived behavior of the faculty member: the students' approaches were not critiqued. These are the students who are going to take care of patients! In any case, it seems that the interaction could have been handled easily with a more well-thought out approach by the Chair.
*Very interactive
*Outstanding. Perhaps the best, and one of the most useful sessions of this type in recent memory.

Immigration Law for Chairs:

*As the United States evolves, the immigration matter becomes full focus. As a Chair, I need to know the latest laws governing my faculty.
*A lot of information that was helpful in the aggregate but could have been summarized as "it's complicated, and you should ask an attorney". Too much detail in places, eg CT Conrad story was way too detailed and not really salient except to make a point that the system is a mess.
*May have been helpful to have more than one presenter to showcase differences between states, rather than focus on CT alone.
*Discussion wandered off topic
*Great current info and vigorous discussion

Philanthropy – Lessons Learned:

*Excellent session! Best of the 3 this year!
*Excellent job!