A community of practice in leadership

Jonathan Fish, MD; Michele Manahan, MD; Timothy Lucas, MD, PhD

Dr. Fish (ΑΩΑ, SUNY Upstate Medical University College of Medicine, 1999) is Associate Professor of Pediatrics at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell and Cohen Children's Medical Center, Northwell Health, New York, NY.

Dr. Manahan (ΑΩΑ, Johns Hopkins University, 2001) is an Associate Professor in Plastic Surgery at John Hopkins School of Medicine in Baltimore, MD.

Dr. Lucas (ΑΩΑ, University of Florida, 2000) is Assistant Professor of Neurosurgery, Surgical Director of the Penn Epilepsy Center, Director of the Penn Laser Neurosurgery Center, and Director of the Neurosurgery Gene Therapy Program, University of Pennsylvania, Philadelphia, PA.

The previous 75 years has seen a steady, disturbing decline in physician leadership of hospitals and health care organizations, from 35 percent physician-led in 1935 to less than five percent today.[1] This decline has led to a marked loss of physician autonomy, and has likely contributed to the current epidemic of physician burnout.[2] In response to this loss of physician leadership, Alpha Omega Alpha Honor Medical Society (ΑΩΑ) has redoubled its commitment to the development of physician leaders. "Encouraging the development of leaders in academia and the community has been, and continues to be, a core ΑΩΑ value, and an important part of the organization's mission."[3] As part of that effort, in 2013 ΑΩΑ developed the Fellow in Leadership Award, a unique, powerful one-year, mid-career physician leadership training program.

Since its inaugural cohort of Fellows in 2014, there have been three Fellows accepted each year, creating a community practice of 15 Fellows. These Fellows have developed and led novel programs, curricula, and companies, and have ascended to positions of meaningful leadership within medicine.

In an effort to further support and develop the Fellows, ΑΩΑ held the inaugural Fellow in Leadership Community of Practice retreat at ΑΩΑ headquarters in Denver in February 2019. This retreat brought together all 15 Fellows (a remarkable testament to value of the program) to further discuss leadership concepts, and brainstorm solutions to leadership challenges.

The nature of leadership

The opening session of the retreat featured a discussion on the nature of leadership by Joshua Hartzell, MD (ΑΩΑ, Uniformed Services University, 2001), Fellow in Leadership 2015; Ronald Robinson, MD, MPH, MBA (ΑΩΑ,

University of Texas McGovern Medical School, 1993), Fellow in Leadership 2016; and Brian Clyne, MD (AΩA, Warren Alpert Medical School of Brown University, 2016, Alumnus), Fellow in Leadership 2016, who presented through the lens of personal leadership challenges.

Clyne opened the session by highlighting the lack of a true definition of leadership. Rather than defining the concept of leadership itself, Clyne opined that leadership is a composite of its ingredients, including the inward qualities, leadership skills, and the environment of the person practicing leadership. Clyne's personal leadership challenge occurred when he was approached to be an interim chair during a major organizational transition. Questions that were addressed included:

- How would an interim chair manage a major shift in how a department is run?
- What is the mandate of an interim chair? If the status quo is not tenable, how much change can an interim chair be reasonably expected to implement?
- What does interim mean? Is there an immediate external search? Is the interim chair a viable candidate?
- How would being an interim chair affect relationships and supports, particularly with colleagues who may be resentful that they were not approached for the interim position?
- What would one have to give up to devote sufficient attention to the interim position?
- How does one negotiate for resources given that the true negotiation would be with the person accepting the permanent position?

The ensuing discussion was centered on how each of these questions required inward reflection and specific leadership skills.

Following Clyne, Hartzell presented his personal leadership challenge. The Department of Defense cut 17,000 health care jobs. This translated to 500-600 physician spots, which meant fewer faculty and fewer training spots. How should this be communicated to trainees?

The discussion revolved around strategies to maintain open communication, including:

- Facilitating face-to-face communication (e.g., town hall);
- Using social capital to provide as supportive an approach as possible, including using more senior subordinates such as chief residents to communicate with junior trainees; and
- Creating a specific and known communication channel for people to turn to.

Hartzell then highlighted that how a leader approaches this type of communication challenge is reflective of their leadership brand, i.e., how does one "show up" to those they lead?

Finally, Robinson presented a case in which he assumed responsibility as a CEO running two critical access hospitals four months after the prior CEO was dismissed for poor behavior. At the time he assumed leadership, there were virtually no liquid assets available. As a consequence, it was necessary to cut many functions that served to maintain staff morale, including all bonuses and the holiday party. The discussion centered on how this challenge could be communicated to the staff in such a way that morale was maintained, as was respect and credibility for the new leadership. The conversation highlighted three necessary leadership qualities:

- Tactical
- Strategic
- Visionary

How many leaders have we created in our wake?

The opening session ended with a reaffirmation of the intent of the retreat, to mold the Fellows into a community of practice that will allow each Fellow to reach out to, and rely on, the others to assist with leadership problem solving as new challenges arise. In addition, Dr. Ron Robinson provided the group with the affirmative words he uses as part of his E-mail signature:

Begin with integrity
Own my situation
Align the system
Empower my colleagues
Act with urgency
End with accountability

Diversity, inclusion, and equity

The opening session was followed by a discussion led by Monica Vela, MD (AΩA, University of Chicago, 2003, Alumnus), Fellow in Leadership 2015; Susan Lane, MD (AΩA Renaissance School of Medicine at Stony Brook University, 2011, Faculty), Fellow in Leadership 2017; and Nora Gimpel, MD (AΩA, University of Texas Southwestern Medical Center at Dallas, 2016, Faculty), Fellow in Leadership 2017.

Dr. Vela presented a review of the history of discrimination in medicine. Dating back to 1869, the Medical Society of the District of Columbia denied admission of minority physician candidates[4] and the American Medical Association (AMA), excluded integrated delegations from membership.[4,5] In 1847, David Jones Peck became the first African-American

medical student to graduate from a U.S. medical school (Rush Medical College).[6] Howard University School of Medicine was established for the purpose of educating African-American doctors, of both genders and races, in 1868. As a consequence, the National Medical Association was founded in 1895 to represent African-American physicians.[4]

The publication of the Flexner Report in 1910 noted wide variability in educational standards across American medical schools.[7] The call to centralize medical institutions and education resulted in the widespread closure of medical schools, many of which included medical schools serving African-American students.[8] The report recommended that the practice of the "negro physician be limited to his own race, and should be trained as sanitarians, not surgeons."[7,9] Of 14 such schools in the South, only Howard and Meharry remained open after 1920.[7,9,10]

At the same time, hospitals developed policies requiring staff physicians to be members of recognized medical societies at the state and national levels.[9] Minority physicians were also excluded from these societies. Thus, minority physicians could not obtain hospital privileges. Minority physicians also could not obtain subspecialty training. Evidence of the effect that this had on African-American physicians can be found in the discrepancy in the number of minority specialist physicians in the 1930s; of 25,000 documented physician specialists nationally, only two were African-American.[10]

The winds of change did not begin blowing until the mid-1960s following passage of the Civil Rights Act, which explicitly outlawed discrimination in labor and education. In 1966, the AMA amended its constitution and bylaws to authorize the investigation of allegations of discrimination in state societies and expel those found guilty.[11]

The modern era

Bias continues to be common in modern medicine. African-American physicians remain underrepresented. While minorities represent roughly 12 percent of the U.S. population, only four percent of physicians, and six percent of medical students, are African-American. [5,10] Likewise, only four percent of AMA members are minorities.[5,10]

Where do we go from here?

Discussants acknowledged the pervasive problem of bias that has plagued medical education and membership in professional organizations in the U.S. Attention was directed to how AΩA members are chosen, which states, "all medical students on entry to medical school, residents, fellows, and all physicians throughout their career are eligible for AΩA." The primary criteria for AΩA selection includes, but is not limited to, scholastic achievement, demonstrated professionalism, leadership capabilities, adherence to ethical standards, fairness in dealing with colleagues, achievement in medicine and/or research, and a record of service to school and community. Scholastic achievement refers to the qualities of becoming, and being, an excellent doctor—trustworthiness, character, caring, knowledge, skills, compassion, empathy, altruism, and servant leadership. It was noted that AΩA explicitly supports and promotes diversity among its members, officers, and Board. AΩA also values diverse, fair, and equitable work and learning for all. Finally, it was noted that AΩA advocates for diversity in all forms—identity, cultural, geographic, experiential, race, ethnicity, gender, age, economic and social status, physical abilities, aptitude, and religious beliefs, political beliefs and other ideology.

It was agreed by discussants that AΩA should continue to champion diversity, in all forms, as it pertains to membership, officers, and the Board, and, it was agreed that the matter of diversity and inclusion must remain a topic of discussion at AΩA meetings. In addition, opportunities to champion diversity to the fullest extent possible will continue to be examined. Finally, it was acknowledged that AΩA does not endorse or sanction any act of discrimination by AΩA Chapters.

The inward journey

An integral component to AΩA's approach to leadership involves what is known as the inward journey. As Wiley W. Souba, MD, ScD, MBA (AΩA, University of Texas McGovern Medical School, 1978) teaches, one must seriously reflect upon one's own person, intentions, and projections. One must maintain a constant, honest, and probing dialogue with one's self to continuously strive to more fully live a life in leadership.[13] Three past Fellows led the reflections on this topic.

Nathan Goldstein, MD, (AΩA, Icahn School of Medicine at Mount Sinai, 1998), Fellow in Leadership 2015, emphasized the nonlinear nature of this journey, sharing pearls particularly focused on mentorship. He recommended that one should "diligently curate your mentors." Goldstein espoused a proactive, energetic cultivation of relationships to strengthen bonds with individuals both more senior, as well as more junior, in effect creating a web of relationships in which all involved benefit. He encouraged leaders to embrace the challenges, to understand that mistakes are inevitable, and to rely on faith in one's inner core to ensure that decisions are made to the best of one's ability. He also emphasized the important role of gratitude in any leader's life.

Cynthia Arndell, MD (AΩA, University of New Mexico, 1994) Fellow in Leadership 2016, stressed the importance of

looking inside oneself to determine one's own true driving forces. In her discussion, she embraced the varied natures of leaders and natural differences in leadership styles. She lauded creativity among leaders and the need to remember and take advantage of individual strengths. Arndell reminded the audience of the importance of this type of diversity in creating a rich and varied multidisciplinary team of individuals, working toward common goals. She strongly warned against biases.

Elizabeth Warner, MD (AΩA, Michigan State University College of Human Medicine, 1998), Fellow in Leadership 2016, encouraged the group to create space and time for inner reflection. She stressed the need to determine one's true identity and to ensure that one reveals this identity in leadership circumstances. She emphasized the spiritual nature of these meditations.

Warner also strongly supports positive organizational thinking. She prepares listeners for possible struggles, reminding others that constant effort to "better serve" others, particularly in the health care arena, requires great energy, dedication, hope, and, most importantly, courage.

The group's moderators, speaking with the wisdom of their experiences, added several pearls to the discussion. Souba implored those assembled to consciously control how they "show up" for others. Alan Robinson, MD, (AΩA, University of Pittsburgh, 1988) reminded the Fellows that an inward journey must be intentional rather than an "inward vacation." Richard Byyny, MD, FACP (AΩA, Keck School of Medicine of the University of Southern California, 1964) recommended aspirational thinking focused on who one wants to be rather than solely upon who one currently is. Joe Stubbs, MD (AΩA, Emory University, 1978) encouraged attendees to remember to "pick [the] stage" upon which they would act. John Tooker, MD (AΩA, University of Colorado, 1970) reminded Fellows of the important roles of following as well as leading.

All in all, the discussion served important and effective purposes, ensuring attendees would think carefully about their own being and impacts on actions and, therefore, others.

Overall, it is hoped that the thoughts presented within this summary of the AΩA Fellows in Leadership Community of Practice Retreat will resonate with all readers. The tenets, when reviewed, will hopefully be seen as widely applicable and implementable with proper care and attention, and the multiplication factor of teaching others will result in effective physician leaders in medicine. One may even envision many communities of practice in leadership employing similar templates of conversation, collegiality, and caring in diverse environments across the health care landscape to enrich our world for the betterment of patients and all those who care for them.

As a group we resolved to continue this Fellows Community of Practice, welcoming future year's Fellows, and taking it upon ourselves to bring the 2020 expanded group of 18 together for an annual retreat.

References

1. Goodall AH. Physician-leaders and hospital performance: is there an association? Soc Sci Med. 2011; 73(4): 535–9.

2. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. J Intern Med. 2018; 283(6): 516–29.

3. Everly GS, Jr., Mitchell JT. The debriefing "controversy" and crisis intervention: a review of lexical and substantive issues. Int J Emerg Ment Health. 2000; 2(4): 211–25.

4. American Medical Association. African American Physicians and Organized Medicine, 1846-1968. 1-16. https://www.ama-assn.org.

5. Baker RB, Washington HA, Olakanmi O, Savitt TL, Jacobs EA, Hoover E, Wynia MK. African American physicians and organized medicine, 1846-1968: Origins of a racial divide. J Amer Med Assoc. 300(3): 306-13.

6. Harris MJ. David Jones Peck, MD: A dream denied. J Natl Med Assoc. 1996: 88(9): 600-4.

7. Flexner A. Medical Education in the United States and Canada. The Carnegie Foundation for the Advancement of Teaching. 1910: Bul 4.

8. National Medical Association. https://www.nmanet.org/page/History.

9. Harley EH. The forgotten history of defunct black medical schools in the 19th and 20th centuries and the impact of the Flexner Report. J Natl Med Assoc. 2006; 98(9): 1425-9.

10. Savitt T. Abraham Flexner and the Black Medical Schools. J Natl Med Assoc. 2006; 98(9): 1415-24.

11. Rao V, Flores G. Why aren't there more African-American physicians? A qualitative study and exploratory inquiry of African-American students' perspectives on careers in medicine. J Natl Med Assoc. 2007; 99(9): 986-93.

12. Washington HA, Baker RB, Olakanmi O, Savitt TL, Jacobs EA, Hoover E, Wynia MK. Segregation, civil rights, and health disparities: The legacy of African American physicians and organized medicine. 1910-68. J Nat Med Assoc. 2009; 101(6): 513-27.

13. Souba WW. The inward journey of leadership. J Surg Res. 2006; 131(2): 159–67.

The authors E-mail addresses are jfish1@northwell.edu, mmanahan@jhmi.edu; timothy.lucas@uphs.upenn.edu.