

National and Chapter news

2017 AΩA Fellows in Leadership complete successful year and are prepared to serve

Leadership in medicine, medical education, and health care is more complex in the 21st century than ever before. Escalating costs, unequal access, less than ideal outcomes, political challenges and the businessification and commercialization of medicine have contributed to an unprecedented level of uncertainty in the delivery of health care and medical education.

The medical profession and the country are in need of leadership that is inspiring, insightful, engaging, and humble; leadership that understands and represents the needs of patients, physicians, medical educators, and trainees. Because of their unique knowledge of the practice of medicine, and understanding of medicine's core professional values, physicians are ideally prepared to serve as leaders.

Encouraging the development of leaders in academia and the community is a core value of AΩA, and an important part of the organization's mission.

The AΩA Fellow in Leadership recognizes and supports the further development of outstanding physician leaders through the tenets of leading from within; upholding AΩA's values and mission; and a commitment to servant leadership.

The five essential components of the AΩA Fellow in Leadership are:

1. Self-examination, the inward journey, leading from within;
2. A structured curriculum focused on leadership, including an understanding of the relationship between leadership and management;
3. Mentors and mentoring;
4. Experiential learning to broaden the perspective and understanding of leadership as it relates to medicine and health care; and
5. Team-based learning, and developing communities of practice.

Nominations for the AΩA Fellow in Leadership are made by the senior executive of a medical school, hospital, or health care organization, who agrees to serve as a mentor for the Fellow. The nominating organization and Fellow designate at least one additional mentor who supports the completion of a leadership project, serves as a role model, offers advice as needed, and connects the Fellow with key individuals in leadership positions. At least one mentor is at the senior leadership level, i.e., a Dean, Chief Executive Officer, or President of an association or an organization that has a regional or national presence.

These relationships, and leadership opportunities

and experiences, are ongoing throughout, and after, the Fellowship year.

The Fellows each receive a \$25,000 award for further leadership development and project funding.

The fourth cohort of AΩA Fellows in Leadership—Jonathan D. Fish, MD (AΩA, SUNY Upstate Medical University College of Medicine, 1999); and Michele Manahan, MD (AΩA, Johns Hopkins University, 2001)—were selected for their diverse backgrounds, career performance and success, leadership experience, mentor support, and proposed leadership project.

The Fellows have successfully completed their year of leadership development and join the growing AΩA Fellows in Leadership Community of Practice. They presented the findings, outcomes, and lessons learned from their projects to the AΩA Board of Directors during the October 2018 annual meeting.



Be Worthy to Serve the Suffering of Those Serving the Suffering

Jonathan D. Fish, MD (AΩA, SUNY Upstate Medical University College of Medicine, 1999)

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Medicine, 1999) serves as Associate Professor of Pediatrics at the Donald and Barbara Zucker School of Medicine at Hofstra/ Northwell and Cohen Children's Medical Center, Northwell Health in New York, NY.

The modern era of medicine has been marked by a steady decline in physician autonomy and a sharp rise in physician burnout.¹ These disturbing trends are related to a concomitant loss of physician leadership of hospitals and health organizations (under five percent of hospitals are headed by physicians, a decline from 35 percent in 1935).² Alpha Omega Alpha (AΩA) is firmly committed to combatting the loss of physician leadership. Indeed, "Encouraging the development of leaders in academia and the community has been, and continues to be, a core AΩA value, and an important part of the organization's mission."³ The Fellow in Leadership Award, which I was honored to receive in 2017, is a powerful manifestation of that commitment.

Applying for the Fellowship required deep introspection as to where I was coming from, and where I wanted

to be in terms of leadership. It forced a solidification of my ideas about how I could potentially influence the practice of medicine for the better, and required me to identify mentors to guide me.

Having been privileged to receive the award, the Fellowship began with a week-long boot-camp at the AΩA national office in Denver, CO. During that week, we Fellows received personal, focused, uninterrupted attention from members of the AΩA Board of Directors, with each faculty being a remarkable leader in their own right (the faculty to fellow ratio was 9:3!). We embarked on our inward journeys, learned about the leadership challenges facing medicine from speakers who are part of the national dialogue, and organized, planned, and refined our leadership projects. That week was unique, and invaluable to my personal growth.

Getting down to work

Once the week in Denver was over, it was time to take the skills and knowledge gained and apply them to my leadership project. While AΩA is tackling physician burnout on a macro level by promoting physician leadership, my project addressed burnout among the health care personnel on the front lines.

Critical incident stress refers to the psychological response experienced by individuals or groups after exposure to a traumatic experience. In the 1980s it was recognized that emergency responders in the United States were being impacted by the trauma they experienced in the course of their work. This led to the development of the comprehensive, systematic, integrated multi-component crisis intervention known as Critical Incident Stress Management (CISM).^{4,5} CISM “enables individuals and groups to receive assessment of need, practical support and follow-up following exposure to traumatic events in the workplace.”⁵

Many critical incidents occur in the hospital setting contributing to critical incident stress among health care personnel. This includes the sudden decline in the health of a patient, an unexpected or difficult death of a patient, and/or the experience of being involved in medical errors.

Despite the high frequency of critical incidents in the hospital setting, hospitals rarely have formal systems in place to assist the staff in the immediate aftermath of an event. As a pediatric oncologist, I know firsthand that critical incident stress is particularly prevalent in pediatric hematology/oncology (PHO) where health care personnel are serving children with complex, life-threatening illnesses. Unsurprisingly, when we reviewed the literature, pediatric oncologists have not been immune from burnout.⁶

My AΩA Fellow in Leadership project was to build and pilot a multidisciplinary, all volunteer, peer response team composed of personnel from within PHO who would be trained in CISM, and would be available to respond in real time to critical incidents occurring within the division of PHO at the Cohen Children’s Medical Center. The project was designed to institute a culture change within the division to acknowledge that the trauma experienced leaves a mark, and to reduce the stigma that may arise from seeking help.

While I have had plenty of experience with critical incident stress, I had no experience in developing mechanisms to address it. In seeking mentorship to guide me in the development of the team, I was fortunate to connect with Patricia Tritt, RN, MA, an instructor at the International Critical Incident Stress Foundation (ICISF). She has been key in the development of a curriculum, and has helped build CISM teams across the country, and internationally.

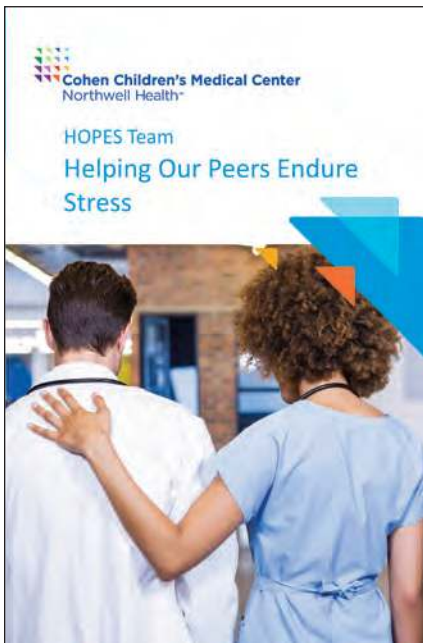
I also needed to seek a mentor who understood the culture of our hospital and could guide me through the trials and tribulations of trying to implement culture change. Charles Schleien, MD, MBA (AΩA, Zucker School of Medicine at Hofstra/Northwell, 2016, Faculty), is Executive Director of Cohen Children’s Medical Center, Chair of Pediatrics, Professor at the Zucker School of Medicine at Hofstra/Northwell, and Senior Vice President and Executive Director of pediatric services at Northwell Health. As a pediatric intensivist, Dr. Schleien has significant experience with critical incidents that occur during the care of children, and was well-positioned to guide me through my project.

From theory to practice

Developing a CISM team required that I identify individuals from nursing, Child Life, social work, psychology, clergy, and physicians. This required utilizing skills that we had worked on during the orientation in Denver. The practice of developing our “elevator pitch” came in handy.

Although I was concerned that the time commitment without any dispensation in terms of time off or pay would be a barrier to people joining the team, I was pleasantly surprised that everyone I approached accepted the invitation. I took this as evidence of the perceived need for the team, and was emboldened to proceed.

Once the team of 15 was assembled, we formed a community of practice, developed a collective vision for the team, and prepared for the formal training. Using funds from the Fellowship, brought Pat to New York, and the entire team devoted three full days to training in the ICISF



(*Helping Our Peers Endure Stress*). We developed a presentation, literature, and brochures.

As per our training, the HOPES team offers 3 types of interventions:

1. Defusings—small group processes that occur as close to the event as possible. It’s an opportunity to begin exploration of the individual’s reactions, and to provide information on healthy coping.
2. Debriefings—structured group discussions occurring within 72 hours of a critical incident that provide an opportunity to discuss thoughts, reactions, and feelings resulting from the incident, and to develop strategies for healthy coping.
3. One-on-one sessions—any member of the division can meet with a member of the HOPES team to address individual stresses surrounding a critical incident, at any time.

Each of these interventions also provides an opportunity for HOPES members to assess the coping of the attendees, and to assist with referral to our organization’s employee assistance program for professional mental health care if needed. Attendance is never taken, and nothing is ever recorded at any HOPES team intervention. Maintaining anonymity is a priority to avoid the concern of stigmatization, or punishment for seeking help.

Since the HOPES team went live in April 2018, we have conducted 25 interventions for critical incidents that have included patient deaths, unplanned prolonged hospitalizations, mistreatment of staff by patients’ families, and the prolonged absence of a key staff member. Many disciplines

courses “Assisting Individuals in Crisis” and “Group Crisis Intervention.”

Having assembled the team and received training, we were almost ready to go live. We continued honing our skills while we solved the logistics of scheduling coverage, developing a means for contacting the team, and communicating about the team. We called ourselves the HOPES team

have availed themselves of the HOPES team’s services, including nurses, physicians, and social workers.

Although the impact of the HOPES team on wellness within the division will be hard to quantify, we performed a baseline assessment of compassion satisfaction and compassion fatigue among all PHO health care workers using the ProQOLv5 and the Brief Resilience Scale, with a response rate of 62 percent (92/150). We are in the process of reporting the results, and intend to re-survey the staff annually. We also seek anonymous feedback after HOPES team interventions, and are using the anecdotes to improve processes.

Challenges faced

Changing the culture has not been without its challenges. While we inform all new PHO staff of the HOPES team and normalize its use to facilitate a culture that acknowledges and addresses the stresses we face, it has been difficult to reach staff who have been caring for children with cancer or blood disorders for many years or decades. Many of these staff members have developed systems of resilience that work for them, and the HOPES team is perceived as unnecessary. We have encouraged these more experienced staff to attend HOPES team interventions to help share their strategies with the more junior members of the division. As time has gone by, the resistance has decreased.

An unexpected challenge arose when the clergy expressed their concern that the HOPES team would duplicate or obstruct their “Code Lavender,” a Northwell Health systemwide pilot to address emotionally charged events. This concern reflects a major barrier facing medicine as it begins to acknowledge burnout as a problem. Each institution is addressing burnout in different ways, and within large institutions and health systems there are often multiple groups each launching their own approach. Communication between groups developing systems for addressing burnout is critical. It is important to look for existing attempts to address the problem within an institution before planning an additional approach (identifying “found pilots”). I have begun working with the Northwell Vice President of Population Health, who has been charged with developing initiatives promoting and engaging health and wellness for the work force, to develop improved communication and more consistent approaches to addressing wellness systemwide.

Final thoughts

I closed out my year as an AΩA Fellow in Leadership by using Fellowship funds to attend the Harvard Macy

Leading Innovations in Health Care & Education course in June 2018 in Boston, MA. As with the AΩA boot camp a year before, this was a highly formative experience that has helped shape my perspective on leadership. I am looking forward to returning as a facilitator in the coming years.

I formally transitioned from Fellow to alumnus Fellow at the AΩA Board of Directors meeting in Philadelphia, PA in October 2018, where we presented our year-long leadership projects. While the formal Fellowship has ended, all past fellows will be convening for the first-ever Fellow in Leadership Community of Practice Retreat in February 2019 in Denver. This will allow us to continue the growth in our leadership skills that was seeded with the Fellowship.

Of course, the HOPES team continues, and I am confident that the lessons I have learned, and experiences I have had, have changed me for the better. I am thankful for AΩA providing me the opportunity to participate in the Fellows in Leadership, and I look forward to providing a high return-on-investment as I progress through my career.

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Climbing the Kilimanjaro of Leadership Development

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Imagine a journey to the pinnacle of the Kilimanjaro Leadership Peak. The first snapshot of the trip: I'm at home, on the sofa, reading the e-mail from AΩA describing the Fellow in Leadership application process. This was an opportunity of monumental importance. Just like preparing for a mountain climb, you can't underestimate the effort that goes into the application process. You can't climb a mountain with bad equipment, and you can't succeed in a leadership development journey without personal preparation. The application process is formative and truly transformative.

I chose a project aimed at improving the reconstructive patient's experience at my home institution. I wrote my essay and wrote it again...and again...about who I was, what I represented, and why I felt I could benefit from the Fellowship. These first few steps of the trip shaped the rest of the journey. You must be strong to choose to embark, for only the courageous and persistent will summit Kilimanjaro.

I submitted my application and was selected to be a 2017 AΩA Fellow in Leadership. I arrived at orientation, my base camp. I was excited and couldn't wait to get started.

During the orientation week, the AΩA leaders helped make my project more concrete through stories, inclusive leadership, and cognizance of scope creep.

I found it heartening to hear the AΩA leaders' personal stories about clinical interactions that they shared as support for my project's goals. This presaged the year's work.

In addition, AΩA leaders' ready willingness to share experiential stories highlighted the need for a grass roots approach. Patients interact with a wide variety of individuals, each of whom should be empowered to optimize the patient experience.

While the AΩA leaders' enthusiasm for the project was heartening, the multifaceted suggestions for potential directional priorities evoked caution. I needed a firm plan with realistic and realizable goals.

The week in Colorado prepared me to ensure all stakeholders were included. My trail guides showed me many paths, but it would be up to me, ultimately, to define my project and how it would proceed.

As I progressed through my project, I encountered some challenges. My AΩA and institutional mentors were there to help me.

My journey included talking, listening, and communicating. I talked to call center staff, front desk registrars, office coordinators, medical technicians, nurses, physicians' assistants, undergraduate and medical students, residents, and surgeons. And, I talked to my patients. These were purposely casual, open, and frank conversations, attempting to decrease the potential biases inherent in studying a situation.

This was a very powerful experience. To formalize the responses, I tested different approaches. Three recurring themes surfaced: Awareness of systems-level frustrations, interpersonal misunderstandings, and inherent assumptions.

As I listened, I realized I could not employ previously failed, standard quality improvement methodologies and then rationalize similar outcomes as the result of disenfranchisement. Past projects had not failed for absence of good intentions, they were just too formal and lacked a direct feel-good component that seemed to be the critical missing element impacting employees and patients.

My project purposely flew under the radar to avoid skepticism and disengagement. Efforts were geared toward rebuilding respect, personal empowerment, and legitimization of the true importance of everyone on the care teams. This could only be done from the heart, not from the academic mind, and knowing my environment, I believed we could open those hearts to a collective greater good. Burnout in health care takes many forms, and I was seeing providers, ancillary health care staff, and patients severely at risk of flaming up and fizzling out.

It was at this point that I began to understand this project more humanistically. The AΩA Fellowship wasn't a research grant, it was a unique opportunity to learn how to live as a leader. I realized this project could help me to learn about myself, my colleagues, and my patients. Together with those around me, we fostered interpersonal connectivity strengthening the human bonds bit by bit, and aiming to demonstrate the power of an engaged team to mold their immediate environment in critical ways.

To their credit, all of my formal and informal mentors, gave me tools and knowledge, but also critical independence.

I have come to value the skill of truly listening. I admire

those who resist changing the dialogue to highlight their own impressions. I applaud when listeners ask to hear more. I consider listening a powerful tool to understand why opinions exist, how they form, and what potential solutions are imagined by the concerned party.

The remainder of the year's efforts focused on the "Happy Patient—Happy Provider" project. We stepped back to basics. We rebuilt our interprofessional relationships, emphasizing respect, openness, and empowerment by living daily the reality which we expected.

We actively looked for, and celebrated, successes. When a patient said how kind our coordinator was, the coordinator heard about it right away with her peers in their shared office space. We fixed problems. We endorsed dialogues that praised improvement. We strengthened the formal triage structure while simultaneously blurring the rigidity of its lines so communication began to flow up and down and side to side in this network (rather than chain) of command. We helped patients to navigate the system. We did all of this openly, without complaint to supervisors, and without the implied punitive overtones of tracking change. This was consequence-free mediation. We subtly embedded these principles in education. In didactics, we highlighted empathy and responsiveness toward real-life stories of patient fear, uncertainty, and suffering, repeatedly emphasizing opportunities for respectful, proactive team actions. We created a team whose members understand each other better, value others' roles more fully, and thrive on more open patterns of communication.

The very essence of this project was to step away from a culture of blame and hypersensitivity. Metrics would have scuttled openness and collegiality, shoring up the inherent power differentials we were trying to break down. We needed to know about, and fix, irritants before they became major problems. Quality measures, by their very nature, formalize the process and erase the core re-humanization that we were trying to accomplish.

My journey to summit the leadership Kilimanjaro has been arduous but fulfilling. However, my overall leadership journey has just begun. It is with infinite thanks to AΩA, my mentors, and my faculty liaisons that I now move to the next stage of my leadership journey.

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