

# AΩA Fellow in Leadership Award

An innovative program for developing physician leaders

Joshua Hartzell, MD, Nathan Goldstein, MD, and Monica Vela, MD

## Introduction

**Richard L. Bynny, MD, Executive Director**

Leadership in medicine, medical education, and health care is more complex in the twenty-first century than ever before. Escalating costs, unequal access, less than ideal outcomes, and political challenges facing health care legislation 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 both 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 suited to serve as leaders in this period of change. The integral parts of the professional life of a physician are the values affirmed in the Medical Professionalism Charter that emphasizes the principles of patient welfare, patient autonomy, and social justice.

Encouraging the development of leaders in academia and the community has been, and continues to be, one of AΩA’s important missions. In 2013, AΩA developed and implemented a Fellow in Leadership Award and selected the first group of Fellows in 2014.

The AΩA Fellow in Leadership Award recognizes and supports the further development of outstanding leaders exemplifying the qualities of:

- **Leading from within**—Leading oneself is about creating access to a broader range of ways of being, thinking, and acting to become more effective in dealing with the challenges for which the usual solutions are inadequate. Unlike most existing programs that teach leadership by imparting someone else’s knowledge (a third-person approach), this fellowship emphasizes creating leaders using a first-person “as-lived/lived-through” methodology. In working with Fellows to “unpack” their hidden beliefs and frames of reference, new contexts will emerge that give them more space and more degrees of freedom to lead effectively as their natural self-expression.

- **AΩA’s professional values**, enumerated in the society’s motto—“Be Worthy to Serve the Suffering”—and its mission statement:

*Alpha Omega Alpha—dedicated to the belief that in the profession of medicine we will improve care for all by*

- recognizing high educational achievement
- honoring gifted teaching
- encouraging the development of leaders in academia and the community
- supporting the ideals of humanism
- promoting service to others.

- **The concepts of servant leadership**—Servant leadership is based on specific core values, ideals, and ethics, in much the way that the culture of medicine is shaped. Because medicine is at its core a profession that serves others, we believe that effective, sustainable, and excellent leadership should be based on

core professional and personal values and the commitment to servant leadership, while recognizing the value of other leadership strategies and approaches.

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

1. Self-examination, the “inward journey,” leading from within.
2. A structured curriculum focused on topics related to 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.
5. Team-based learning and developing communities of practice.

Fellows are mid-career physicians who provide outstanding leadership within organizations in medicine and health care, including schools of medicine, academic health centers, community hospitals, clinics, agencies, or organizations, with a high promise for future success, leadership, and future contribution.

Nominations for the AΩA Fellow in Leadership Award are made by the senior executive of the medical school, hospital, or health care organization, who also agrees to serve as a mentor for the Fellow. The nominating organization and Fellow designate at least one additional mentor who, with the executive leadership mentor, 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 the President of an association or an organization that has a regional or national presence. Fellows may also choose mentors and coaches outside of their immediate organizations or work groups.

These relationships and leadership opportunities and experiences, are ongoing through and after the fellowship year. The mentors in the Fellow’s organization commit to the mentoring plan and to allocating time to support the Fellow’s ongoing leadership opportunities after completion of the fellowship. The Fellows develop and implement an action project for experiential leadership development to be completed during the course of the year. Fellows and faculty leaders in AΩA attend a leadership orientation session that is combined with the course “The Science and Practice of Leading Yourself.” Throughout the year, Fellows participate in a defined and structured curriculum with faculty leaders from the AΩA Board of Directors and others with leadership development experiences. The Fellows and faculty are expected to develop a network of leaders and a Community of Practice.

The Fellows each received a \$25,000 award for further development as future leaders, and recognition as an AΩA Fellow in Leadership.

The three inaugural AΩA Fellows in Leadership—Monica Vela, MD; Nathan Goldstein, MD; and Joshua Hartzell, MD—were selected for their diverse backgrounds, and employment and educational experiences. They presented the findings, outcomes, and lessons learned from their projects to the AΩA Board of Directors during the 2016 meeting of the AΩA Board of Directors. The Fellows have now successfully completed their year of leadership development and are the first-ever alumni of the AΩA Fellows in Leadership Award program.

The Fellows have made major progress in developing as leaders, including gaining knowledge and understanding of leadership and models of leadership; understanding the “inward journey” and applying it to leadership; exhibiting knowledge and awareness about the importance of diversity in leadership; developing improved communication skills and writing effectiveness; developing a sense of social and civic responsibility and understanding of servant leadership; observing the importance of leading based on professional values; successfully implementing, pursuing, and completing a leadership project—all of which will guide them in their careers and lives.

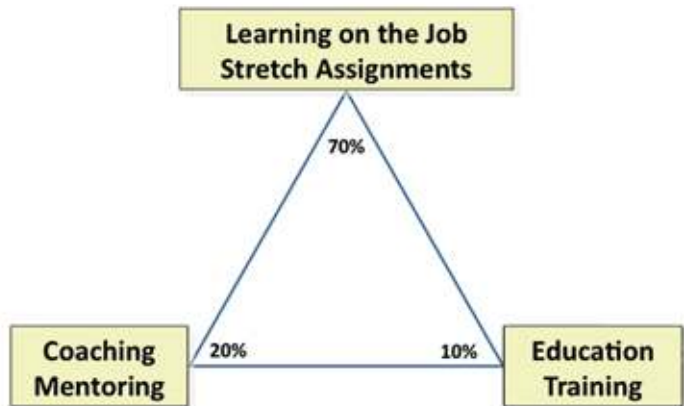
For this issue of *The Pharos*, we invited the Fellows to describe, reflect, and summarize their AΩA Fellow in Leadership journeys and experiences, and tell us how they have begun to develop a community of practice and network in leadership.

### **The AΩA Fellow in Leadership Award** **Joshua Hartzell, MD, Nathan Goldstein, MD, and Monica Vela, MD**

Medicine is no longer about the lone cowboy riding in and saving the day, but rather the ability to work within teams to provide the best clinical care.<sup>1</sup> Despite the ever growing need for leadership in medicine, there remains a gap in the training and development of physicians as leaders. At the undergraduate level, a recent paper illustrated that leadership training is uncommon.<sup>2</sup> Similarly, a paper related to Graduate Medical Education shows that the training of leaders is not that much better at the later stage of physicians’ careers.<sup>3</sup> Only forty-five papers relating to leadership development were identified in more than fifty years of publications. It is evident that most physicians are not formally trained to be leaders, but rather develop through trial and error during leadership roles in what some have called “accidental leadership.”<sup>4</sup>

The obvious question is: If leadership is so important, why are we as a profession not devoting time and resources to developing more leaders? If we do not address this issue, we will find that we are ceding leadership to those who may not have the same view of medicine or the same relationship with patients that physicians do. We must act now to ensure that we are adequately preparing physicians to become the next generation of leadership in medicine.

As the three physicians who were honored to be the inaugural Fellows for this award, we reflect on our experiences and the ways that the program has enhanced our careers.



The 70-20-10 Model for learning and development.<sup>6</sup> The majority of learning is what occurs on the job, while the gaps are filled in with mentoring, coaching, and specific training. Adapted from Tom Aretz, Harvard Macy Program for Educators in Health Professions, 2015.

**LTC Joshua D. Hartzell, MD**

**Assistant Chief of Graduate Medical Education  
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Leadership and learning are indispensable to each other.  
—John F. Kennedy

As I reflect back on the past year, I see how the AΩA Fellowship has helped me to mature as a leader. We began the year at the leadership course given by Wiley “Chip” Souba, former Dean of the Geisel School of Medicine at Dartmouth College. During the course, “The Science and Practice of Leading Yourself,” I quickly developed a better appreciation for reflection as a practice to improve as a leader. We explored the importance of context and mental maps, and the bias that these bring into our decision making and behavior. Being more aware of these elements allows me to be both more objective and conscious of what might be driving my actions or the actions of others. I have developed a much greater appreciation for the study of leadership, and how developing as a leader directly improves my ability to be a better physician, husband, father, and community member. The fellowship has given me a deeper confidence in my abilities that allows me to better advocate for those I lead.

During the past year, I have meditated on the importance of learning in leadership. In their book, *The Leadership*

*Challenge*, James Kouzes and Barry Posner point out that “The best leaders are simply the best learners, and life is their laboratory.”<sup>5p21</sup> Leadership requires that we continually develop new skills and learn new things. It requires constant reflection about our leadership experiences so that we can evolve.

During residency and early in our careers we are mainly focused on developing our clinical expertise. The larger question is: How do we learn to meet the changing demands of leadership? Much like medicine, leadership is a constant journey that never ends and requires lifelong learning. The AΩA Fellowship afforded me the opportunity to explore how we grow and learn as professionals and the importance of networking and being part of a community of learners. Throughout the year, I found myself repeatedly wishing I had previously learned many of the things I was being exposed to—they would have allowed me to be more successful as an educator and leader much sooner in my career.

Tom Aretz from Partner’s Healthcare International introduced me to a concept that I have found very useful. The fact is that we learn in many different ways, but, in general, we learn only what we need to accomplish our daily tasks. The 70-20-10 model is a useful framework for physicians as they consider how to develop the skills necessary to become leaders.<sup>6</sup>

We are often faced with challenging new positions requiring us to identify and learn new skills. These stretch assignments, while initially uncomfortable, become incredibly valuable learning experiences. During these assignments,

having a coach or a mentor can be vitally important. The distinction between these two elements of career development are important, but they can, and do, overlap at times.<sup>7</sup> A coach is specifically sought out to help develop a particular skill. A mentor, however, is someone with more experience in the types of challenges you face, and will provide more holistic guidance about your career or what to do, or what not to do, in certain situations. During the past year, I have been fortunate to have had multiple mentors both within and outside my institution. I would like to thank Colonel Clifton Yu, Colonel Michael Nelson, Dean Arthur Kellermann, Lieutenant General (Retired) Eric Schoemaker, and Page Morahan for their time and remarkable counsel and insights. These mentors have provided me with advice, and have challenged me to consider different perspectives or even different career paths. Each provided a different look into my professional development as a leader and educator.

In addition to the informal learning from mentors, I attended two Harvard Macy Programs: Leading Innovations in Health Care and Education, and Program for Educators in Health Professions. What I quickly learned in each program was that I had been lacking many important skills that would help me to be much more effective at my job. I have always considered myself a good teacher, but the educator course challenged many of my assumptions about teaching, and made me start to look at teaching in a much more scientific way. It is always just assumed that physicians should be good teachers despite the fact that we receive no training. The course inspired and challenged me to be more aware of how I teach and of the teaching of those with whom I work. The course director Elizabeth Armstrong consistently emphasized that we should experiment with our teaching. Since the course, I have become much more driven to experiment and to foster this in others.

The second course I took was the Leading Innovations Course. It is largely based on Clayton Christensen's disruptive innovation theory, but goes beyond that to examining how we approach change in medicine. The course challenges the way we think about doing things. So much of what we do in medicine is because we have done it that way for decades. Given the growing use and impact of technology and the many changes we face in medicine, we need to examine everything we do and ask ourselves if it can be done better, more efficiently, or more economically. One example would be how we round on patients. Is it necessary to have students present in a SOAP format now that most attending physicians already have all the data and it is readily available? Could we not just go directly to the assessment and plan? It would be obvious if a student or resident is missing data because their plan would be off. Breaking the tradition of rounds is not easily done, but rounds are not likely to be conducted the same way ten years from now as they are today. It is vital to point out that innovation in medicine is going to require leaders with the courage to risk failure.

The courses (the 10 percent of the 70-20-10) opened my eyes to many new possibilities, and have inspired me to pursue a Master's degree in Health Professions Education, which I started in September 2015. For anyone who wants to learn more about teaching and leading in academic medicine, working towards an advanced degree would be a valuable step. These degrees are designed for working physicians and help fill important gaps in our training—educating and leading. Similarly, for those who have an interest in other areas (business of medicine, technology in medicine, public policy, etc.) an advanced degree will likely allow them to be much more effective in their chosen fields. It is obvious now more than ever that *being* a physician does not fully prepare physicians for some of these roles.

The importance of a community of learners or networking cannot be over emphasized. We are all connected via e-mail, Facetime, Twitter, etc., yet we still spend most of our time working within our own institutions. Even within our own institutions, we work in silos and not across departments. Many of us face the same problems, but we continue to recreate the wheel on our own. My project for the AQA Fellowship was to develop a leadership curriculum for our graduate medical education trainees. As I began to search for resources, I found many others who were working on the same idea at other institutions. We have been able to share background materials, lecture outlines, and in some cases, collaborate on giving the lectures at other institutions. The ability to collaborate or have this community of learners has been vital to keeping the project moving forward.

The challenges we face in medicine and the small amount of time that we have to devise solutions means that, more than ever, we need to be working on these issues together. Large academic organizations need to focus on these joint problems and create solutions together. A recent example is the cost conscious care curriculum that the American College of Physicians developed. Professional societies have the ability to pull people together to tackle tough problems, alleviating the stress of individuals each trying to independently solve the same problem at their home institutions. Could each professional society coordinate to develop or tackle one problem each year or create task forces within their organizations to tackle multiple problems? These organizations have thousands of physicians who would love to be part of something meaningful. We need to put this human capital to better use.

The fellowship afforded me many opportunities to grow through formal classes, mentoring, and self-reflection about leadership. It has fostered relationships that have been invaluable in my professional development. Thus, it has significantly enhanced my preparation for future leadership positions in academic medicine, and has reminded me that as I move forward in these positions I must continue to evolve to be an effective leader. The fellowship's impact may be greatest in that I have been able to bring back all that I have learned to

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my institution, and have challenged others to think about their own educational or leadership development.

### **Nathan Goldstein, MD**

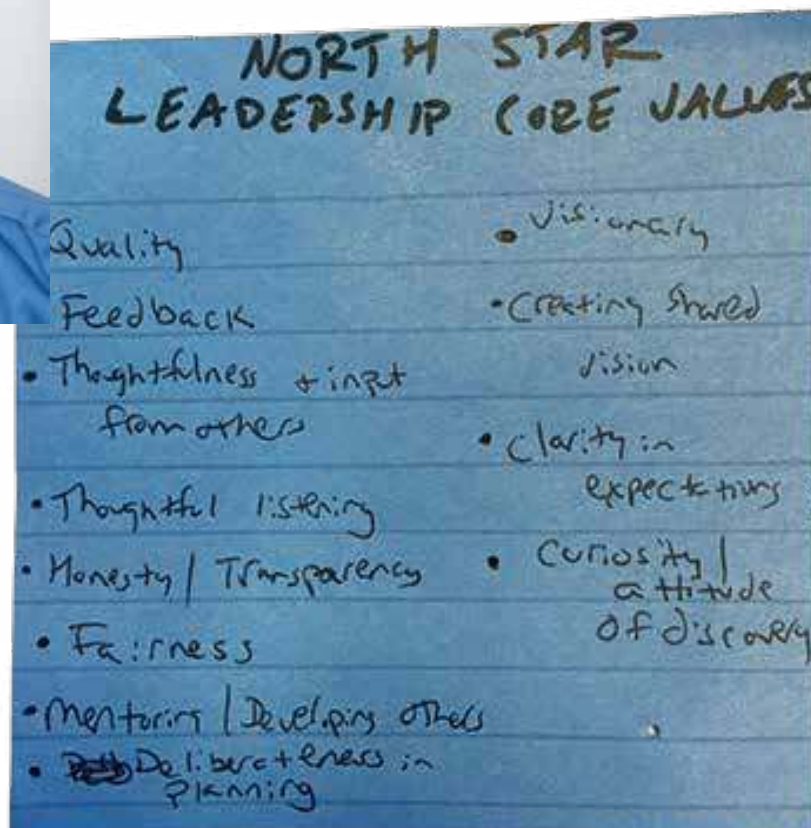
**Chief of the Division of Palliative Medicine**

**Mount Sinai Beth Israel, New York, New York**

I have dedicated my career to providing the highest quality of palliative care to patients and their families. Palliative care is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatments.<sup>8</sup> While my original proposal for the AQA Fellowship

was to explore ways to improve the integration of palliative care into the care of patients with advanced heart failure, shortly after being selected I became the Interim Director of the Palliative Care Program at Mount Sinai Beth Israel.

In September 2013, Mount Sinai Medical Center acquired several new hospitals as part of a merger of health systems in the greater New York City area. One of these hospitals, now named Mount Sinai Beth Israel, is an 856-bed teaching hospital founded in 1889 on Manhattan's Lower East Side. Previously, the palliative care program at Beth Israel was part of the Department of Pain and Palliative Medicine; it was an independent department with a single chairman. As part of this transition, the chairman resigned and the department was split into two sections: Palliative Care, and Pain Medicine. I took the interim position in June 2014, and was charged with redesigning the organizational structure of this new, stand-alone division; revising the strategic plan and business case for the service; and improving the quality of care delivered by



Nate's Leadership North Star.

the service to patients and their families. Many faculty and staff left in the wake of this merger, and as a result there were significant growing pains associated with the transition. At the same time there was, and continues to be, considerable and unwavering support from hospital leadership for the Division of Palliative Care at Mount Sinai Beth Israel, especially from hospital President Susan Somerville and Chief Medical Officer Barbara Barnett.

As Josh notes above, 70 percent of learning leadership on the job involves “stretch assignments,” and this new position was most definitely a growth opportunity for my leadership skills. One of the greatest advantages of my fellowship was the access to the AΩA leadership team, especially to my dedicated mentor from the program, Dr. John Tooker, the Emeritus Vice President and CEO of the American College of Physicians. Dr. Tooker, along with the entire faculty of the AΩA Fellowship, used their combined experience and knowledge of academic health care systems to help me better understand the organizational culture of my institution, and how to align both my position and requests for resources with that of the hospital and the health system to better improve care of seriously ill patients and their families. The AΩA leadership team, former deans and CEOs of medical centers and systems themselves, was able to provide me with valuable insights into the world of academic medicine. They also helped me to better understand the needs and viewpoints of the senior administrators of my hospital and showed me how to meet administration expectations and frame negotiations in a way that resulted in a win-win for seriously ill patients and their families, as well as for the hospital.

As both Josh and Monica note, growing into leadership involves personal transformation. One of the most important steps in this process is envisioning oneself as someone qualified to take over a senior leadership role and avoiding, or at least minimizing, the imposter syndrome. While there were many times when I sat in my office thinking, “I can’t do this” or “What happens when they find out they put the wrong person in this job . . . me?” a quick text with Josh and Monica, or a phone session with Dr. Tooker, or a conference call with the AΩA leadership team gave me the confidence boost that I needed, as well as the helpful advice to guide me through whatever the current struggle or challenge was. In addition to this team, I engaged a leadership coach using the funds that the fellowship provided. I worked with Dorothy Moga, a certified leadership coach with decades of experience in health care. I was particularly lucky in that Dorothy has many years of direct experience working in both hospice and palliative care. While content knowledge such as this is not required for a leadership coach, it did provide additional value to the work we did together, since she was familiar with the particular challenges associated with running a palliative medicine program in an academic medical center.

Dorothy and I spoke every two weeks throughout the

fellowship year. We started with a series of exercises through which I developed my leadership “North Star”—the core values and traits I identified as the principles that I wanted to embody as a leader. My “North Star” is a simple blue note with my illegible handwriting on it that I keep tacked onto my bulletin board at my desk and review regularly. It reminds me that I want thoughtful listening, fairness, developing others, and curiosity to be the fundamental elements of my daily work as a leader. On calls with Dorothy, I would struggle with both the core work of leadership (e.g., how to design my organizational chart), as well as my journey to better understand the elements of my personality into which I could tap to improve the work of our division (e.g., my sense of humor). We also created a list of directed readings, which included some of the classics of leadership publications such as Michael Watkins’ *The First 90 Days*,<sup>9</sup> Thomas Neff’s and James Citrin’s *You’re in Charge—Now What?*<sup>10</sup> and Patrick Lencioni’s *The Five Dysfunctions of a Team*.<sup>11</sup> Dorothy and I then applied these concepts of leadership to my daily work, allowing me to apply in real time the new skills and knowledge I was learning.

While the last year has been full of challenges and change, it was a fortuitous moment in my career to have been thrust into a leadership role at exactly the same time I received the Fellow in Leadership Award. The award not only provided support for my leadership training, but also provided me with time to reflect on exactly what kind of leader I wanted to become. Indeed, the ability to reflect on my journey to become a leader as I was actually going through the process may have been one of the most valuable aspects of the fellowship itself. I believe that I have grown both personally and as a leader, and my division has expanded and become a highly functional team. While there is still much work to be done in the coming months and years as health care changes, I believe that the advantages offered to me by this award have truly helped me forge a new career path that will ultimately improve the care of seriously ill patients and their families. In July of 2015, I was officially named Chief of the Division of Palliative Care, a testament to my success in my new role and the ways that the AΩA Fellow in Leadership Award has helped me grow.

### **Monica Vela, MD**

**Associate Professor of Medicine, Department of Medicine  
Associate Dean of Multicultural Affairs  
University of Chicago Pritzker School of Medicine,  
Chicago, Illinois**

Our journey began with a week-long intensive orientation designed to provide time for reflection, problem-solving, and recognition of our strengths and weaknesses. Imagine being placed in a room with some of the top leaders in the medical profession and being asked to reflect and share your perspectives on the following questions:

What did we hope to achieve for the medical profession?  
Who was on “our bus” and who was missing?



What was keeping us from making a difference?

Where were we in the leadership continuum?

In an effort to answer, all three of us quickly reviewed our applications for the program. We had each included an essay on our current projects and had delineated our visions for completing those projects. My mentorship team was solid, and I felt proud of the work we were accomplishing at our institution. I have a great working relationship with the dean of our medical school, the chairman of my department, and the chief of my section. I was already mentoring very successful junior faculty. I already felt valued and supported at my institution.

Each of us outlined our resources and needs, our supports and weaknesses, and explored the personal characteristics that made us successful—as well as those that kept us from moving forward. We made lists upon lists and drew up elaborate schema covered in Post-Its on a Grove Gameplan. By the end of the second day, we were exhausted; the two-day journey had taken a great deal out of us. We had expressed appreciation of our mentors; healthy cynicism over the current system of health care and education; had identified obstacles in our workdays; and, we had learned that each of us was missing the mark in some way on the opportunities to become true leaders in the profession.

Specifically, I began to see that I felt most fulfilled spending much of my time “in the trenches”—creating and teaching new curricula, caring for very ill patients, traveling to recruit students, and mentoring students and junior faculty. What I was not doing, however, was spending enough time reflecting and writing. Why had I not written and published more of my work? I struggled to answer.

Over time, and with extended discussions with the AQA leaders, the answer came in two parts. First, I had failed to claim expertise in the fields I knew well. Despite being listed as an expert in diversity in medicine in a recent U.S. Supreme Court writ, having spent more than a decade as an Associate Vice Chair for Diversity within my department, and Associate Dean for Multicultural Affairs at my institution’s medical school for four years, I had never made the claim to be an expert in diversity.

I know the literature regarding women in medicine quite well. Women in medicine are known for their collaborative spirit. They are more likely to devote time and energy to committee work, but less likely to be the committee leaders. They are also less likely to advance to the senior ranks of medical school faculties. While much of this failure to rise in the ranks is due to bias at the workplace, some is due to women’s reluctance to claim expertise in our appointed fields. Failing to recognize our own expertise is unfortunately a common issue for women in medicine. I began to read a great deal about leadership and found great lessons in books like *The Leadership Challenge: How to Make Extraordinary Things Happen in Organizations* by James M. Kouzes and Barry Z. Posner.<sup>5</sup> Sharing expertise is a common practice and commitment among most leaders.

The AQA Fellowship provided me with time and funding to attend leadership conferences specific to my areas of interest. Much of my career has been spent building a knowledge base in diversity, health disparities, and teaching on health disparities. Attending the Society of General Medicine’s Associate of Chiefs and Leaders in Medicine conference exposed me to inspirational leaders in these fields, and provided me some confidence that I could contribute to the growing conversations surrounding diversity in medicine. Attending leadership conferences helped me to find my voice and made me realize that it was time to start sharing that knowledge base outside of my own institution through collaborations and written work.

Once I had found my voice and claimed my expertise, I was able to acknowledge that the second thing keeping me from sharing that expertise was my discomfort with writing. I had completed a graduate level writing course years ago, and this certainly improved my writing skills. Now, books like *Bird by Bird* by Anne Lamott,<sup>12</sup> and *On Writing Well: The Classic Guide to Writing Nonfiction* by William Zinsser,<sup>13</sup> became dog-eared through good use in my office. In the words of a fellow faculty member, “good papers are rarely written, they are re-written.” I scheduled time for writing into my day, just as I would schedule time for a meeting. I joined a writing group that meets every two weeks to edit group members’ manuscripts, and I became an avid contributor. These measures made a difference.

I am particularly proud of a recent publication in the *Journal of General Internal Medicine*, titled “National Survey

of Medical Spanish Curriculum in U.S. Medical Schools.”<sup>14</sup> This was the result of collaborative work with the national Latino Medical Student Association, an organization seeking to improve the health care of Latinos, as well as to improve the representation of Latinos among U.S. medical students. Advocating for language concordant care of limited English proficient (LEP) patients to promote the quality and equity of their care is a passion of mine. The students and I had begun data collection on a national survey of U.S. medical schools and the curriculum surrounding medical Spanish. As the students graduated and began their respective internships, the project lost momentum. Leaving the data unpublished, I now felt, was not an option. The survey revealed that medical educators were making great efforts to teach the curricula but that few schools used validated instruments to measure language proficiency of the students after completion. This was particularly disturbing given that untrained or *ad hoc* interpreters can actually worsen the health outcomes of LEP patients.

I reached back and re-charged the group. Despite now being scattered across the country at various institutions, we managed to pull together to complete the manuscript. We concluded by calling for further research into the best practices for developing and evaluating the curriculum for medical students so that we could work together as a profession to improve the care of LEP patients. In the short time since publication, the manuscript has already been cited twice and is in the top 5 percent of all articles scored by Altmetric, a company that tracks relevant mentions from social media sites, newspapers, and policy documents.

One paper is certainly not cause for a wild celebration. However, perspective pieces, letters to editors, and other original manuscripts have begun to find their way out of my office and into the review process. The process itself has become fulfilling because I have now used writing as a possible lever for change and advocacy. I have begun to teach my mentees that claiming expertise, sharing expertise through teaching and writing, and collaborating with others outside of our own institution is a form of advocacy, as well as leadership. I wish to thank my mentors, Drs. Marshall Chin, Deborah Burnet, and Holly Humphrey for supporting my application to this fellowship and for their continued support in my development as a leader in medicine.

## Conclusion

Each of our journeys were different, but we recognize the incredible opportunity we had to meet, collaborate, and learn from each other and our mentors. Each of us grew as leaders based on the experiences that we took part in during this past year. As the AQA Fellowship moves forward, we know that future recipients will benefit from the program. Ultimately, leadership development starts simply with a motivation to become a better leader. Each of us as physicians has a responsibility to be better leaders for our patients, the health care system

we work within, and our families. As members of AQA, the expectation is that you are a leader and we hope that we have provided some ideas about how you can sharpen your skills.

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