# AΩA Fellows in Leadership complete program 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 now the pandemic, 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 has been, and continues to be, a core AΩA value, 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 through the inward journey;
2. A structured curriculum focused on leadership, and 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.

These relationships, and leadership opportunities and experiences, are ongoing throughout, and after, the Fellowship year.

The Fellows each receive a $30,000 award for further leadership development and project funding.

This group of AΩA Fellows in Leadership program—Alexandra Clark (AΩA, Albany Medical College, 1999), Fassil Mesfin, MD (AΩA, Albany Medical College, 2009), and Deep Shah (AΩA, Emory University School of Medicine, 2020, Faculty)—was selected for diverse backgrounds, career performance and success, leadership experience, mentor support, and each one's 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 9, 2021 annual meeting.

## Alexandra Clark, MD

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One of the essential qualities of the clinician is interest in humanity; for the secret of the care of the patient is in caring for the patient.

—Dr. Peabody (AΩA, Harvard, 1906)[1]

The year of virtual AΩA Fellows in Leadership began like any other. We were all eager to see how to balance the whirlwind of our current responsibilities with the program requirements. We felt up to the task and excited about the prospect. And then the Spring of 2020 came and everyone's lives turned upside down, and none more than those of us providing medical care on the frontlines while the world dove headfirst into a global pandemic.

AΩA pivoted with the rest of the health care community, turning the Fellowship virtual and spinning up a newly formatted orientation with synchronous and asynchronous virtual resources. As a Fellow, I was looking forward to making in-person connections with a new community of practice. However, I value and appreciate the way in which the AΩA leadership team strove to make sure those connections happened during our pandemic Fellowship year. The dedication to our personal growth was evident from the very first phone call through our ongoing community of practice. It has made a significant impact on my personal growth as I assisted our home team in navigating the pandemic.

### Burnout

Pre-pandemic, the rate of burnout and compassion fatigue among physicians was already making news. Both internal and increasing external stressors contribute to the growing levels of burnout and compassion fatigue being seen in health care professionals. The COVID-19 pandemic has added a layer to our lives, at work and at home, that has accelerated these issues. Burnout is identified as a syndrome that consists of emotional exhaustion, depersonalization, and decreased

personal accomplishment. Compassion fatigue, while similar, is thought of as secondary traumatic stress in the caregivers.[2]

Both burnout and compassion fatigue are impacting the physician workforce today in ways that are still yet to be fully realized. Most studies and interventions have focused on what to do once the provider has been exposed to the environment and trauma that is leading to these phenomena. The psychological impact of health care professionals' working environment cannot be underestimated. It is chaotic and demanding, time-pressured, and filled with the anxiety of patients and families that are projected outward. And yet, excellence in both mental and physical performance is required daily to achieve optimal outcomes for patients, and to provide quality and compassionate care when death is the outcome.

## Sports performance psychology

In other high-pressure professions, e.g., professional sports, performance psychology has been deployed to maximize individual and team performance as well as to improve psychological well-being and satisfaction with the athlete's working environment.[3]

Before knowing that a pandemic was about to hit, my project was the development of a workshop series to teach the tools and skills used in sports performance psychology to our attending providers, and then track their use and the impact of these tools over their upcoming clinical years. After this pilot year, we planned to expand this education to residents and fellows, as there exists a small body of evidence showing that the tools utilized in sports performance psychology can be modified and used in non-sports environments to maximize performance and job satisfaction.[4]

Like my co-Fellows, I altered my project to start with a pilot group of attending providers and then taught the series to all of our MS3 students right before they started their clinical year. I have been tracking the impact with serial surveys. When could just such added tools to our toolbelt be more important than as we battle the emotional stress, the physical fatigue, and psychological burden that health care delivery has endured with this pandemic?

Medical school imparts the technical knowledge of how to be a physician, to take histories, do detailed physical exams, collate that information and decide on workups, differential diagnosis, and treatment plans. It does not fully prepare medical students to be mentally protected against repeated stressors in a short period of time.

Being a physician is a beautiful, meaningful, and purposeful career but roughly one United States physician every day commits suicide. This is double the rate of the general population. How do we as physician leaders make an impact for ourselves and our colleagues?

We must learn to lead ourselves and then apply that knowledge in ripples across our spheres of influence.

As part of my Fellowship I employed autoethnography for the first time—the idea of lived in, lived through experiences being documented and explored to impact future growth of the intervention and self-awareness. Critics of autoethnography argue against its use due to concern for lack of objectivity. I would argue that no one understands the stress of the health care team more than the team itself. Individuals outside of the environment cannot express the reality or add substantive contributions to the knowledge of whether the interventions employed have made an impact in health care providers' sense of personal satisfaction, or have decreased compassion fatigue and burnout.

Similarly, no one but myself can say whether my internal narrative has changed as a result of the AΩA Fellowship, thereby impacting the way in which the situation occurs to me, and, as a result, the way in which I choose to be and act, which, of course, shapes my team and my performance.

## The beginning

"I am starting this journey not 100% sure where it will end. I began my journey by journaling. COVID-19 has disrupted normal process and not only has the AΩA Fellowship structure been forced to adapt, our day-to-day operations have too. Nevertheless, I choose to start this journal using a beautiful blue—cheerful, bright, and reminiscent of the ocean—a place for me of great tranquility.

I have found it difficult with the whirlwind of my job to take time for the inward journey and have to be very intentional about blocking spots on my calendar. Will that be as effective? Organic? Or will a pause in the middle of a whirlwind just get sucked up with the energy surrounding it and about to come? We will see…"

Sometimes I did get sucked up by the tornado of COVID-19. Planning and response meetings, algorithm creations and re-creations as ever-changing data was released, front line work, emotional support to my team, a stretch of 42 days straight without a day off became my daily whirlwind. At times it felt that the weight would never lift and as is oft the case, at other times, we seemed to move in slow motion—seeing the particles of dust in the air and acknowledging the beauty in the simplest of things.

A kind word, a piece of chocolate left on my desk, a hot shower, the family walk with the dog before bed helped to rejuvenate me. Rejuvenation of the soul comes in many ways and I had to ensure the teacher was being a good student. I know that to fulfill our calling as providers, to be worthy to serve the suffering, we must ensure that neither our students, our residents, our colleagues, or ourselves succumb to apathy and indifference when caring for patients.

In our pre-workshop survey more than half of the attendings polled felt that neither their medical school nor residency

taught them specific ways to combat burnout or compassion fatigue. Yet, all of them felt that these tools would be useful.

The MS3 students are halfway into this clinical year and on serial surveys, those who have embraced the tools, and are applying them, are telling us stories of impact. They are being faced with a daily barrage of minor- and major-stressors. The goal should be that each and every one of us becomes the very best we are personally capable of. That is how our patients win. Ensuring mental wellness and the ability to practice at our peak performance even under the most stressful situations that medicine will bring us. Because it will bring us difficult days, pandemic days, short staffed and difficult conversation days. But it will also bring us beauty and days of grace and healing, of being fully present to witness the birth of a new life or the passing of a life well lived. It brings us together. It is a life worth living.

## A final entry

My last journal entry: "What is the whole story? Maybe the beauty is in the unknowing, the possibilities of all it can be if we are open to it. The being open to listening and not telling. What is my stand? What do I care deeply about, and what is it that the world urgently needs?

That each of my faculty—no—each health care worker is being the very best version of themselves. This can only happen if we equip them with more than medical knowledge. We must teach them tools to guard against compassion fatigue and burnout, to understand the other person's situational occurring, and to live authentically with integrity, awareness, and the commitment to stand for a future bigger than ourself."

This is my call to action: Lift each other up and cheer for other's success. Help each other be the best version of themselves. Focus on your inward journey to be the best version of yourself. Together we can change the narrative of health care burnout and compassion fatigue.

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**Fassil Mesfin, MD**

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I vividly remember the phone call from Alpha Omega Alpha (ΑΩΑ) informing me that I had been selected for an ΑΩΑ Fellow in Leadership. I thought it was an opportunity to conduct a multicenter outcome study. After embarking on the inward journey, my initial proposed project transformed into developing a mentorship for medical students that supports them in their inward journey, as they become servant leaders in medicine.

Physicians have natural advantages to be servant leaders given their passion for serving others. However, this natural advantage is at risk due to the increased complexity of health care delivery that imposes elevated demand for physicians to spend more time doing clinical activities rather than developing leadership skills. Programs that enhance physicians' engagement in leadership are needed to mitigate this risk. Medical schools are ideal for consciously integrating and cultivating servant leadership through mentorship programs.

How will we enhance the inherent gift of servant leadership in the next generation of physicians? This is a question constantly on my mind as co-chair of the admissions committee at the University of Missouri School of Medicine (MU SOM), and in working with my mentees. Although medical education, research, and health care are constantly evolving, we must focus on mentoring trainees to capitalize on the natural servant leadership talents of physicians.

With faculty guidance, mentorship can strengthen future physicians' ties to their school, expose them to the dynamic nature of academic medicine, help them grow personally and professionally, and encourage their leadership development.

The ΑΩΑ Fellowship in Leadership allowed me to create a mentorship program that supports medical students and opened the door to committed servant leader faculty to be mentors.

## Program conception

The MU SOM has historically lacked ethnic, racial, and gender diversity. In 2016, MU SOM began a holistic review of medical school applications, including the applicants' life experiences, ethnicity, race, and gender identity in addition to the MCAT and GPA. The past four years have seen a steady increase in interviews offered to Black, Indigenous, and People

of Color (BIPOC), low socio-economic status (SES), and LGBTQ students. The last three MU SOM classes were the most inclusive and diverse since the change in applicant screening four years ago.

There is an opportunity through this mentorship program to help medical students, including underrepresented minority (URM) students, to succeed in medical school and make optimal career decisions. Therefore, I established the MU SOM Training and Innovation Ground for Educational and Research Support (TIGERS) program. This program uses basic science and clinical research to create mentor-mentee relationships.

Studies emphasize the need to develop mentoring programs to enhance medical students' experiences and professional success. Dimitriadis et al.;[1] reported that the mentor-mentee relationship is bidirectional, and committed mentors contribute to students' success in achieving their goals.

Zier et al.;[2] reported that one-to-one mentoring of medical students in biomedical research increased research skills, publication, and increased interest in academic medicine.

In addition, Tekian et al.;[3] studied the effect of one-to-one mentoring in reducing academic difficulties experienced by underrepresented minority medical students. This study indicated that one-to-one mentoring improved medical school performance. Additionally, Taherian et al.[4] reported that close mentor-mentee relationships lead to a life-long relationship. Such close relationships may lead to positive learning experiences in medical school followed by optimal career choices.

## Program design and delivery

TIGERS is a pilot program designed to enroll medical students in a four-year mentorship program using medical research as a vehicle to create mentor-mentee relationships. The principal objective is to help medical students succeed during medical school and achieve desired post-graduate training.

As a pilot program, 20 medical students will participate annually, beginning with 2021 and 2022 incoming students. We anticipate opening the program to all students depending on funding from the medical school.

Using evaluation tools, the program will be assessed and the outcome published. It is anticipated that positive outcomes of the program will be scalable to other medical schools.

Participants are paired based on shared interests. Committed mentors and students participate in a meaningful research project they design. Students receive training in responsible research, participate in laboratory activities, and attend lectures presented by MU SOM faculty and guest lecturers.

Students have the opportunity to learn about and apply to the TIGERS program starting with the Second Look Day and continuing through the spring and early summer before their first year of medical school. In addition, video and advertising materials have been created and sent to incoming students.

The first year the program had 45 applicants (out of approximately 113 eligible to participate) and 20 were selected to participate in the program.

Twenty mentors from the MU SOM faculty, physicians, and basic science researchers across different departments were selected. TIGERS allows medical students to become familiar with research and provide them with an opportunity to address medical school challenges. Mentees and mentors attend eight seminar lectures during the students' first year, and meet once per month to discuss their progress in medical school and develop their research projects.

Mentors receive CME credit for attending the lectures and meeting with their students each month. There are four lectures each semester, with the first semester focusing on an introduction to research, research as a career, goal setting, comparative medicine, and statistics. The second semester focuses on scientific writing, grants, research presentations, and qualitative research. In addition, some lectures have short guest lecturers, such as senior physician mentors and medical students taking research gap years.

Students are also encouraged to submit the proposal to the MU SOM Summer Research Fellowship Program, where they might qualify for funding to complete the project and present at the school's annual Health Science Research Day. The hope is that students will continue working on research with their mentor past the summer program and explore research questions.

Medical students do not need to work exclusively with their assigned mentors; however, the primary mentor is designated as a point person to increase a sense of belonging. A balance is necessary between mentors actively involved in mentoring while allowing the medical students to interact with other people in the school. Mentors also guide critical aspects of a medical school experience, such as professionalism, career options, and assisting students in achieving their goals.

The program will be evaluated biannually.

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**Deep Shah, MD**

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Five years ago, I elected to join an endangered species, that of independent primary care physicians (PCPs). To my knowledge, I am the only physician out of both my medical school (Harvard 2013) and residency (Emory Internal Medicine 2016) classes to join these dwindling ranks. Yet, my first few years in practice have been magical in almost every way, and our group practice has proven its worth in the metro Atlanta market. Both patients and market stakeholders recognize the unique value of independent primary care in a health care environment dominated by megamedicine.

In early 2020, I began to evaluate strategies for sharing my experience as a successful independent PCP, specifically the role of physician assistants (PAs) and nurse practitioners (NPs). Inspired by my mentor, Dr. Joe Stubbs (ΑΩΑ, Emory University School of Medicine, 1978), I hoped to collaborate with colleagues in my field across the country to share best practices. As a first step, my original ΑΩΑ Fellow in Leadership project focused on developing best practices for the onboarding and training of NPs/PAs in independent primary care practices.

But then COVID-19 struck and my plans were challenged, altered, and eventually shelved. As it turned out, my ΑΩΑ one-year fellowship allowed me to pursue my inward journey and develop the situational leadership skills, that turn managers into leaders.

## The narrative of inspiration

Before COVID-19, I accepted a "top of [our] license" narrative, according to which PCPs lead large teams of health care professionals in caring for panels and populations. In other words, PCPs do what only the physician can or must do, while working with a wider health care team to serve the patient's needs. This primary care ideal has attracted both younger, newer physicians and more experienced, but burned out physicians. Senior care practices have popularized this model (often backed by private equity or other third-party health care financiers). My aim was to develop an onboarding guide to smooth independent PCPs' transition to this model. In addition, I hoped to learn from other independent primary care and specialty groups that use NPs/PAs for a combination of chronic, preventive, and acute care. I assumed a top-of-license was the most sustainable path. However, COVID-19 and concurrent changes in the financing of care challenged my assumptions about how best to serve my field.

## The call

On March 12, 2020, I received a call from the local health department about COVID-19. At that time, the emphasis was on disease detection and testing. The initial discussion centered around the government's need for community PCP participation, and initiated a cascade of events that profoundly changed the course and trajectory of my ΑΩΑ Fellow in Leadership project.

In the short term, the pandemic upended the top-of-license approach. COVID-19 compelled an all-hands-on-deck approach to almost every aspect of care delivery. Roles overlapped, blended, changed, grew, and shrank. Suddenly, instead of directing care (or flying the plane), physicians were

swabbing and jabbing. Workforce shortages, potential cash-flow shortages, and the personal health risks of COVID-19 became top concerns. Defining the roles of NPs/PAs and other team members to preserve the model of a successful 21st-century PCP suddenly seemed like a luxury, if not a distraction.

## Realization

I realized that I needed to pivot and rework my project as an endeavor in leading adaptable teams. I asked myself, "Are effective independent PCPs committed to one model of care, or the broader mission of achieving the quadruple aim with added attention to financial solvency and joy in practice?"

COVID-19 forced me to count pennies for the first time as a practice leader.

Initially, I flinched from having to think so carefully about cost and value on a daily basis. Eventually, though, I realized the exercise sharpened my ability to critically appraise the health care environment. My value as an independent PCP was strengthened by a unique perspective. This new perspective has proven valuable when contributing to state and national health policy dialogue.

Not taking enough time for self-reflection amid the COVID-19 crisis delayed my appreciation of this new best practice of situational leadership. However, over time, I did come to see that what enabled our group to flourish was not necessarily the way that we organized our teams, but rather, it was our adaptiveness. We cultivated the humility to change—an invaluable competitive advantage for any leader. We were direct, honest, and transparent about what we needed and when and how we needed it.

Multiple conversations with AΩA faculty and mentors, rooted in a robust literature based on leadership and the inward journey, inspired confidence in me to own the reality of my situation.

## Community of practice

After COVID-19 turned the carefully wrought top-of-license model upside down, I was forced to reevaluate my project and its value to my leadership journey. In the second-, third-, and fourth-quarters of 2020, my practice felt tremendous financial and clinical pressure—a common theme among colleagues who operate independent practices. I sought out a community of practice with which to share my experiences and challenges.

This community of practice provided me with invaluable counsel and support as I balanced leadership of my practice and patients with the personal demands of having two small children and a physician spouse. As the youngest of the Fellows in my cohort, I leaned on my co-Fellows and faculty for wisdom during this period.

I now realize that the single greatest tradeoff that I made in choosing community primary care over academic medicine was giving up regular mentorship opportunities, a void that my AΩA Fellowship filled at the time I needed it most.

## Timing is everything

As the country entered the third- and fourth-waves of the pandemic, the rate-limiting step in serving the community became a shortage of medical assistants. My focus on the physician-NP/PA axis turned out to be myopic. I failed to anticipate the broader staff challenges, though others in leadership had warned me.

Through the inward journey, I began identifying my strengths and weaknesses as a leader. My natural leadership style had been successful, but the crisis exposed its shortcomings: a lack of appreciation for experience in situational leadership; a lack of focus on professional development and feedback for practice associates; and insufficient attention to reports from on-the-ground staff.

I shared my experiences and change in perspective with AΩA faculty and leadership throughout the program. I was humbled by the trust they placed in me and in my commitment to use time and funds appropriately in a year of many forced changes.

## My inward journey

I have taken more time to reflect on my character as a leader over the last 12 months than I ever have before. The timing of the Fellowship was serendipitous, and the chemistry among my co-Fellows has been a godsend. Learning the framework for continuously evaluating oneself as a leader through the inward journey will be the greatest lesson I take from the year.

Investing time and energy into learning my voice is a prerequisite to advancing in self-growth and self-discovery. This year has shown me the value of this process and given me a head start as an early career physician. My hope is that it allows me to contribute to an ultimate goal of nurturing the resurgence of independent primary care physicians across the country.

I plan to use some of my funds to travel and visit successful physician leaders whose practices have thrived in competitive, dynamic health care markets—masters of situational leadership. The goal of reclaiming independent primary care's leadership position in medicine has a much greater chance of success if the movement's leaders appreciate the value of self-evaluation through the inward journey.

If I have learned anything as an AΩA Fellow, it is that to lead any group, or the profession as a whole, I must first lead myself.

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