National and Chapter news

2024 AΩA Fellows in Leadership ready to lead

Encouraging the development of leaders in the community and academia has been, and continues to be, a core Alpha Omega Alpha Honor Medical Society (AΩA) value, and an essential part of the organization's mission. The Richard L. Byyny Fellow in Leadership program recognizes and supports the development of outstanding physicians through the tenets of the Inward Journey; upholding AΩA's values and mission; and a commitment to servant leadership.

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

1. Self-examination through the Inward Journey (learning to lead oneself before leading others);
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. Developing communities of practice.

Nominations for the Fellowship 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 an experiential leadership project, serves as a role model, offers advice, and connects the Fellow with key individuals in leadership positions. These relationships, leadership opportunities and experiences are ongoing throughout, and after, the Fellowship year.

The most recent graduates of AΩA Fellows in Leadership program—Ganesh Asaithambi, MD, MBA, FAAN, FAHA (AΩA, University of Missouri-Kansas City School of Medicine, 2020, Alumni), Mary T. Killackey, MD (AΩA, Tulane University School of Medicine, 2017, Faculty), and Sarah Tevis, MD (AΩA, University of Wisconsin School of Medicine and Public Health, 2010)—were selected for their diverse backgrounds, career performance and success, leadership experience, mentor support, and each one's leadership project.

Finding my voice: A journey through doubt to purposeful leadership

Ganesh Asaithambi, MD, MBA, FAAN, FAHA

Dr. Asaithambi (AΩA, University of Missouri-Kansas City School of Medicine, 2020, Alumni), is a Vascular Neurologist and System Medical Director for Stroke and Hospital Neurology at Allina Health Brain & Spine Institute in Minneapolis, MN.

When I first started as an Alpha Omega Alpha (AΩA) Fellow in Leadership, I thought that I would be doing a traditional project. I imagined undertaking a quality initiative—instituting a new protocol or procedure or a quantifiable operational outcome. This is what physician leaders are taught to do: identify a problem, fix systems, and produce results. As I contemplated the options available to me, I realized that the most important contribution that I could make was not to my organization, but to myself.

I have spent my entire career chasing excellence: earning three board certifications, leading a system-wide stroke program, and driving innovation at dozens of hospitals. On paper, such accomplishments should have been sufficient for me to enter any room with confidence. Instead, a feeling of self-doubt never went away. Quiet and persistent, an imposter syndrome kept whispering that I did not belong, that somehow the opportunities that had come to me were never truly earned.

To make sense of it all, I resorted to one of psychology's most tried-and-true models: Sigmund Freud's structural model of the mind.[1] Freud posited three distinct parts of our inner world. The id is the source of our innermost wants and desires or, in my case, a deep-down need to prove myself, to accomplish, and to achieve. The superego is the voice of reason and morality, or the part of the self that holds the self to impossible standards. And the ego? The ego serves as a mediator between those two forces, navigating reality and balancing aspiration with practicality. For me, the imposter syndrome owed to my constant battle between my id's hunger for validation and my superego's demand for perfection, with my ego caught in the middle.

The AΩA Fellowship was an invitation to confront that inner conflict. Rather than creating a process-improvement initiative, I designed a process of self-discovery. With Freud's structural model as my guide and Dr. Chip Souba's framework for an inward journey as my map,[2] I mined the assumptions, fears, and beliefs that had silently been informing my leadership. This report is the story of that journey of how I confronted my imposter syndrome, claimed my success, and learned to invest in myself so that I could lead with integrity, courage, and purpose.

The first time that I can remember the imposter syndrome surfacing was during my residency training. I was in the middle of an emergent stroke assessment, and I can still recollect the experience vividly: a patient had been brought in via ambulance, a team was waiting for me to give orders, and precious time was ticking away with each lost minute of brain tissue. I spoke, and everyone responded: I assessed the patient, reviewed the scans, and prepared for thrombolysis. All the while, a voice screamed inside my mind, "Are you sure? What if you're wrong? What if everyone figures out that you don't belong here?" The voice persisted even after the patient was proven to have received appropriate and timely treatment. Instead, the feeling settled in me, a secret companion that I dragged through fellowship and into my practice.

After I assumed the role of System Medical Director for Stroke and Hospital Neurology at Allina Health, that voice came back to me again—only this time, the stakes were higher. No longer was I the code leader for a single case or responsible for a single patient at a time; instead, I was building systems of care for stroke patients across multiple hospitals. Whenever I walked into a meeting or presented metrics to leaders, I would sense an internal compulsion to prove myself to them.

Once I started looking at my internal dialogue through the lens of Freud's structural model, I found that my id was strong. It was driving me to achieve, to build on my knowledge and skillset, to always say yes to new challenges. Yet no less forceful was my superego, which made me fear that whatever I had done had fallen short of good enough, that I would, in fact, never succeed in doing or being enough. There was always something more that I could have accomplished, something more that I could have learned. My ego, stuck between these two sides, seemed depleted, worn out by the effort to reconcile them. That dynamic created a relentless cycle: achieve, doubt, achieve again. As the achievements piled up, I rarely gave myself a moment to pat myself on the back. I simply moved on to the next challenge in hopes of quieting the conflict for good.

When I started the AΩA Fellowship in July 2024, I knew that this conflict was what my work had to address. The project could not be just a means to affect another notch on my belt; it had to involve a process that taught me how to trust in my own journey—how to see the beauty in my own growth, and how to lead from a place of confidence rather than fear. The fellowship ultimately granted me something that I had not had in a long time: the time and space to slow down and look within. For years I had been running, indeed sprinting, towards the next project, the next shiny object, and the next chance to make something of myself. The fellowship allowed me to pause, to look inward, and to ask myself a much harder question: who am I becoming as a leader?

The turning point came early in the Fellowship during a conversation with my leadership coach. I shared my initial idea for a project, a traditional quality-improvement initiative that would yield measurable outcomes and align nicely with my position as System Medical Director. My mentor listened carefully, then asked a simple but disarming question: "What if the Fellowship changed you more than it changed the system?" This question stayed with me for several weeks. It led me to consider my imposter syndrome as not an obstacle to overcome, but a teacher that could inspire change. I began to value the Fellowship as more than a mere bullet item on a resume, to recognize it as a potential mirror.

An inward journey provided me with a framework to make sense of this awareness. Souba defines such a journey as a shift from the "doing" of leadership to the "being" of leadership. It involves questioning the narratives that we tell ourselves, surfacing the unconscious assumptions that guide our behavior, and acting in a manner consistent with our deepest values. For me, that journey required understanding why I felt the need to do so much and why, no matter how much I had accomplished, I never seemed to silence the internal voice of self-doubt. It also involved unmasking the story that I had been telling myself about my leadership role. Instead of continually trying to prove myself worthy of being a leader, I could simply be one.

The AΩA Fellowship became a laboratory for me to do this reflective work. I journaled; I charted the voices of my id, ego, and superego; and I began to see how these

voices would manifest in real time, during meetings, presentations, or decision-making. I noticed patterns: moments when fear would compel me to overprepare, when perfectionism would cause me to be tentative, or when I would hold back on mentioning a great idea because I was worried about how it would be received. As I began to identify those patterns more clearly, I started to make different choices. I started speaking up sooner. I started trusting my clinical and operational instincts more. I started to let go of the need for every idea that I shared to be perfect before mentioning. Slowly I began to feel a change not only in how I behaved, but also in who I was and who I was becoming.

As my inward journey deepened, my professional life appeared through a new lens. Achievements that once felt like items to check off a list began to feel like opportunities to learn and grow. My focus shifted from proving myself to positioning myself to have the greatest impact.

In the summer of 2025, I reached an important milestone in this process by stepping into a new leadership role as a Market Physician Executive. For the first time, my influence extended far beyond the walls of specialty care and encompassed the full scope of hospital operations. No longer am I leading a siloed program; rather, I am working to support other leaders to align medical staff priorities and collaborating with hospital presidents to better serve the communities that we call home. I have learned to slow down and listen (truly listen!) as various leaders share their concerns, taking the time necessary to understand the unique strengths and opportunities of each individual facility. As opposed to jumping headfirst into problem-solving mode, I am working to earn trust from, and create space for, each of the leaders to do their work. The Fellowship has prepared me for that kind of leadership by teaching me that genuine change comes not from swift action, but from relationships built with care and deliberation.

Even before the brief Fellowship period came to an end, I glimpsed early wins: improved communication between operations and physician leaders, closer alignment around shared priorities, and stronger cohesion around a vision for what success looks like in our organization. These outcomes may have yet to register in metrics on a dashboard, but they represent seeds of transformation regardless. This more purposeful mindset has begun to shape my neuroscience work as well: projects such as improving stroke triage or partnering with ambulance services now feel less like stand-alone activities than like parts of a larger goal—practices ensuring that every patient receives seamless, high-quality care regardless of where they enter our system.

Throughout the Fellowship period, the voice of the imposter syndrome has still been present, particularly as I step into boardrooms with seasoned executives and leaders whom I am still getting to know. But rather than letting that voice undermine me, I use it as a prompt to pause, to ground myself and lead from a place of clarity. Each interaction becomes an opportunity to practice being the leader whom I am hoping to become: collaborative, confident, and committed to the greater good.

As I look back on this Fellowship year, I can see evidence of how my identity as a leader is starting to shift. The constant voice of imposter syndrome, which for so long had narrated my life, is no longer the primary voice in my head. It still shows up from time to time, but I now recognize it for what it is: an indication to pause, recalibrate, and re-root myself in intention. The change that has mattered the most has been an internal shift. I no longer perceive leadership as a series of tests to pass or boxes to check. I instead perceive—and practice—leadership as a design challenge, as an opportunity to create systems, relationships, and culture that work best for patients, teams, and communities. In such a way, I am no longer just a guest at the table. I am now designing the table itself.

This shift has changed how I show up in every space. In executive meetings, I speak with more confidence because I know that I am in the conference room not by accident, but by intention. In meetings with hospital leaders, I focus less on directing and more on listening and aligning. In times of challenge, I have the courage to pause to consider not just the immediate solution, but the culture that I am helping to build over the long term through my decisions or actions. Over the course of my journey, I have leaned into any suggestions that prompted me to look inward, question old assumptions, and reimagine what it means to lead. This introspection has reminded me that leadership starts with being who I am, not just doing what I am doing, and that my most powerful contributions will stem not from what I can do alone, but from the conditions that I create for others in which to thrive.

Transformation is not a one-off event; it is an ongoing practice. Each day grants me the opportunity to choose courage over fear, collaboration over control, and purpose over perfectionism. This Fellowship has given

me the clarity to make such choices with intention. I now see myself as not just a neurologist, a program director, or a physician executive, but a leader capable of influencing the trajectory of hospitals and the health of entire communities. Although the journey is far from complete, I am no longer running to prove that I belong. I am building the future with confidence and care.

As I close the Fellowship year, I can see more clearly than ever that my greatest project has not been something that I could implement in a hospital or present on a dashboard. It has been the work of reimagining who I am as a leader. That inward journey has given me a new way of moving through the world. Whereas I once defined myself by the titles that I hold or the initiatives that I have led, I now define myself by the purpose that I bring into every room: to do what is right, not what is easy, and to create systems that allow others to thrive.

Looking forward, I feel a renewed sense of responsibility—not just to deliver outcomes, but to shape the culture in which I achieve those outcomes. My focus is on building trust with teams, aligning leaders around shared priorities, and strengthening the communities that our hospitals serve. My larger objective is to leave behind an organization that is both high performing and deeply human. As this Fellowship has reminded me, leadership is not a destination; it is a practice of courage, reflection, and service. The journey is not over. In fact, it feels as though it may be just beginning. However, I now walk it with more clarity, more confidence, and more conviction.

I would like to express my deepest gratitude to those who have guided and supported me throughout the AΩA Fellowship. I am profoundly thankful to Dr. Chip Souba (AΩA, University of Texas McGovern Medical School, 1978), whose work on the inward journey gave me the language and framework to reexamine my own leadership at a deeper level. I am equally grateful to Drs. Jennifer M. Hagen (AΩA, University of Nevada, Reno School of Medicine, 1998) and Jay MacGregor (AΩA, University of North Dakota School of Medicine and Health Sciences, 2010) for their mentorship, encouragement, and wisdom; together they challenged me to stretch beyond my comfort zone and embrace growth. Finally, I wish to thank the entire Fellowship faculty for creating the space, the community, and the inspiration that made my transformation as a leader possible. This Fellowship has been a gift, and I will carry its lessons with me into every conversation, every decision, and every step of my journey ahead.

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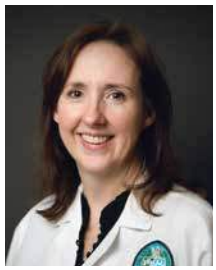
Building trust and leading change: My AΩA Fellowship leadership experience



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The opportunity to participate in the AΩA Fellow in Leadership program came at a pivotal moment in my development as a leader. I have been extremely fortunate in my career thus far, working within an academic medical environment that is open to growth and supportive of new ideas. Rarely have I heard the response "That's the way we always do it" when suggesting improvements to current practices at the Tulane School of Medicine. This openness has allowed me to hone my leadership skills through a variety of different initiatives and experiences.

In 2023, we began the arduous process of planning the shift to a new healthcare system. This move would not only include the closure of our historic primary hospital and transitioning to EPIC, it also meant integrating into a new hospital that had heretofore been wholly community-based. The predictable culture clashes began even before the move itself. In my development of the Tulane Professionalism Program, I had experienced significant skepticism at the start, but that skepticism receded so long as the larger goals remained at the forefront of our planning process with any fears that we were creating a punitive system assuaged. I set out with a plan to lean on these experiences, where I had brought a variety of stakeholders together to implement a comprehensive program.

I saw an opportunity to ease anxiety over the upcoming transition by establishing agreed-upon principles for overcoming conflict, whether existing or anticipated. Fear of change, particularly fear of potential lost revenue or authority, led to contention on many fronts. I understood that standard leadership training would likely offer little preparation for such a highly complex, matrixed problem, so I sought specialized training to guide me in this project.

Leading Organizations to Health (LOH)

I was fortunate that a trusted advisor recommended that I attend the well-established Leading Organizations to Health (LOH) program, which had recently been incorporated into the Association of American Medical Colleges (AAMC) course offerings on leadership development. The core principle of this program is to make organizations more "change-agile:"

> [S]uccessful organizational change requires a culture of engagement, collaboration, innovation and continuous improvement at all levels. Change-agile organizations create cultures that motivate their employees and bring out the best in them, offering them meaningful and challenging work and an ever-growing sense of personal capacity and competence.[1]

LOH seeks to impact health care provision by training physician-leaders to be able to shepherd organizational change. Such leaders have the skills necessary to "deal with the interpersonal and behavioral aspects of leading change that are so crucial to ... success."[1]

The six-month LOH program consisted of two in-person sessions with several sessions of virtual instruction in between. The outline of the curriculum was as follows:

Leadership from the inside out:
In-person session, Sept. 20–22, 2023

Helping groups perform:
Virtual sessions, Oct. 19, 24, and 26, 2023, and Nov. 14 and 16, 2023

Leading adaptive change:
Virtual sessions, Dec. 19 and 20, 2023, and Jan. 16, 18 and 23, 2024

Implementing and integrating the LOH Model:
In-person session, Feb. 7–9, 2024

Mentors

Because this type of organizational change requires support from above, I secured top leaders from both the Tulane School of Medicine and the Louisiana Children's Medical Center (LCMC) as mentors:

1. Lee Hamm, MD, the Dean of the Medical School and Senior Vice President of Health Sciences at Tulane, whose broad understanding of the working environment of our shared institution helped to guide me throughout.
2. Greg Feirn, the CEO of LCMC Health, who, as the senior leader of the partnering health system, helped to ensure that the many people in the LCMC system who had yet to work with me directly would have the opportunity to do so.

Description of the leadership project

Academic medical centers (AMCs) are undeniably an essential component of the United States health care system. AMCs, as the primary institutions of higher learning for the next generation of physicians, play a crucial role in innovations that improve the standard of care. Through cutting-edge research and pioneering clinical practice, AMCs provide the patients who have the most complex cases access to the most advanced medical care. AMCs designated as "centers of excellence" focus on certain diseases or conditions, often by facilitating multidisciplinary care.

A 2017 *Journal of the American Medical Association (JAMA)* publication reported that 20 percent of annual hospital mergers occur between academic institutions and non-academic health systems.[2] Strategies for successful transitions generally begin with acknowledging the strengths and weaknesses of each partner. Most crucial for success, however, are bi-directional trust and communication, combined with a shared vision for the future enterprise.

On January 1, 2023, the Tulane University School of Medicine ended its academic affiliation with the Hospital Corporation of America (HCA) and entered into a new partnership with the largest health system in the greater New Orleans area, LCMC Health. Prior to this partnership, all but one of the hospitals within the LCMC Health system had been community-based facilities. The partnership offered each entity an opportunity to take part in the creation of an academic medical center, one that would become a true destination health system. While many other AMCs had transitioned into affiliations

of various kinds with non-academic health providers, the affiliation of the Tulane School of Medicine with LCMC was unique: it included not only another, entirely separate medical school, Louisiana State University (LSU), but also a non-academic health provider that was comprised of a mix of hospital employees and independent practitioners. Together these constituents formed a melting pot of diverse backgrounds and perspectives. The expanded medical center promised to bring significant changes for all the parties involved, along with opportunities for each to create something far larger than the sum of its parts.

Successful integration would require recognition of prior, and sometimes long-standing, competitive stances, the moderation of which necessitated buy-in from the executive leadership. LCMC Health CEO Feirn expressed his commitment to excellence in leadership by prioritizing effective teamwork. The foundation for success is trust, which takes time and intention to build yet can be damaged in an instant.

My initial project proposal was focused on building (and maintaining) trust—both among the different physician groups (LSU, LCMC employed, independent and Tulane), and between the physicians and their administrative partners. A few years earlier, under the charge of Dean Hamm, I led an effort to define the Guiding Principles of Professionalism for the Tulane School of Medicine. What began in 2018 as an Executive Leadership in Academic Medicine (ELAM) institutional action plan evolved into a steering committee to establish the Guiding Principles and, ultimately, to a Tulane-wide Professionalism Program that I continue to oversee seven years later.

In a similar fashion, my proposal was to create a "steering committee" for the new medical center that would operate in a similar fashion. The committee was to have representatives from each of the identified groups, to provide input on, and guide the process of, establishing agreed-upon principles and achievable goals for the future. I sought to engage someone external to my institution to collaborate on the facilitation of this work, mindful that my strong affiliation with one group might from the start endanger the trust that I aspired to build between all groups.

The plan entailed the following steps:

1. Define the charge/purpose of the project with executive leadership
2. Work with mentors to establish the charge/purpose of the executive committee
3. Delineate the core principles for the medical center (e.g., striving for equity, transparency, integrity, excellence, or respect) through such mechanisms as surveys, focus groups, and interviews
4. Create a shared vision for the medical center based on the core principles
5. Determine parameters consistent with this vision for processes like conflict resolution, new program proposals, or changes to current policies and bylaws
6. Identify and implement effective communication strategies to engage a critical mass of each constituent group
7. Agree on measures of success for the new institution
8. Create a sustainable structure for its continuing success

My experience in ELAM reinforced the importance of starting big and then outlining the individual, smaller steps necessary to meet broader goals. I knew that I would need to delineate a more focused, achievable project for the duration of the Fellowship—the plan above being a multi-year endeavor that I had committed to completing well beyond the timeframe of the Fellowship.

It became clear early on that the amount of work involved in planning and implementing the transition far exceeded what anyone could have imagined. The leaders of both Tulane and LCMC Health aspired to take an organizational, principled approach to the transition to prevent, mitigate, or resolve any conflict that arose. However, the sheer enormity of this undertaking quickly pushed us into more of a reactive mode to provide stability at every level. We had neither the time to consider nor the capacity to apply the tools of adaptive change proactively. In retrospect, it was unlikely that we would have been successful.

Pivot #1

My first pivot was downsizing the scope of my project to one particular service line—cardiovascular care—that involved the key parties: Tulane faculty, LSU faculty, LCMC employees, and community physicians. This concentration dovetailed with a multi-year, nearly finalized project of expanding cardiothoracic (CT) surgery to high-complexity cases, including both heart and lung transplants. My proposal was to attend the system-wide meetings on that service line, not only to observe the discussions and interactions, identify the stakeholders,

and try to build a rapport with them, but also to uncover the fears of the individual groups and to better understand how those groups communicate with each other without the outside mediation of administrators. After a few attempts to attend a meeting and to get buy-in from the administrative service-line leader, I came to discover that even coming together as a group was mired in conflict due to unpredictable schedules, incompatible agendas, and so on. While I was still committed to the creation of sustainable processes that can be incorporated into everyday functions and implemented independently of any given person, I knew that I needed to regroup to find another means of doing so.

Pivot #2

Having recently completed the AAMC's Leading Organizations to Health program, I was fortunate that one of the founders offered to continue coaching me after it finished (pro bono). In conversations with her and other mentors, I came to the realization that not everyone is interested in the "how" of organizational change. I could only introduce the concepts of adaptive change to people who wanted to learn and had the time to do so. More importantly, role modeling the techniques to implement adaptive change would be the most effective way to "teach" it.

Nine months after the transition, the stress of the massive transition became undeniable. Several leaders were tired and burned out and, in retrospect, I may have been too. It was around this time that a medical emergency prevented me from attending the 2024 AΩA board meeting to present my project. After several weeks of recovery, I came back with a renewed sense of purpose and greater clarity about my goal. I decided that my project would pivot to appointing an executive leadership committee within my own department and would focus on developing a highly effective team by employing the techniques of adaptive change. LOH had taught me the methods for and principles behind such a process, and the proposed project was my opportunity to put them into action.

Beginning in the winter of 2025, my executive leadership team began meeting monthly to review our own mission, purpose, and goals. Each session was focused on one or two questions, and I utilized tools from LOH both to lead the meetings and to model the principles, hoping to make the concepts accessible and adaptable. There were three main stages:

Stage One: Leadership sessions

- January: Rules of engagement—How do we want to show up and participate to make meetings the most effective?
- February: Commitments to the department and the faculty
- March: Effective Communication—Ladder of Inference introduction (sharing examples)
- April: Department of Surgery—Why are you here at Tulane?
- May: Leadership Styles—Why do you want to be a leader?
- June: Brainstorming—Suppose that you fall asleep, wake in 2030, and arrive at work happy/content. What does that look like?
- August: Review and synthesize main themes from above—Categorize each as under our direct control, influence, or neither (let it go!). Do these themes align with our old vision/pillars? Do they align with the health system?

Stage Two: Annual department retreat

- September 27, 2025: Turning Points—This retreat focused on turning points reached a year and a half after the integration. Utilizing the DISC process, a facilitator demonstrated how different individuals receive, process, value, or otherwise react to information differently—a difference that affects, in turn, where they may be on the continuum of a turning point. It was important for the leadership team to understand the differences between the direct reports of each member.

Stage Three: Leadership 360s

- December 2025–March 2026: Facilitators will implement 360 assessments, in groups of three to four leaders. Each leader will be debriefed and we will reconvene our executive leadership group to voluntarily share things we learned about ourselves, anything that surprised us and one goal to work on.

I have not given up my goal of influencing the organization of the larger health system, but my next steps will be to apply these methods to the organizational leadership of the operating room at the main hospital, in particular. It is my hope that if the executive leadership team succeeds in meeting its overall goals, our effort will be recognized and sought as a template for

other problem-solving endeavors within the academic medical center as a whole.

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Improving quality of life for women with breast cancer

Sarah Tevis, MD

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As breast-cancer screening and treatment continue to improve, women are living increasingly longer after a diagnosis. For many of the more than 3.5 million breast-cancer survivors, sexual-health concerns impair the quality of life, yet these concerns remain poorly addressed by the health care system. As our team has shown in previous surveys on sexual health, almost all breast-cancer patients experience adverse sexual side effects, both physical and mental, from their treatment (97%), and the majority of breast-cancer survivors report low sexual desire (64%) and overall diminished sexual health (37–77%). Breast-cancer patients also report negative body image, infertility, menopausal symptoms, intimacy issues, and struggles with dating—each of which can contribute to emotional distress, anxiety, and diminished self-esteem. Sexual health, in all its complexity, continues to be an unmet need for many women living with breast cancer.

The various barriers to patient-provider communication around sexual health compound this problem. Oncology teams report challenges to incorporating sexual-health education in clinical encounters, including inadequate training or time, the prioritization of more pressing medical issues, and embarrassment or discomfort when discussing sexual health. Additionally, clinicians often assume that someone else will address sexual health with their patients or feel that addressing it themselves is not their responsibility. Those clinicians who do bring up sexual health tend to focus on the medical aspects of sexuality, such as fertility, contraception, or menopausal status, leaving out other components, physical, mental, or emotional, that are also impacted.

Innovative approaches are required to effectively educate and empower patients given the time restrictions and topic discomfort frequently associated with clinical conversations about sexual health. In response to that need, our clinic developed an educational video series for women with breast cancer to provide information about the impact of various treatments, common sexual-health side effects, mitigation strategies, and communication tools. Our video series was found to be accessible, appropriate, and feasible. However, many of our patients still lack sufficient resources for managing their persistent sexual-health symptoms, would often benefit from a physical exam to better understand those symptoms, and could use referrals to other supportive services. We therefore sought to develop and implement a sexual-health clinic to embed within our larger clinic for breast cancer.

Project aims

- To leverage a multidisciplinary team to plan and implement a sexual-health clinic
- To pilot this clinic with a schedule of one visit per week
- To conduct a process evaluation to assess the treatments and therapies that the clinic provides, the referrals given to and from the clinic, the utilization of the clinic, and the symptom improvements of patients
- To expand the clinic to a schedule of half a day per week

Planning phase

I began by engaging key leaders and decision makers in the Cancer Center, the Diane O'Connor Thompson Breast Center, and the Department of Surgery in the planning phase of the project to ensure my goals were aligned with institutional and leader goals. I also

identified two successful yet divergent programs that had already implemented sexual-health clinics for cancer patients at other institutions. From these, I learned about possible barriers to and ways of facilitating the launch of our own clinic, and about how it might function and continue to grow based on two separate models. Next, I spoke during a "lunch and learn" session in the Breast Center to educate clinic staff about sexual health for breast-cancer patients and the plans for the new clinic. I described what the clinic would do and who would be eligible for treatment in it, and provided logistical information about its opening and operations.

Finally, we engaged collaborators across the health care system including groups that may refer patients to our clinic, services we may refer patients to, and other clinicians seeing patients for sexual-health symptoms. At the same time, I created a communication plan to disseminate information about the new clinic after its opening. The plan involved various communication mechanisms, including emails, flyers, meeting announcements, and highlights on patient referrals and stories.

Clinic design

I was fortunate that one of the Advanced Practice Providers (APPs) in the Breast Center was an expert in sexual health who had previously worked in a sexual-health clinic at a large academic institution. We were able to help this APP achieve the qualification of Certified Menopause Practitioner from the Menopause Society, and she was excited to be a part of the initiative. She worked with the Breast Center leadership to ensure that the clinic would have all the supplies necessary for patient visits, including supplies for performing gynecological exams.

We developed a plan for documenting sexual-health visits as a visit type in both the schedule and electronic health records. We could afterwards track the number of sexual-health visits together with such metrics as fill rates, patient no-shows, and wait times. We also created educational materials for patients and clinicians, such as the Sexual Health Information and Navigation through Empowerment (S.H.I.N.E.) brochure. Other materials described the clinic and its APPs, what symptoms or concerns would be appropriate for patient visits, and instructions for scheduling an appointment.

Evaluation method

We used a process-evaluation model to assess the extent to which the Sexual Health Clinic services were delivered and utilized as intended, and whether the clinic met the needs of the patients who visited during the pilot year. Short-term metrics of interest included overall clinic utilization, referral sources, and visit outcomes, along with information about patients (e.g., their characteristics and primary concerns, the number of them who visited, and which of those visiting had follow-ups).

We used the data both to describe the patient population and to demonstrate to potential skeptics that the clinic addressed an unmet need.

Preliminary outcomes

During the first year of operation, the clinic conducted 60 visits with 37 unique patients. Most of the patients had referrals from clinicians (78%), but some of them had self-referred (22%). The clinic achieved high fill rates (92%) with low no-show rates (3%). Nearly 40% of patients returned for at least one follow-up visit in that time frame.

The average age of patients seen in the clinic was 53 years old, with an age range between 33 and 70 years old. While most were White (86%), additional representation came from Black/African American (5%), Hispanic/Latina (8%), and multiracial (8%) patients. A large majority of the patients were married or in partnerships (72%), but the rest of the patients, more than a quarter, were single (28%). Over half of the patients were receiving long-term endocrine-suppression therapy to prevent cancer recurrence (57%). Others were undergoing active breast-cancer treatment (19%), in treatment because they were at high risk of developing breast cancer (16%), or in survivorship (8%).

The most common concerns that patients presented reflected symptoms described in the literature; namely, vaginal dryness, dyspareunia, and loss of libido. The APP at our clinic provided thorough education and counseling on these concerns, helping to normalize patients' experiences of them and to build the trust necessary to communicate about them with patients despite the sensitivity involved. In addition, the APP offered tailored support, including referrals to other services (e.g., for pelvic-floor physical therapy or psycho-oncology), recommendations for over-the-counter treatments, and prescriptions for evidence-based medications.

We have expanded the schedule of the Sexual Health Clinic since its launch from one visit to two visits per week. We have also recruited a new faculty member trained in breast surgical oncology as well as in obstetrics

and gynecology. That hire will enable the expansion of the clinic schedule to up to two full days per week as needed. Moreover, we have ensured that we can assess patient sexual health and evaluate the impact of the clinic over time through the PROMIS Brief Sexual Function Profile v2, which we ask patients to complete before their initial and follow-up visits as appropriate.

Another form of assessment is the feedback that we have received from clinicians and staff in the Diane O'Connor Thompson Breast Center. Both report that the Sexual Health Clinic has provided a specialized, trusted referral option for sexual-health concerns, one that has allowed more attention to be devoted to other aspects of breast-cancer treatment during patient consultations. Embedding sexual-health expertise within the care setting has proved successful: normalizing conversations about sexuality and fostering a culture that recognizes sexual health as part of routine care. Moreover, the integration of dedicated specialists into the oncology team has reduced the burden on the remaining team members to maintain in-depth knowledge about sexual health.

While the Sexual Health Clinic has been very successful, we have encountered some challenges: not only lack of space to accommodate its rapid expansion, but also insufficient APPs to provide routine care as the sexual-health clinic grows together with the larger breast-cancer clinic. These challenges have prevented us from advertising the clinic as widely as we would have hoped. I am working with the Cancer Center and the hospital leadership to overcome these barriers.

A year of growth

I applied for the AΩA Fellows in Leadership program with the encouragement of two alumni of the program. They each remarked how it had transformed their leadership style, career trajectory, and interpersonal relationships. These remarks gave me high expectations for the Fellowship program, expectations that were very quickly exceeded. Indeed, even before the Fellowship began, I was blown away by the faculty mentors, the dedicated alumni, and my co-fellows in the program.

Just before the Fellowship began, I found myself in the position of applying for two new leadership roles that had unexpectedly become available. These roles had not been part of my five-year plan and, I gladly leaned into the inward journey that Dr. Wiley (Chip) Souba facilitated during the four-day retreat to kick off the leadership program. He taught us the qualities that constitute the foundation of leadership: awareness, integrity, authenticity, and commitment. This model was particularly helpful for me as I was deciding whether to pursue the new leadership opportunities, making me consider how they might change my career trajectory and contemplate if I was the right person for either job. I ultimately decided to apply for both positions, and I began serving as the Section Chief of Breast Surgical Oncology and the Co-Director of the Diane O'Connor Thompson Breast Center in November.

Throughout the year, I drew on the readings, mentorship, and self-examination that the Fellowship provided as I navigated the new leadership positions. Negotiation and the business of medicine have each been issues integral to my advocacy for the sexual-health program and the resources that it needs. What I learned from the AΩA Fellowship has given me clarity of purpose in carrying out my new roles. It has helped to remind me of those whom I serve and the core values that drive our team as we recruited two new surgeons this year. The many discussions about effective leadership during the Fellowship further guided my mentorship of the team as I encouraged all members to grow and thrive through promotions and new opportunities.

Through the leadership program, AΩA has not only supported my creation of a successful sexual-health clinic, one that has the potential to impact the thousands of breast-cancer patients whom we care for each year, but the program has also given me the self-confidence, tools, and resources that I needed to step out of my comfort zone into new leadership roles. I am extremely grateful to Drs. Jay MacGregor and Nasia Safdar, who took the time to teach me about the Fellowship program and encouraged me to apply. I am also grateful for the dedication of our mentors, Drs. Wiley (Chip) Souba, Diane Magrane, Brad Barth, Alan Robinson, Richard Byyny, and Steven Wartman, each of whom have had a profound influence on the AΩA Fellows. Their commitment has made a lasting impact on my life and career. Finally, I am grateful to the leaders at my own institution, in both the department and the larger division, whose mentorship and support have allowed me to participate in AΩA program. I look forward to continuing to engage in the AΩA community and welcoming the new 2025 AΩA Fellows into the fold!

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