Leadership Development Taskforce
Final Report to CAFM

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I. Introduction

The Council of Academic Family Medicine (CAFM) has identified a need for a better and more diverse leadership pipeline for academic family medicine. While the number of women and underrepresented minorities in the field is increasing, the number of women and minorities in senior leadership positions has not kept pace. In addition, turnover among family medicine program directors and department chairs is high. *A burning question is how do we get more people into and sustain them in leadership in academic family medicine, particularly women and minorities?*

Across the organizations represented in CAFM, we have many excellent leadership development programs and an electronic inventory which describes the various opportunities. There remains, however, a gap in how we are addressing the pipeline of future leaders in academic family medicine. *The need to fill this gap is a culture conducive to developing and sustaining leaders of diverse backgrounds which derives from personal connections, nurturing, mentoring and career navigation. We must attend to key factors, other than programmatic, which impact the pathway to leadership in academic family medicine: environment, career navigation, mentoring, promoting equity and identifying and eliminating bias – both conscious and unconscious.*

In 2016, CAFM established a Leadership Development Task Force to develop a plan to explore what we know about leadership development for academic family medicine and to address gaps.

This report is being provided to CAFM as the final report of this appointed Taskforce.

II. Taskforce Composition

The composition of this taskforce was deliberately and intentionally formed. We set out to form a leadership task force consisting of members who represent leadership in medical schools, departments, residency programs, and “emerging” leaders (stellar residents destined for leadership), and also who are ethnically diverse. Given the impetus for the focus coming from ADFM (ADFM’s Leadership Development Committee) and STFM, CAFM agreed that ADFM and STFM would identify leaders to lead (ADFM) and co-lead (STFM) the work of the Taskforce. Jeannette South-Paul (ADFM) and Kristen Goodell (STFM) were asked by ADFM and STFM, respectively, to serve in these critical roles. Joining them early on in the work were family medicine faculty representing a variety of ethnic/gender backgrounds as well as a variety of current leadership roles and areas of expertise. An important constituent on the taskforce not identified at the start, was that of a young, truly emerging, leader in academic family medicine. We were fortunate to identify two individuals representing ADFM in the AAMC’s Organization of Resident Representatives to provide this important voice to the work. The taskforce met roughly every 2-3 months by teleconference between December 2016 and December 2017, with occasional sub-sets of members meeting in person at meetings where they were fortunate to find time to meet informally. The current composition of the Taskforce is listed below.
III. Work of the Taskforce

We defined Our Main Question:

- How do we identify and sustain more people, particularly women and under-represented minorities (URMs), through a leadership pathway in academic family medicine?

- We defined the Need within the context of the four CAFM Organizations’ existing leadership development programming as depicted below

  - **ADFM Programming in Existence** for Department Chairs and Administrators, Aspiring Department Chairs, and Senior Leaders
  - **AFMRD Programming in Existence** for Program Directors, Associate Program Directors and aspiring Program Directors
  - **STFM Programming in Existence** for emerging leaders, teams leading change, behavioral science fellows, faculty, residents and students
  - **NAPCRG Programming in Existence** for Research Directors, research faculty, PBRN Leaders, residents, students

We clarified Our Charge:

- Examine the current landscape of leadership development and report to CAFM by August 2017, focusing on what we don’t know about leadership development.
Define a mechanism conducive to a broader diversity of individuals seeking and sustaining leadership careers in family medicine.

Activities of the Taskforce:

1. Reviewed and catalogued leadership training opportunities that are available through our various family medicine organizations: (http://www.stfm.org/CareerDevelopment/FMLeadershipDevelopmentOpportunities)

2. Developed an excel spreadsheet of leadership development opportunities outside of our family medicine organizations which are relevant for family medicine faculty. This excel spreadsheet accompanies this final report of the taskforce.

3. Reviewed data pertaining to current and recent-past leaders – who are they, how did they get there, how long do they stay – and identified gaps in available information. Developed recommendations for what data we need to collect going forward, and suggestions for how to collect it. These suggestions focus on using CERA as a data collection mechanism and focusing initially on four constituent groups represented across the four CAFM Organizations (Chairs, residency Program Directors, Clerkship Directors, Research Directors) so that we can establish baseline metrics.

4. Reviewed and discussed frameworks and individual experiences in leadership development in order to get a sense not just of the programs, but of the pathways people follow as they take on leadership roles.

5. Developed tools for articulating a pathway for leadership development and mentoring guide for use by individual faculty and their mentors. These two tools accompany this final report of the Taskforce:
   a. Leadership Development (pathways) and Diversity in Academic Family Medicine
   b. Role of Mentors for Leadership Development in Academic Family Medicine

6. Identified additional needs from our would-be leaders, and from our organizations that should be addressed to meet our goal.

IV. Findings of the Taskforce

1. Many leadership development training programs across our organizations, targeted towards multiple career stages already exist. These can be found at: http://www.stfm.org/CareerDevelopment/FMLeadershipDevelopmentOpportunities

   We do not see a need for further program development, but we do need to make sure that everyone is aware of these opportunities. People tend to find out about them from attending meetings, reading organizational literature/websites, or by recommendation from a colleague or mentor. We think we might be missing people. We need to brainstorm additional ways to steer people towards these opportunities. Can we work with residency
programs, departments, state academies, or other groups to reach a wider audience?

2. Data on who are assuming leadership roles and how long they stay in those roles is scanty and inconsistent across organizations and role types. We often have snapshots for a year here and there but no consistent tracking mechanism.

3. We identified and modified several “pathways” to leadership, and collected feedback on our proposed pathways from our own task force and from STFM members at the 2017 Spring STFM conference. The tools we developed may provide an overall framework for thinking about leadership development, but don’t have specifics and miss individual nuance.

4. There are MANY opportunities for family physicians to be leaders – in our organizations and institutions, in academia, in government at all levels, in the clinical realm. All of these are valuable and we want all of them to involve a diverse group of well-supported family physicians who can be effective, long-term leaders. That said, we believe we should focus our initial efforts on academic family medicine, and specifically on four specific leadership roles – clerkship directors/MSE directors, residency directors, department chairs, and research directors. These groups are trackable over time through CERA, are core constituents of our professional organizations (hence we have access to them) and hence make a practical group with whom to work initially. Once we have identified successful strategies for cultivating leaders, we can spread the work to other roles (clinic and hospital leadership, government, state academy/national academy leadership, etc.)

Additional areas of inquiry identified by the Taskforce are:

- How can existing leaders identify, support, and encourage emerging ones? Should we provide mentorship training with that as a goal?

- What are the cultural factors that encourage a diverse group of people to be interested in leadership, and to strive for various leadership roles? Is there a “closed” club that we aren’t aware of? Are there cultural norms (around work expectations, role models, etc.) that are inhibiting people?

V. Immediate Recommendations for CAFM Organizations to Implement

1. Target leadership development activities within each CAFM organization with our four constituent groups (Chairs, PDs, Med Stu Education Directors, Research Directors) to ensure that the available leadership development resources are being tapped and that the tools the Taskforce has developed are widely available. The tools are intended to be improved over time but are being presented with this Final Report in a form the Taskforce believes will enhance organizational work in this area.

A key question for each CAFM organization to ask of themselves is how will these targeted leadership development efforts be different from what we are already doing. All of the CAFM organizations are largely about leadership development – how will the recommendations of this Taskforce change what they are currently doing?
2. Ensure that our respective CAFM websites/communication vehicles have the information and resources clearly accessible for our constituents to access and readily use.

A key question for the CAFM organizations is to determine where the materials should be housed and how each CAFM organization can provide visible, user-friendly links to one repository where all of the resources live.

The Taskforce tools will link to the current leadership development opportunities in family medicine website
http://www.stfm.org/CareerDevelopment/FMLeadershipDevelopmentOpportunities in a way which enables use by a mentor and mentee. Other development opportunities outside family medicine which the Taskforce has assembled via an Excel spreadsheet will also be accessible at this website.

3. Ensure that each CAFM organization address issues of diversity and inclusion and unconscious bias into their respective leadership development training activities;

Below is a preliminary list of resources which the Taskforce has identified as a place to start for CAFM organizations in this area.

   a. Susan Naimark, has consulted with many organizations; generally communities/community organizations, non-profits, and schools/school systems to decrease bias among the people in those organizations. It seems as though she designs custom interventions: http://naimark.org/

   b. AAMC: https://www.aamc.org/initiatives/diversity/322996/labelearningonunconsciousbias.html

   c. The AAMC also produced this publication on Unconscious bias and how it impacts diversity: https://members.aamc.org/eweb/upload/Unconscious_Bias.pdf

   d. Systematic review from 2016 from BioMed Central: https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-017-0179-8

   e. Web-based programs offered by CookRoss, who worked with the AAMC and the AMA. https://cookross.com/webinars/ They also offer a four-day in-person course for thousands of dollars.

   f. Implicit Assumptions Test https://implicit.harvard.edu/ - promotes dialogue following completion of the IAT.

4. Engage state AFPs to explicitly reach out to younger people to pull into our academic family medicine leadership pipeline

CAFM should follow up with the Working party and our AAFP liaison to CAFM about mechanisms of engaging our state AFPs in identifying young leaders for the academic family medicine leadership pipeline. What we learned is that often the “entry” point for medical
students into a career in academic family medicine is through the state academies. We, therefore, need to alert the State academies to this and to develop ways of identifying and nurturing promising young academicians over time as they navigate their way through medical school and into residency training. They do not necessarily find an “academic home” unless they find STFM or another academic organization. There are other groups such as Community Preceptors, residents/students on our Family Medicine organization boards, and Pisacano scholars to engage in this outreach as well.

5. **Track our current state of minority and underrepresented leaders within the four constituent groups in academic family medicine**

It is critical that CAFM begin to measure at baseline and then track over time the emergence of women and minority faculty leaders into the four constituent roles (Chairs, PDs, Clerkship Directors and Research Directors) The CAFM Education Research Alliance (CERA) conducts annual surveys of the constituent groups and within each survey data are collected regarding demographic/ethnic questions so that these variables can be tracked in aggregate over time. Specific demographic questions have been recommended by this Taskforce to include as part of the annual CERA data collection effort with Chairs, PDs, and Clerkship Directors. CAFM will need to recommend how to collect similar data from Research Directors as CERA does not survey Research Directors.

VI. **Longer Term Recommendations for CAFM’s Consideration/Commitment**

1. **Each CAFM organization commit to incorporating leadership training consistent with these recommendations over time through their annual meetings** –

   This would need to be different from what we already do – something like a track or pathway which targets the leaders we are intending to produce. If people come to one annual meeting, what do we do in the meantime? Can we implement mechanisms whereby we can follow individuals longitudinally perhaps through targeted mentorship?

   We have identified a clear need to find young leaders through our state AFPs and to help guide them intentionally toward academic family medicine careers. This is important, but longitudinally, how do we then follow them through mid-career phases? It is important that we do not lose our future academic family medicine leaders along the way. This is especially critical during that mid-career phase where choices they make directly impact how they continue to evolve (or not) as academic family medicine leaders.

2. **Offer Mentorship Training.**

   Training is essential for successful mentoring. This might relate to the first recommendation with regard to what we include in our respective annual meetings in the way of training. We might have mentors complete a training workshop – with pre and post analysis.

3. **Commit to tracking use and evolution of the CAFM Tools.**

   After we determine where the two CAFM Tools will be placed, commit to monitoring the use of the tools. When someone downloads them, ensure that we can obtain their name, role, intended use so that we can track use of the tools and eventually follow up to find out how they were used.
One year later consider how tools should be revised.

4. **Focus on Changing the Culture:**

CAFM needs to consider how we can help change the culture of leadership advancement within our academic institutions. Other examples of leadership development in today’s environment illustrate the importance of personal relationships, sponsorship and mentorship over time with policy change. Accompanying this final report is a report on ‘Breaking down the Barriers for Women Physicians of Color’. This report and a program of the Texas Academy of Family Physicians, the TAFP Leadership Experience [http://www.tafp.org/membership/fmle](http://www.tafp.org/membership/fmle) offer innovative thoughts about developing leaders longitudinally for the future of academic family medicine.

One immediate step toward understanding how to create culture change would be to identify Departments, residency programs and institutions where explicit efforts are being made to change the culture. Within the organizations of CAFM, we can work now to identify best practices on changing the culture and on disseminating them through our meetings and communication channels. This would be one tangible step toward moving in the direction of broader culture change.

On a more ambitious level, we can consider a joint longitudinal CAFM effort (with the following elements) to follow cohorts of leaders within our constituent groups to understand the context and cultural implications:

- Advisory group to plan the curriculum representing each organization to ensure relevance to members
- Identified goals for completion of entire cycle of offerings
- Defined cohort of potential leaders to follow longitudinally
- Assigned mentors for each potential/young leader
- Leadership workshops at annual meetings of each CAFM partner + one additional meeting annually
- Endeavor to target workshops already being offered
- Suggested reading list + longitudinal project that benefits home organization
- Pre- and post-assessment to document achievement of goals, impact of contextual and cultural factors at play