Some of these are listed below:
• In April 2022, the free URM Leadership Pathways in Academic Medicine online course was launched. It features interactive content with video recordings from experienced faculty and assignments to build leadership skills and help identify opportunities for career advancement.
• The URM Journey to Academic Medicine (URM JAM) podcast has now released 24 episodes on topics relevant to URM students and residents considering a career in academic medicine. The podcast has been downloaded more than 2,000 times.
• The Mentoring Underrepresented Faculty to Academic Excellence toolkit for creating a mentorship program at your institution. A facilitator's guide & 4 recorded webinars train mentors to understand and appropriately address the unique needs of URM/BIPOC faculty in academic settings.
• The URM Scholarship webinar series, designed to provide accessible training for early career learners and faculty to find research mentors and produce scholarly research.

Ongoing Programing

Some of the outcomes of the URM Initiative include career development and mentorship programs that are more time- and resource-intensive, while still being extremely high yield. We reach a smaller, more targeted audience with mentorship dyads, fellowship programs, coaching, and conference workshops, but recognize that these personal connections are powerful. These include:
• The STFM URiM Mentorship program, which provides early-career faculty with longitudinal mentorship with mentor-mentee dyads. The focus is on addressing barriers unique to URM faculty, giving tips on overcoming those barriers, and helping guide faculty toward careers that are rewarding and fulfilling. More than 60 mentees have been matched over 3 years of the program.
• The Leadership through Scholarship Fellowship, which focuses on developing scholarly writing skills for URM faculty, is now on its 3rd fellowship cohort. A prolific number of papers have been published as an outcome of this fellowship.
• The URiFM scholarship workgroup is presenting workshops and sessions at the Conference on Medical Student Education and the Annual Spring Conference in collaboration with the editors of PRiMER.
• Members of the URM Initiative have submitted multiple presentations for 2023 on URM leadership and barriers to academic careers for STFM Annual, AAFP National Conference for Residents and Students, and more.

Dissemination and Next Steps

The entire URM Initiative will be evaluated in 2023 based on progress in achieving the following 2 aims:
1. Increase the percentage of URM family medicine faculty
2. Increase the number of solutions-focused, adaptable family-medicine URM leaders within and across our health care system

Throughout the 3 years of the Initiative, each of the 4 work groups have worked to measure the success of individual components/resources within the broader goals for each focus area. The work groups have used pre- and post-measurement tools where possible, monitored usage of resources and attendance of workshops, and surveyed learners and faculty to identify successful interventions. Additional evaluation will be conducted on overall metrics of success for the aims of the initiative.

As the 3 years of the URM Initiative draws to a close, the members of the 4 work groups and the URM Oversight Committee have much to celebrate. Significant accomplishments have been achieved in building lasting resources and innovative ongoing programming. The work will continue, yet we are grateful to pause and recognize what has been achieved.

Emily Walters

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

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A CALL TO LEADERSHIP

Academic family medicine faces an impending leadership crisis,[1-4] embodied by a deficit of available applicants for vacant chair positions nationwide. The most recent data from the Association of Departments of Family Medicine (ADFM) that includes most allopathic departments of family medicine in the United States, and a number of osteopathic departments, large academic medical center departments, and some Canadian departments of family medicine, suggests that about 25% of family medicine chair positions (42 of 158 member departments) remained unfilled as of summer 2022.[5] Compounding this, a 2021 Association of American Medical Colleges (AAMC) survey documented that department chairs are 10 years older compared with 1977,[6] and with the average age of clinical department chairs being 59.4 years, potential retirements of an aging workforce may further exacerbate this shortage.[7] In a 2021 ADFM survey of the family medicine chairs, the majority (85%, 56/66 respondents) reported that they did not seek the chair role in their career before they became the chair.[8] This prompted the ADFM's Leadership Development Committee to study and address this leadership vacuum in family medicine.

Leadership and the Role of the Chair

The chair role defines strategy, shapes the culture, develops people, and promotes a shared vision that is greater than the sum of its parts.[9] As full-time leaders, chairs must leverage their strengths, while employing faculty with complementary

expertise in research, education, and administration to forge a balanced team. Chairs prioritize a comprehensive mission and work to effectively manage inevitable conflicts between the academic and clinical missions.[10]

The role of the department chair has changed in recent decades,[11-13] and most department chairs felt "ill prepared to succeed in this difficult leadership position."[14-15] However, as Souba wrote in 2004, "Leadership is created in and emerges from the relational space that connects people—accordingly, leadership development involves building high-quality connections between people."[16] Building relationships represents a core family medicine skill that can be utilized to cultivate a leadership workforce—and a large pool of mid-career faculty and clinically practicing family physicians often have the foundational skills necessary for success. Reorienting the perception of academic leadership from one of hardship to a more enticing, more functional, and rewarding career move is imperative.

However, significant barriers exist for that goal. These include a shortage of primary care physicians, difficulty in recruiting, retaining, and promoting primary care faculty,[17] attrition of faculty, a challenging work-life balance, and the costs of recruitment.[18,21] A 2015 survey of internal medicine chairs documented that leadership searches took 7 to 9 months with a shortage of qualified candidates being the key barrier.[22] One may assume the combination of the COVID-19 pandemic, senior leadership retirement, burnout, and unaddressed systemic bias and racism serves only to deepen the leadership void. Women and underrepresented in medicine (URiM) individuals in particular may underestimate their leadership potential, despite high achievements.[23] Improved mentorship and sponsorship for these groups will prove essential to overcoming this barrier within the pathways that exist toward leadership roles.[24-25]

The Council for Academic Family Medicine (CAFM) Leadership Development Task Force identified 4 dominant leadership domains that exist in academic medicine. These pathways include clinical, undergraduate and graduate medical education, and research.[26] Experience and skills development may also be gained by local and national committee work, advocacy, quality improvement, community service, and other roles that reflect critical thinking and building relationships to achieve goals.[27] In a 25-year longitudinal study of science, technology, engineering, and mathematics (STEM) graduate students, those that advanced to higher leadership positions (ie, chairs, CEOs, etc.) possessed greater levels of interpersonal presence, finished tasks independently, and favored career growth choices over other activities.[28] Women and URiM individuals also have a greater diversity of outside interests that lend themselves to leadership roles.[29] Recognizing qualities such as these in medical students and residents, in particular, may foster potential and interest in future leadership roles.

A Call to Leadership

As noted earlier, most family medicine department chairs did not purposefully pursue that leadership role but accepted the role based on their acquired skills, experience, and relationships. Even ambitious leaders face challenges and barriers that may impede successful leadership transitions. Insufficient training, clinical demands, organizational conflict, and confounding culture challenge anyone in the chair role. Voices calling for continued leadership training, by whatever pathway, continue to grow, to inspire those to seek out the role as an academic medicine leader.[30-33]

This committee asks the community of academic family medicine to embrace a leadership identity, share rewarding experiences of leadership and encourage others in our networks to embark on a leadership path. Regardless of someone's starting point, when considering leadership positions, reviewing the position description for responsibilities and time commitments should provide insight into the demands, complexity, and needs of the role. We have created core leadership competencies for academic leaders to assist in assessing one's strengths and developmental needs for higher leadership.[34]

The demand for leadership within our discipline is not unlike society's need at our beginnings in 1969. Then, as now, challenges exist requiring a response. Navigating a global pandemic, widening disparities in health, and climate change, with fewer US medical student graduates applying to family medicine residencies, demands leadership. Candidates from a broad range of backgrounds and skills within family medicine are needed to fill the department chair vacancies and other leadership positions within our discipline. A variety of pathways exist that capitalize on the strengths of family medicine—relationship building, empathy, critical thinking, and attunement to context and systems—to serve in leadership roles. Please apply and encourage others to join in the leadership journey.

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THE PROGRAM DIRECTOR AND PROGRAM COORDINATOR RELATIONSHIP

"Program directors and coordinators have tremendous responsibility for developing, overseeing, and improving residency or fellowship programs, implementing changes based on the current accreditation requirements, and preparing for accreditation site visits and review by the ACGME Review Committees."[1] This statement by the Accreditation Council for Graduate Medical Education (ACGME) lays out one of the most important relationships in a residency program—the director and coordinator. While each role has its distinct responsibility and oversight, this relationship can truly reach its potential when thought of as a dyad.

A dyad relationship can be defined in health care as "the pairing of a physician with a non-physician administrator for strategic and operational oversight."[2] In most dyad relationships in health care, the physician leader will typically assume responsibility for clinical work and vision while the administrative leader will operationalize the vision. Their roles touch every corner of the program and set the cultural tone for all program personnel.

In the infancy of a program director and program coordinator dyad relationship, a solid foundation must be established. Each dyad partner must clearly understand his or her key function and roles, in addition to that of their partner. Each program should define these. Dyad partners must have