The University of Michigan Department of Urology
3875 Taubman Center, 1500 E. Medical Center Drive, SPC 5330, Ann Arbor, Michigan 48109-5330
Academic Office: (734) 232-4943 FAX: (734) 936-8037 www.medicine.umich.edu/dept/urology http://matulathoughts.org/

What's New February 12, 2016

John Park

Urology Department Faculty and Staff

3 Items, 10 Minutes

In this, my personal "What's new," I wanted spend a little bit of time and reflect on the lessons that I learned during my first 3-year term as the Mott Surgeon-in-Chief. The feeling I remember when I was first appointed was that I really had no idea what I was supposed to do. There was no coach. I had no playbook. The first 6 months were overwhelming. The UMHS Medical Staff Bylaws Section 2.5 describes the role, responsibility, and appointment/renewal process of the Mott Surgeon-in-Chief, but at first they did not make much practical sense to me. Last year, I underwent a formal review conducted by the Executive Director, **Paul King**, and 40+ health system leaders, division chiefs and department chairs provided feedback on what I did well and what I need to do better. Many were encouraging, but some were not. Although painful, evaluations were very useful. It gave me the clarity of where to focus my attention for my second and final term. The list of Surgeon-in-Chief tasks is long, but I summarized them simply as a

call to be a leader, to align the interests and concerns of every staff persons – physicians, nurses, clerical team, technicians, child life, schedulers, social workers and many others – who consider Mott OR their professional "home," so that patients receive the best care possible and the staff find a great joy in their daily work. These lessons are what I learned during my first term.

1. **Communication is by far the most important – and difficult – task.** What we would consider as the "Mott OR community" is rather large; I counted a list of at least 500 people that included surgeons/medical proceduralists, anesthesiologists (faculty and CRNA), nurses and technicians (OR and PACU), medical assistants, CSPD staff, PRC, schedulers, clerical team (including check-in and family waiting), child life team, social workers, custodians, ambassadors/volunteers and various trainees (residents/fellows). Although we all aspired toward the same goal of delivering the best and the most compassionate care, our perspectives were sometimes narrow and disconnected. ***We tended to behave more like a collection of tribes rather than a cohesive team.*** I felt that this dilemma was caused by lack of effective communication and understanding. Hard work and best-

intentioned plans often seemed to result in a paradoxically poor outcome, primarily because of bad communication. Improving communication therefore has been my obsession.

2. **We needed to become an organization that embraced – and even welcomed – the change.** Since we moved into the new hospital, so much has changed. We immediately went from 11 operating rooms to 20 (with a capability to go to 22) that were spread over the length of a football field. The CSPD and sterile supply used to be just around the corner, but in the new Mott, instrument processing and OR were separated by two floors and case cart system. The radiology used to be just across the hallway in the old Mott, but in the new building, we were now separated on completely different floors, creating communication and patient care issues. Even the procedures that did not belong to the OR previously – medical services (such as gastroenterology) and interventional radiology – were now integrated into the OR and were expected to function like all other surgical services. The opening of intraoperative MR-OR, along with migration of adult surgical patients, created a major change in our primarily children's surgical area. And we continued to incorporate complex, high medical acuity adult ophthalmology patients to receive surgery at Mott. Ultimately, this would lead to a complete reshuffling of the PACU staff for adult and pediatric care. All these changes came fast and furious. As much as we wished for the bygone days of how things used to be, the new reality was that we would face changes continuously. Managing the status quo was no longer an option; I, as the Surgeon-in-Chief, needed to help all our teams to navigate through these changes, preserve our core purpose in spite of them, and somehow come out for the better.
3. **Trust is hard to build, easy to break, and even harder to rebuild.** When faced with so many changes and communication challenges, the biggest threat was the loss of trust in one

another. When trust is broken, one who suffers is the most important person in all of this – the patient. As the Surgeon-in-Chief, the most important task for me was to build up and preserve the "bank account" of trust – between staff, between units, between divisions, between management and frontline workers, between patients and us.

According to James Kouzes and Barry Posner, leadership is defined as **"the art of mobilizing others to want to struggle for shared aspiration."** I liked this definition very much, since I have found that many aspects of this statement aptly applied to the role of Surgeon-in-Chief. Kouzes and Posner further describe the leader's tasks, to which I tried to adapt my approach in the following way:

1. *Challenge the process* – by experimenting, taking risks, learning from mistakes, questioning the status quo, looking for something to fix, giving people a chance to fix it.
2. *Inspire a shared vision* – by finding common ground, speaking from the heart, listening first and often.
3. *Enable others to act* – by always saying "we," focusing on gains rather than losses, going first to people rather than having them come to me, developing competency and confidence in others, teaching and educating, making heroes of others, enlarging people's sphere of influence, recognizing others' efforts.
4. *Model the way* – by always taking a look at myself in the mirror, being generous, setting an example for others to see and follow, getting to know other people.
5. *Encourage the heart* – by celebrating the "team," by having "family" events to connect people with each other, making Mott OR feel smaller, being the Encourager-in-Chief.

A good way to summarize my last 3 years would be to quote one of the well-read leadership authors, **Pastor Andy Stanley**, *"Blessed is the man who gets the opportunity to devote his life to something bigger than himself and who finds himself surrounded by friends who share his passion."* In this way I have been disproportionately blessed. In looking back, I have made many mistakes, but the impact of these mishaps was minimized by the hard work of the gracious leadership team that surrounded me. I still consider being a pediatric urologist and urology faculty my primary identity, but being able to serve the team of people with whom I work alongside as their servant leader has been one of the most surprising and unexpected joys. Although none of the staff members were required to follow my orders (no one reported to me, and I managed no budget), when I was able to help all these disparate units of people go toward a common goal and produce results, it felt magical. At times, working in leadership feels much like working in a garden. There is always ground to till, trees to prune and weeds to pull. And no matter how much you do today, there will be more work to do tomorrow. But any gardener who loves to garden will tell you that he does not consider such work with a sense of frustration. Rather, seeing a beautiful garden full of flowers and well-trimmed bushes at the end of hard working day, he comes back to work again and again with a sense of joy.