Michigan Surgery Sessions: MWSC – Advancing Diversity, Equity, and Inclusion in Healthcare

Speakers: Dawn Coleman, MD; Zara Cooper, MD, MSc; Jennifer Waljee, MD, MPH, MS

Narrator:

Welcome to Michigan surgery sessions. Where we discuss the latest in clinical care, education, and surgery culture with faculty, residents, and medical students.

Dr. Jennifer Waljee:

Welcome everyone. We are back with the Michigan Women's Surgical Collaborative, at the Michigan Medicine Department of Surgery in Ann Arbor. I am Dr. Jennifer Waljee and I'm joined today by Dr. Dawn Coleman. And we are focusing on the role of healthcare systems to foster and advance workplace diversity, equity, and inclusion.

Our guest today is Dr. Zara Cooper. Dr. Cooper is an Acute Care Surgeon, intensivist and trauma surgeon at Brigham and Women's Hospital. She's also a health services researcher with deep expertise in the intersection of hospice and palliative medicine and surgical care, and is the director and founder of the Center for Geriatric Surgery at Brigham and Women's. She also serves as the Kessler Director for the center for surgery and public health. And she also serves as the chair of the executive advisory council for diversity equity and inclusion at Brigham health. Which leads system-wide initiatives to improve equitable care for patients and employees. We are really honored to have her join us today. I'll start with the first question. Fostering workforce diversity equity and inclusion has been recognized as a top priority for many organizations across the United States. Why is it particularly important in healthcare systems?

Dr. Zara Cooper:

First of all, I just want to say thank you for having me. I think it's great that you all are doing this podcast. And as usual, the University of Michigan Department of Surgery is leading away in a lot of this work. And a lot of the things that I've brought into this position, I've actually learned from watching you all. So, it's great to have this conversation, and I hope that we can learn together. I think there are two critical pieces here. The first is that if we want our healthcare systems to be truly patient centered, then we know that marginalized patients receive better care when they're treated by physicians, who look like them and share common experiences. And so, it's really important that if we're going to truly eliminate disparities on healthcare, that we have not only a variety of clinicians with respect to gender, race, ethnicity, socioeconomic status, geography, but also that we have research that reflects the concerns of the population at large.

And so, I think that one of the challenges for us is that we've been looking through this very, quite frankly, majority white male lens in how we do things, how we approach our healthcare systems, and how we approach patient care, how we approach research. That's really blinded us to the richness that the diverse experiences of our entire populous have to offer. I think the other key thing here, and something that's really been struck home to me as I've gone out in my role and spoken to members of

our community and our neighborhoods, about how we can be more deeply engaged in the healthcare system is that healthcare is the largest employer in the country. That in fact, in particularly for academic anchor institutions, we exert a tremendous amount of influence, not only because of how we care for patients, but also because we are often an economic engine.

And when I think about MGB, which is Mass General Brigham, which is partners healthcare and the partnership between Mass General and Brigham Women's Hospital, and number of other hospitals in the area, we are the largest employer in the state. Everybody knows somebody who works for us. And so, as we think about how we're going to improve social justice, eliminate income inequality, we have a huge role in that as an employer. And as physicians, I think we have a tremendous amount influence to exert. And so, I think those are just two reasons why we need to do this, aside from the fact that it's the right thing to do. And also, because I really believe that if anything, the events of the last five years have really shown us is that, quite frankly we're declining, as a society we're not doing things right and I think we need to either get with the program or step aside.

Dr. Dawn Coleman:

As a physician who's not necessarily in a leadership position, thinking about the healthcare system, or kind of smaller branches within as employers, I think that's really nuanced and important. You're going to have an impact in a local level I presume, by thinking about who you are recruiting, who you're retaining, how you're employing. Can you speak to that local impact I guess with your experience in Boston?

Dr. Zara Cooper:

The challenge that is now, is that there is a need, and I think it's really coming from the generation below us. It's our trainees who are pushing us to be genuine and authentic in this. They don't want window dressing. They don't want one minority leader in the C-suite, in HR, they don't want one resident. They want to be in a truly inclusive environment. And it's not just coming from under-represented minorities. It's also coming from majority individuals who have grown up in medical schools, and in colleges that are focused on social justice and inclusion and equity. I mean, this is language that has been baked into what they have known as their experience coming up. It's just new to us because we've been in these very kind of state antiquated systems. Now, I don't want to speak for all of academic medicine.

And certainly, I think that Harvard is not known for being at the forefront of progressiveness, but I think that we're really being pushed by the generations below us to do this well and to do this right. And so, what does that mean? What that means is that, as a black woman in my healthcare system I can see that maybe I can climb the ladder, but that my hospital system still looks like Apartheid South Africa where the majority of the folks in environmental services and food service are color, and the majority of the physicians are not. Or physicians are not proportionately represented. And I see an environment where my colleagues, wherever they may be in their role in healthcare don't necessarily feel like they are included. They don't necessarily feel like they can thrive. They don't necessarily feel like they can be engaged, that they have the same opportunities.

Ultimately this is about opportunity and power. And that leaves a bad taste in my mouth. That makes me feel like I have less of a sense of belonging than others. And our patients know that. Our patients feel that way. When they walk in the door and they don't see themselves, they feel that way. And so, I think that part of the challenge here for us, is to actually think long and hard about what are the factors that are contributing to this lack of inclusivity, and this lack of diversity, and how can we start to dismantle them. And so, what I've been challenged by our community leaders is, are you doing your

internal work? It's not enough that you're coming to us and saying, how can we be a better neighbor? And should we set up a special hotline for folks in the community to get care first or something like that. We want to know that internally you're doing your work, and that this is a genuine change in your organization.

Dr. Dawn Coleman:

So, could you share with us some of your experiences within your own organization, regarding awareness and recognition of lags or gaps in workforce diversity, equity, and inclusion? And then the strategies that you've used to close these gaps?

Dr. Zara Cooper:

We are making progress. I think we're still at the exploration and identification phase, to be honest with you. I think we're still trying to unearth what the issues are. And those conversations are complicated. And I think one of the challenges for all of us who are participating in this work, which should be all of us. Is that this is truly a marathon and not a sprint. Even if I compare it to health services research, it's going to be slower. It's not like we're going to do kind of the administrative data, and then we'll do some qualitative research, and then we'll identify the targets for intervention, and then we'll do pilot studies, and then we'll do something broader. I mean, all of that is true, but in the midst of all that comes some really difficult conversations. Really difficult and really important conversations that take time, that are nuanced, where you have to create a culture of safety for those topics to even be broached.

And so, I think looking at the long game where we are, is that we are dealing with awareness and recognition. Our human resources department has really focused on the Brigham experience, which includes the experience for patients and employees, stood up diversity leadership, but also stood up ONCOS, which is, I can't remember what it stands for. But basically, it's an internal ombuds program to help mediate conflict. And a lot of the conflict we've identified has racial components to it, has gender-based components to it, whether it's between nurses and residents and the OR, whether it's between administrative supervisors and others who feel like they are being unduly watched or disciplined. And so, recognizing a lot of the cultural context that's to that. The other thing is where they've been incredibly helpful is, looking at our exit interviews and our strategies, and actually taking data on what our turnover is.

It's not just about recruitment. It's also about retention. And so, if we gain five but we lose five, what does that mean? And why are they leaving, and really trying to then identify what are the underlying problems, so that we can close those gaps. So, I think we're still in the awareness recognition phase, primarily. I think some of the stress strategies that we've used to close the gaps is, we have like many of their organizations, paid a lot of attention to how we interview, and changing our interviewing strategies, our interviewing techniques, we've been much more aggressive I should say about increasing our inclusion criteria. So, not emphasizing so much on board scores, not emphasizing so much on other metrics that we know have inherent bias. And really don't necessarily indicate how effective a resident or a trainee may be. Recruiting from institutions where we may not have looked in the past.

And so, right now in internal medicine, for example, I think our current resident class is 30% UIM because we we've done a lot of that. And in surgery, we also had an increase. So, I think we're all kind of learning together. And I think all of our organizations are going at a similar pace. I will say in a lot of ways, University of Michigan, and others as public institutions, are also very far ahead of us because your public institutions, we're very much a private institution. And we actually have a different relationship with our medical school than many hospitals do. And so, I think in terms of this, that's actually set us back as well.

Dr. Dawn Coleman:

Thanks for that. I want to just follow up again on one of the points you made earlier. Especially in the space of, kind of checking yourself internally, when you were speaking earlier in your response. And you referenced the equivalent of an internal ombudsman to help mediate, maybe conflict and thinking about some of the challenges and those difficult conversations that you were referencing. I wonder as a leader, locally, how you specifically are helping to enable those difficult conversations? And what you're doing to perhaps optimize that kind of culture, or kind of space of psychological safety so people can have those conversations? Because I personally feel that that can be a very real challenge depending on your audience, and where they're at in the whole scope of this marathon that you're talking us through.

Dr. Zara Cooper:

Let's talk about women in surgery, and I'm going to make some broad generalizations here. And I hope that there won't be rotten tomatoes thrown at me, but I'm going to make broad generalizations just thinking about how things have changed in the time that I've been in surgery. And now it's been 20 years. The first woman that I saw who were senior surgeons, they weren't married, they didn't have kids, and surgery was their focus. And that was the way to be a woman in surgery. Then when I was coming along there were women who had kids, but you had these legendary stories about how their water broke while they were in the operating room and they still continued operating, or they had a fully catheter in place while, because they didn't want to take breaks. And that was what it meant to be a woman in surgery. Now I'm so excited to be part of this dialogue that Erica Rangel, who's one of mentees is leading about the price of that.

We know that women in surgery have lower fertility rates, and that's not OK. And that we're not being supported by our departments to lactate, and that's not OK. And that our children have lower birth weight, and that's not okay. And so, if you look at the evolution of how that's changed over time, and part of that was because people started being honest, stopped pretending that they weren't leaving for a soccer game in the middle of the day, stop pretending that they weren't organizing their OR schedule to get to a PTA meeting or whatever it might be. And I think part of it is that we have to force ourselves to be authentic. Quite frankly it's a lot easier to be authentic when you're an associate professor, or professor. And you feel like, I have some standing within the leadership.

And so, there is a power differential there, even amongst those of us who are marginalized in one way or another. And so, I think that we need to be honest and really encouraged. So, I talk about how complicated it is to have a family and children, and a husband who's not in medicine, and an older mother all the time, across the operating room table. I talk about my Imposter Syndrome probably too much. But I mean, it's something that plagues most of us. And is particularly problematic for those of us who are women in UIM. And so, we really have to be genuine and authentic. And I think at the same time our leadership, and we, as leaders need to embrace that authenticity, because that's the diversity that we want. That's what we're striving for. So, it's a complicated thing, and I feel like in some ways it's easy for me to say it all from the position that I'm in, but I haven't been in this position very long. But I do feel like I owe it to the people coming up behind me, to say this is messy and that's okay.

Dr. Jennifer Waljee:

Building on that. When you think about the messiness of having these conversations and developing strategies, that address diversity equity and inclusion in healthcare systems specifically, what are the critical considerations that you've relied on best practices or sort of core principles when navigating that?

Dr. Zara Cooper:

Interesting. Because this is where my palliative care training is really coming in handy. But I think it's really approaching everything with curiosity and creating a culture of safety in that, I'm not judging. And that's really important. And then I'm going to be honest about, how I've been in very high-level meetings where I've been very honest about my own personal experiences with racism and sexism within this organization. And I've used the term 'white supremacy' in these high-level meetings. It's uncomfortable but that's what we've got to kind of acknowledge that, that's how we've been operating.

So, I think that trying to create a culture where discomfort is okay, and that you're not pointing fingers. One way that I've been able to do this is also, my mother is white, my husband is white, and we've had some really challenging conversations over the past about race. It's been really eye opening for all of us. And we've all learned a lot, but by kind of starting the conversation and saying, "I've had to have difficult conversations with my own family about this" Like, "nobody gets this right". I mean my mother marched with the Black Panthers but yet she doesn't see it in the way that I do in 2020. Kind of acknowledging that, helps at the stage. When acknowledging what you don't know and saying it's going to be hard.

Dr. Dawn Coleman:

How should some of these strategies that you've been talking about this morning, be tailored to teach members of all of these teams? When you think about environmental services, food and nutrition, phlebotomy, even the transport teams, mid-level providers as an example. And so, I think that probably most of the audience that's tuning into this podcast is going to be thinking about, implementation of intentional and enduring change at a very local departmental level. But the patient experience encompasses so much more than that. And you touched on this early on and I kind of want to circle back to it if you don't mind.

Dr. Zara Cooper:

I think it's a great question. And I don't know that I have a great answer for it. I think one of the challenges is, that we have to think about this hierarchy. The way I just told you that I have benefited from the hierarchy, because now I can say things that I couldn't say before because of this hierarchy. But we have to think about this hierarchy and the reason why I say that is because we can teach kind of all members of the organization. So, we're very focused as an organization right now on teaching the highest-ranking managers and leaders and, and because of the hierarchy, the leadership sets the tone. At the same time, if the rest of the organization is not experiencing it, and this is the piece about, we have to do our own internal work.

So, we can teach for example, members of our environmental services team or a transport team, how to be culturally dexterous when dealing with patients. But if they don't feel that they're in an organization that respects their own individuality, and it's giving them a fair wage. Then it's hollow. It doesn't reign true. And so, it's kind of silly for us to say to them, well you have to look them in the eye, but yet whenever they're walking down the hall, half of the interns look down and don't look them in the eye. And so, this is where we have to do the honest work. The sounds are cheesy. The healing really has to kind of permeate everything.

The difficulty is saying, you're right! Why don't I know everybody's name? Why are there people that I've been seeing in this hospital for 15 years and I don't know their name? They know my name because I have a name on my coat, but I don't know their name, and that's not OK. Just those small gestures of humanity and equity, I think will go a long way. And there are things that each of us can do

individually to try and level the playing field to make a more inclusive environment. And that's not all of it. We got to pay people better and give them a better future, and give them more opportunity. We can't hog all the opportunity for ourselves. But I think that just even thinking in our own behavior about microaggressions that we don't even know that we're doing, can be very illuminating.

Dr. Jennifer Waljee:

Along those lines. As we kind of close out with the final question. What do you think is the ideal state then for healthcare systems, and their workforce with respect to diversity, equity, and inclusion? And do you have thoughts on the roadmap to get there?

Dr. Zara Cooper:

We talk a lot about reflecting the communities that we serve. And I struggle with that, because that implies that we have to be proportionate and that implies quotas. And I don't know what you do with that. So, as far as that's concerned, I'm not entirely sure. But what I do know is that we need to be more representative of experience and of thought. And so that's not just about race, it's not just about gender. And I think that if we can do that and truly value that. I think that will lead to more inclusion, but there is something about representation and proportionality. I mean healthcare touches everybody and it's a microcosm of the culture of society. We're just reflecting back. And so, I think that there is something about representation there that's critically important. And representation at all levels and genuine acceptance.

Dr. Dawn Coleman:

We can't thank you enough for sharing so authentically today with us. On behalf of our collaborative, Dr. Waljee and myself, please accept our gratitude, not just for all of the work and the effort that you're putting in locally at your own institution, but for kind of the guidance that you're sharing with others to follow. There's a lot that was discussed today that resonated with me. And I hope that it resonates with others that are listening. I'll end this by just encouraging everybody to follow your guidance, to act as individuals and also as leaders, because we all are setting the tone for ourselves and others watching on. Thank you again.

Dr. Zara Cooper:

Oh my gosh. Well, thank you. And there's so much that I have learned from all of your efforts and the leadership with respect to faculty development, and equity and diversity within the residency program, and authenticity of leadership. We really have set the bar in a lot of cool ways. So, thank you.

Narrator:

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