Michigan Surgery Sessions: Michigan Women's Surgical Collaborative - Implementing Strategies in a Change-Averse Environment

Featuring: Chelsea Harris, MD, MS; Erika Newman, MD; Erin Perrone, MD

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. Erin Perrone:

We're discussing another important topic in today's podcast, designed by the members of the Michigan Women's Surgical Collaborative, implementing strategies in a change averse or hostile environment. I am Dr. Erin Perrone, who recently took over as lead of the MWSC. With me today are Dr. Erika Newman, and special guest Dr. Chelsea Harris.

Dr. Newman is an associate professor in the section of Pediatric Surgery, the surgical director of the Mott Solid Tumor Oncology program, an interim section head for Pediatric Surgery. She is also the associate chief clinical office for Health Equity for the University of Michigan Medical Group. Dr. Newman completed general surgery training at the University of Michigan, and fellowship training at the University of Chicago Comer Children's Hospital. She's an active member of the Children's Oncology Group, the American Pediatric Surgical Association, the Society of Black Academic Surgeons, and the Association for Academic Surgery. Dr. Newman's specific clinical interests are pediatric surgical oncology, including neuroblastoma, Wilms tumor, and soft tissue sarcoma. She is also interested in surgical diseases of the biliary tract, including liver tumors.

Dr. Chelsea Harris is in her first year of plastic surgery fellowship at Johns Hopkins University. She was at Michigan [inaudible 00:01:32] for two years in 2016 and '18. She was on a T32 research fellowship with Dr. Kevin Chung. During that time, she got a master's in health services research, and she also helped us develop our cultural complications curriculum, which we will discuss in just a little bit. So, to get started, Dr. Newman, I've been able to watch and learn from your leadership for many years. Can you tell us about the major changes you have seen and been part of implementing in the department of surgery around culture?

Dr. Erika Newman:

Probably about five years ago we decided to make an intentional change to really grow a culture that everyone could be successful. When I look now back at sort of like the 30-foot view of that, I think traditionally there has not been a lot of time really in focus on culture. Why? Because we're trying to focus on being excellent surgeons and excellent in the operating room and teach. Environment and sort of the health of the culture, I think, has never really been at the forefront. I think that that over time has

harmed us. I think that it has created this sense of almost like survival of the fittest where you just motor through. I know that we've all experienced that. It was an exciting time as we were strategizing and working towards thinking more about how do you build culture.

A lot of it, Erin, started with the leadership development program that Dr. Dimick started many years ago, where people in the department got to grow as a leader, which is again, something that we don't think about as surgeons and being intentional. I think a definite component of leadership and leadership development is creating an environment, creating that space for people to grow and to be successful. That really set precedence for us to really focus and kind of hone in on building culture and environments. Michigan Promise, I think really came to be because of the work that was sort of set by LDP and sort of like this grassroots effort of people coming together saying, "We're good as a department. We have clinical excellence. We have the best research programs with one of the top residencies."

Something else is stopping us from being as great and as high performing as we can be. Of course, diversity, equity, and inclusion came through that too. It's like we realize that unless we are super diverse, unless we are inclusive, unless we provide equitable opportunities, then we're not as excellent. Where we've grown from that is that we just keep working on it. Couple years ago, we said, let's put a team of people together that can think about culture and there we started a Culture Crew. Then through Culture Crew, other strategies and initiatives that we think enhance culture. We have not arrived. It is something that we need to keep focusing on and keep intentionality around because if we don't, then not only will we not progress, we will lose progress. So, I do think about that a lot and sometimes even worry that we can't let up.

Dr. Erin Perrone:

Yeah. So, for those listening, the Michigan Promise, if you're not aware, sort of a multifaceted attempt at our Department of Surgery to attack some of these issues with the environment or with achievement or recruitment. It's six pronged, but there's plenty of different things that fall within there. Dr. Newman, you helped with a lot of that. Was it easy to push this forward?

Dr. Erika Newman:

Change is never easy, but I will say that I think we have a special environment here at Michigan that was really ready for change and accepting of change. Not only that, just remember thinking back having all those meetings and we had so many teams going and people were presenting their ideas and people could feel that wow, we can really do this. We can really make an environment where no matter what your race, your social economic status, your abilities. We were thinking about gender equity. That no matter who you were and what your identity was that you could be successful in our department. These were the things that we knew we had to do. We had to think about bias and do some implicit bias training. We had to provide really good mentorship and mentorship teams.

So, the Launch Teams came. We had to recruit. We had to understand who was coming into the department. I would say like anything else, I remember one of our bosses said, "There's the 20%, the early adapters that are all in and so supportive and active. Then there's that middle, about 60% of the people that are willing to learn and willing to grow and change. Then there's always going to be that 20% that are resistant to change." I think that that is still challenging for us. I think for our, I would say as an organization, just understanding how we can do things that are all inclusive. Even the diversity work, we have to be careful where everybody may not agree with the things that we're trying to do. So how do we make sure that they are successful, and they can express their perspectives?

Dr. Erin Perrone:

I know, I've been thinking lately, we need to allow everyone a little grace too, to make mistakes, especially in the space of culture and DEI because if people just walk around scared that they're going to always say the wrong thing, then nobody says anything. As opposed to being okay and providing a culture where it's okay to make a mistake and be corrected and live in that sort of constant learning motion.

So, Dr. Harris, one of the ways our department has aimed to change culture was to discuss openly in a morbidity and mortality format. We called this the Culture of Complications. I know you were part of developing that initiative and we are so thankful for your help with that. Can you tell us a little bit more exactly what that is and how that was rolled out at Michigan Medicine?

Dr. Chelsea Harris:

The spark for the idea started right at the end of my research time. Dr. Lesly Dossett and I were sort of the point people for it. The genesis that I got wrapped into it was the Association for Women's Surgeons had developed a He for She committee and had very astutely recognized that if they just had a whole bunch of very prominent men in surgery together, repeating what women had been saying for a long time, that it may just be a bunch of very prominent men getting credit for the women's ideas that have been in circulation for decades. So, one of the caveats for that was that you had to nominate a faculty member and a resident to be a part of that committee as well. So that's how I got looped into this. Dr. Dimick was appointed to the He for She committee. He asked Dr. Dossett and myself to join him in that initiative.

Then once we had all these really excellent people together, that the next question is, is often the case in diversity, equity, and inclusion work is what do we actually do? We have all these interested parties. I believe that Dr. Dossett had had this idea, I think through Culture Club to start talking about instances of cultural breakdown with the same gravity and analytical eye that they were applying to medical complications. So, she had raised this idea and that kind of fit in my nexus of skills in terms of really wanting to understand diversity and equity and inclusion work. Also, I've done a lot of work in visual abstracts. So being able to condense those points down to a few core bullets and then create visuals to go along with them.

Over the next year while I returned to clinical work nights, weekends, 2:00 AM on the overnight stuff, I started building out the curriculum. The idea is that we'd have 12 core topics in diversity, equity, and inclusion. So that included things like stereotype threat, microaggressions, implicit bias, differences in evaluation, gender fair language, a whole gamut of things. The idea was that we would provide highly data driven, very succinct overviews about what is this topic? What is the terminology? What's the science behind how this fits into medical practice in particular, but sometimes the greater sociological frameworks?

Then we would match them to how that shows up in the clinical environment, either in the provider experience or in the patient experience. Then once that curriculum is built, the idea was that the sample case would then replace one of the standard medical or surgical complications. You'd present the case, you'd go through the data, and you'd open it up to group discussion the same way that you would look at what the factors that made medical error. You would look at that in cultural as well.

The University of Michigan and University of Maryland were the first two pilot sites. Based on some of the positive feedback we got on that, I then built a website and made the curriculum freely requestable for anyone who wants to have it. It was sort of the right idea for the times. I think a lot of places had recognized that there was a real gap in this education, but they didn't necessarily know how to fill it in a

meaningful way. So, I think we're over about 300 unique requests from departments. It's not just surgery, it's all kinds of different areas. It's across multiple countries at this point. So, US, Canada, UK, Australia, for the most part. So, we're really thrilled with how it's taking off. Another hope is that it's really customizable. That's how cultural complications works. It's been quite a rollercoaster.

Dr. Erin Perrone:

Let me restate that. Did you say it's been over 300 places?

Dr. Chelsea Harris:

So, I will say there's been at least 300 unique requests. So that's people wishing to access the curriculum and not everybody who asks for the curriculum actually moves on to the implementation stage. But I think we're at somewhere around 20 to 30 programs actively rolling it out in some form. Then there's things like Kaiser in Northern California is doing it. That was one point person. But Kaiser is enormous. So, then they're moving it out to all of their associated sites.

Dr. Erin Perrone:

You had some experience helping some of these places get started. Was it welcomed? Were there any resistors?

Dr. Chelsea Harris:

Dr. Newman basically took the words out of my mouth that when we were thinking about this curriculum and how to roll it out, we thought about it in those three audiences, that there's the early adopters, the people who are doing the work, there's the middle group. We sort of looked at it as the people who maybe already, they're interested, but don't know what to do next, and the blissfully unaware. We kind of lumped them all in the same category. Then there's the skeptics or perhaps critics at the end. Thinking about your audience in this way is fairly important because one of the things that I think many of us involved in the DEI space have found is a lot of the voluntary activities is just that top 20%, that it's the same people in every meeting over and over.

We don't need to learn about microaggressions or implicit bias anymore. We know the data backwards and forwards. We decided to really try to focus that curriculum on that middle group, the people who needed action strategies and the people who needed to see real data and understand that this is not just some fluffy afterthought, but it's a real thing that's affecting their colleagues, their patients, and in many aspects, themselves and really creating a strong scientific basis for that. However, that doesn't magically rid us of the 20% that are not going to like this thing. I have definitely faced some vocal opposition, both directly and when I've been strategizing with people who want to roll this out at their home institutions. They are often able to identify individuals who are going to be vocal opposition as well.

I think it's also really important to recognize that the hostile environment exists at every single institution, even someplace as committed to this as Michigan is. I really think you guys are at the forefront. You're going to have the microcosm, the OR with a person who thinks that maybe this is all a bunch of garbage and you're in that environment for four, six hours with the person, and it's sort of just you and them, or just you and a couple other people. You might be in a clinic where you're isolated. You're going to get a microcosm.

I find this even in my own self that I have blind spots. So, I try to look at my own approach to this and find where do I have the hostile environment within me and how can I go about identifying it and rectifying that if I need to. Figuring out who you think your critics are going to be from the beginning, making sure that you have allies and understanding where you fit in the hierarchy. So, when I was rolling this out, I was a fourth-year resident, so I had some cache within the residency, but I was lower in the attending hierarchy. So, you need to understand your ability to affect change from your position.

If you're somewhere towards the bottom of the hierarchy, you need to get allies on your team who can help address the top because I think in a hierarchical environment like medicine and surgery in particular, culture is often a very top-down affair. It's wonderful to have grassroots efforts, but if you don't have the people at the top who can stand behind you and water your grassroots, you're going to be doomed for some failure. Then I think as you were speaking, I flip flop on this all the time, but I think ultimately if you want to succeed and keep going, you do have to have some grace and some compassion for the people who are resistant because if you dig in your heels, then they dig in their heels and often these are much more established figures who you're potentially not going to win against.

So, some of the things that I've found to be important and effective are figuring out who you think your opposition is, and then meeting with them and talking to them about what you're doing and why. Making sure that it's not something that they feel is forced upon them. It's not a forced mandate. There's some degree to which that will be successful and there's some degree where you may have to be like, time to get with the times. This is an important part of being a competent surgeon and clinician and leader and you have some learning to do.

It's just like you have learning in any surgical skill. It's uncomfortable. I say this early in my fellowship. It's uncomfortable to not know what you're doing and to be in situations that push you to grow. It is very understandable to want to withdraw from that and go back to your safe comfort space. But if you encourage people to continue that growth and applaud them when they make progress, even if you think that it is 20 years overdue progress, I think that that's going to help you.

Dr. Erin Perrone:

I just applaud you for all of your efforts in really moving this forward. I know on social media, you're amazing in being able to put together a very quick virtual abstract. I'm sure that helped with the adoption and getting this out there.

Dr. Chelsea Harris:

It's very much been a labor of love.

Dr. Erin Perrone:

Dr. Newman, I'm going to switch roles a little bit now. I know you recently took on a new leadership role, as the interim section head of Pediatric Surgery at the Department of Surgery with University of Michigan. Can you tell us about your approach to this new role as change is always a little challenging for a group, especially one that's been so established?

Dr. Erika Newman:

I'm really excited. I think that, in my opinion, of course, maybe I'm biased, maybe I'm not, but I think we have the best pediatric surgery program in the country. We stand on the shoulders of giants with our clinical expertise and clinical excellence, through what has been built by Dr. Coran and Dr. Hirschl. Our

learning, our learners and our fellowship program, I think is again, one of the best. Our research program, I mean, we have academic surgeons that are, Dr. Hirschl and his liquid ventilation, and Dr. Mychaliska and the fetal placenta. So amazing and incredible research. We are family. So that too, I think, contributes to our excellence. So, I will just say that it is extremely humbling to fill this role.

I think the way that I'm approaching the role is I'm going to spend the next month just listening and learning. I think, Erin, maybe you and I have talked about this before, the way that I approach leadership, I keep adding these Ls. I plan to learn more and listen more. I think that is so important. I think I know about pediatric surgery because I've been here for so long. I trained here. I'm viewing my role as really to serve the faculty and to understand how I can best support our faculty and our section, really focusing on our people. I know that if we focus on our people and their excellence and their advancement, then our results are going to be there.

Listen more, learn more. The other L is just to put it out there because this is, I think about the stuff all the time, is that language matters. Ensuring that we're all speaking the same language and that when we are talking and thinking and using words that we understand what we mean by that. One example that I use is that if we were to say the word diversity, we can all go around the room, and we probably have a different explanation of what that meant. So, I try not to even use that word anymore, even though I can't help it sometimes, but should we be using words like representation or identity.

Lowering bias, and so just thinking about even my own biases, but always focusing on bias as we are thinking about progress and our teams and what the role of biases and the decisions we make, particularly if we're making big decisions. So just trying to understand and making sure that I can check my own biases and that I'm keeping bias sort of at least in our field of view, as we're thinking about how we can keep getting better. When people, when you mention bias, they automatically go to the more common explanation around bias and implicit bias. But I really think of it as we all have it.

It's the shortcut that our brains take to keep us safe and just realizing them, recognizing that what our biases are, therefore we can mitigate them and mitigate their influence. Particularly when we're making a big decision. Level and load the pipeline is another one. So thinking about our pipeline in pediatric surgery and preparing them, our students, and our residents and making our section one where people want to come and be and become pediatric surgeons. That's really exciting to me. Then the last one I think is just lead with love and compassion. Does it sound cheesy? I don't really care if it does because it's what I do. I think that, yeah, you want a leader that can love and lead with compassion. So those are my guiding principles.

Dr. Erin Perrone:

I love that. Certainly, all of us in the MWSC are rooting behind you and so proud of you. Thanks so much, new boss.

Dr. Erika Newman:

Thank you. Well, I'm relying on your leadership. Listen, you're right there leading right alongside me, and I look so forward to doing this and being on this journey with you and with my sisters in the MWSC.

Dr. Erin Perrone:

Thank you both so much for coming. It's been such an honor to have you both and learn from your ways that you've had to create change and make things anew. Any words of wisdom you want to leave?

Dr. Chelsea Harris:

Understand that change is worth it and understand the context that you are operating in and make sure that you build a team and allies and that you are as willing to change and to reexamine yourself as you're asking the people around you to do as well. Then if you really lead from a place of this is a shared issue, we all have growth, just like surgical skill. This will be a growth pattern that you need to apply to your life in continuity. It's not a tick box that will be over once. It's something that we can work towards as a collective.

Dr. Erika Newman:

In a change averse environment, stick to your why and your purpose as your guiding light, and then just go for it.

Narrator:

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