Ruth Adewuya, MD (host):

Hello, you are listening to Stanford Medcast, Stanford CME's podcast, where we bring you insights from the world's leading physicians and scientists. This podcast is available on Apple Podcasts, Amazon Music, Spotify, Google Podcast, and Stitcher. I am your host, Dr. Ruth Adewuya. Welcome to season four of Stanford Medcast.

This episode is part of our leadership miniseries, and in this episode I'm chatting with Dr. Michaela Kerrissey, an assistant professor of management at the Harvard T.H. Chan School of Public Health. Her research work mainly focuses on identifying how healthcare organizations can integrate, innovate, and improve their services, particularly in solving problems that cross organizational boundaries. She has been published in various leading academic journals in both healthcare and management, and she's a proud alumnus of Duke University, the Harvard School of Public Health, and Harvard University, where she received her BA, MS, and PhD degrees. She was honored with several awards during her academic career, including the Robertson Scholarship at Duke, the Hart Leaders Fellowship, and the Reynolds Fellowship at Harvard.

Before joining Harvard, she worked as a consulting team leader at the Bridgespan Group, which was launched by Bain & Company, and she was recently shortlisted by Thinkers50 as one of the top eight radar thinkers, which is a global list of top management thinkers. Dr. Kerrissey, thank you so much for chatting with me today.

Michaela June Kerrissey, PhD (guest speaker):

Thanks for having me.

Ruth Adewuya, MD (host):

I am excited to continue our leadership miniseries talking about team dynamics and team development. Let's set the stage and define concepts. Let's start with the concept of teaming, especially in healthcare. What does that mean to you?

Michaela June Kerrissey, PhD (guest speaker):

Teaming is really the verb form of team. And the reason we landed there is that traditional teams research for about 30 years was really focused on stable and bounded teams. You can think of it like a basketball team, you know who is on the team and who is off the team, and they basically stay together throughout a season and have a clear interdependent task.

But for contemporary work environments, especially in healthcare, that reality of a clearly bounded stable team that stays together and always does the same thing is just often not the case.

And so teaming is a way for us to conceptualize and think about what has to happen. I used to have these much more dynamic groups of experts come together to try to team up, without the luxury of the stable team boundary that we often think of when we think of a traditional team.

Ruth Adewuya, MD (host):

That's a really great point. Could you expound then on the significance of effective team dynamics within a clinical setting, specifically in relation to patient care and outcomes?

Michaela June Kerrissey, PhD (guest speaker):

This is a great question, because the reality is when I get out and I talk to clinicians, this is one of those things, the need for teamwork and its association with patient care and outcomes, is clear to basically every clinician. If you ask what's the core of your job, people say, "I do teamwork every day. It is definitely a core part of what I do in generating outcomes for patients."

But then from a process standpoint or a management standpoint, many clinicians are left with this feeling that in their organizations, and their hospitals, and their health systems, and their practices, we're still leaving teamwork up to habit, and intuition, and chance, right? It's just something that you basically are relied upon to figure out on your own.

So some of my research is just in the vein of essentially trying to make this tie between team dynamics and outcomes, care quality, patient experience, provider experience. And my research in that area, it's not surprising at all. You show it to a clinician and they're like, "Yeah, duh. I know that teamwork matters."

But I think it's important to put numbers to it, because in this field, everything is quantified, and we care a lot about quantifying things. And so if we don't do the work to try to be really crisp in defining aspects of teen dynamics and then associating them with outcomes, we can't keep teamwork on the agenda, and it just leaves it to habit, and intuition, and all of the things that we've been relying on for so long.

Ruth Adewuya, MD (host):

Let's dig into some of the data and what you found in your research.

Michaela June Kerrissey, PhD (guest speaker):

Sure. So here is one example, and this is a great example for you because this is done in collaboration with some of my colleagues at Stanford actually, where we've been really interested in this issue of ownership consolidation in healthcare in the United States, which has been a massive trend in the last 10 to 15 years. We see huge swaths of practices buying up practices and health systems buying up practices. So it's both horizontal and vertical ownership consolidation or integration.

And yet my economist friends down the hall do research to figure out whether or not this ownership consolidation, which purportedly should be helping these health systems to have more integrated systems, whether or not it actually leads to higher quality care for patients. And it's been broadly disappointing in that on average, it appears that most of this ownership consolidation doesn't seem to lead to any improvements in care quality on average for patients. And that has left this kind of big gaping hole of if not ownership consolidation, what might really lead to better integrated services for patients?

So we took a step back and went back to the organizational theory around teams and social relationships and organizations, and tried to expand the conceptual models more comprehensively about what's really going on when you're trying to integrate a system. We know that ownership maybe is one step on the path, but it's not sufficient.

So what we created was a set of measures to get at the social relationships and the norms that exist within systems. So the kind of taken for granted assumptions about how you work together within and across units in a large health system. And we measured it across a set of health systems nationally, the focal management unit was within primary care practices that were bought up in consolidated systems. That in those practices, when they reported more interpersonal integration, teamwork, and norms around integration, that there was a statistically significant positive association with better perceptions of care quality. And then in a later study with one of our fabulous doctoral students, we looked at associations with measures of care quality that were externally collected, and also found a significant association there as well.

And so it starts to unpack for us, when we think about large health systems, that these social relationships are not things that should be a nice to have or when we get to it, but actually a core part of generating the kind of coordinated integrated care that we care about.

Ruth Adewuya, MD (host):

That's really powerful. It's important to pay attention to the people and how they are connecting to each other in order for it to have a positive outcome. I heard you say how we are just sometimes expected to know how to work as a team and it impacts so much of what we do.

What have you seen as some of the prevalent challenges that clinicians encounter in teams, whether they're leading teams or they're just part of the team? And then a second part to that is, what have you seen are strategies that could be employed to surmount those obstacles?

Michaela June Kerrissey, PhD (guest speaker):

At its core, we think about teams and the challenges around teamwork. It's essentially an information problem. You have people coming from different expertise areas, who have to be able to get some set of common information that then they can mutually adjust around.

So if you have one consulting physician who knows something about their domain of expertise and you have another that knows about their domain, it's an information problem to get a common set and then to be able to traverse what is different, to get to the same page, to make a set of decisions with patients.

So in healthcare, when we have these very fluid teams where it's not always the same people working together, they don't have longstanding relationships where they know exactly what other people know and how to retrieve it, you have a lot of missed opportunities for getting common information and getting it efficiently.

And so we talk about this in teams research. It's called a transactive memory system, but what it's getting at is this idea of establishing an efficient system for locating information across the silos of essentially individual experts' brains. And fluid team environments, you basically have interruptions in that system.

And so what you see happening is these failed handoffs or inability to update based on what others know. And you get these problems where you think that there should be more information because you are bringing more experts to the task, and yet it's not there. People spend time talking about the wrong things, they don't learn what they need to know, and they don't know where to retrieve it.

So a lot of our work has been around how do you get these interrupted systems as teams fluidly come together and maybe some people work together for 10 minutes, and then they're not together for the rest of the day, but then they maybe come back together in some other configuration the next day. How do you get those teams to basically get enough of a memory system up for enough time, and to do it quickly so that they can come together, team up really quickly, and do what they need to do in the moment given that they're not going to have the luxury of developing familiarity and knowing?

Ruth Adewuya, MD (host):

When we talk about the healthcare team, we are talking generally, but also understand that there are nuances to how teams are formed. And I'm wondering if in your research, have you seen a difference in the challenges depending on the clinician profile?

Michaela June Kerrissey, PhD (guest speaker):

Absolutely, and this is a really important point, because lack of clarity on what we are talking about when we talk about the team entity in healthcare has been a massive problem. And we see it, basically every clinician in America has to fill out these surveys of their work experience usually annually, biannually. And sometimes there are questions about their teams. And we've done some research on this actually, because I was always suspicious of whether or not people were answering about something cogent and similar when they answer about their teams. And so we did a study looking at this, and we basically found that there's massive variation when people in clinical environments, when you ask them who is part of their team, how they're responding, and what they're even referring to is very different. Which has both a

methodological problem to it. If you think about trying to measure teams, we have to get a lot more precise, and not all teams are the same.

And secondly, there's a conceptual issue around if these teams are actually different in type because perhaps the mix of type of clinician is different, the environment, the task is different, that they may actually have different flavors of problems.

Often, the information problem is an animating problem, but how it manifests and how you might fix it would be different in say a nurse team versus a multidisciplinary care team that is formed around a patient and has the patient actually supposedly on the team.

So I think we need to do a lot more and get a lot more precise about the types of teams. The information problem is salient almost always, but how it plays out and the intensity of the problem varies. It tends to be more extreme when people have more boundaries separating them.

And you can think about boundaries as different expertise. So you're trained in different domains. But it could also be a unit boundary, right? So you're working on different floors and you're not actually interfacing. It could be an organizational boundary. For example, when we examine clinicians trying to team up with social service agencies for a referral of a patient, the further out you get, the harder it gets because the boundaries are higher. And that makes more problems for the common information mismatch.

Ruth Adewuya, MD (host):

There's also a hierarchy. Informal or formal shows up in the clinical space with different clinician profiles. So when you talk about team dynamics, and teaming, and collaboration, how can clinicians achieve that equilibrium between leadership and promoting collaboration among team members?

Michaela June Kerrissey, PhD (guest speaker):

This issue of hierarchy is core to what is going on within healthcare teams, and it's related to the information problem. Hierarchy, some say it's a problem in its own right and it may have other problems just in and of itself. But it's problematic for the information problem, because it has to do with how information is treated or discounted based on a hierarchy.

So if you have people who are lower in the hierarchy who have critical insight into say a care process, and they bring it up, and then it gets dismissed just because of where they are on the hierarchy, that's a problem for patient outcomes and for the work.

And so getting really laser focused on those issues is critical for improving teamwork. And it's really important for leaders in healthcare at heart, because often what happens is people are moving around the hierarchy throughout their days.

We have this assumption that there's this really steep hierarchy in healthcare. And so if you're at the top, you're at the top. There are ways and times when that's true, but people's experiences when we study them and look at them throughout their days, they're basically moving between rooms and spaces where maybe they're at the top of the hierarchy in one moment, and then five minutes later they're in a different room and they're at the bottom.

And one of the things that's really hard for leaders is if you say, "You are at the top of the hierarchy, and so you have to change your behaviors in these ways." They say, "I don't feel like I'm at the top of the hierarchy." In part it's because they're not always.

So one of the things that leaders have to be able to do... When I say leaders here, this is really leaders with a lowercase L. It's anybody who's showing up who has a role to play in the work. They're having to shift their behaviors according to where they are throughout their day, and recognizing where they are in that hierarchy, and being strategic about the tools that they use in each moment.

Psychological safety is one of the topics that we talk a lot about when we're thinking about the issues of hierarchy and how you can overcome them. So I'm happy to talk about that.

Ruth Adewuya, MD (host):

These concepts dog tail into strategies that we can lean into, to make sure that we are enhancing the teams that we are a part of. So please continue.

Michaela June Kerrissey, PhD (guest speaker):

So psychological safety... And people are now mostly broadly familiar with it in healthcare, which is amazing, because five years ago if I would go into a health system and talk about psychological safety, nobody had heard about it. And now I go in and everyone's like, "I already know what this means," which is an amazing sign of progress in the field.

But for those that don't know, that's fine. You can think of it as a felt permission for candor. The idea that you can speak up with questions that you have, admit mistakes, concerns, bring forward ideas, without a fear that there will be repercussions from others, or that it will be held against you interpersonally by others.

And there has been now about 20 years of research measuring psychological safety, including in healthcare environments, but other environments as well. And showing relationships with all kinds of outcomes that we care about. I've looked at it in relationship to care quality, to reducing burnout in healthcare, creativity, innovation, a broad set of outcomes that we care about for teams.

And the reason in part that it's functioning is that it's reducing this sense of interpersonal risk that might lead you to withhold information or to have your information be swept aside. And so by establishing a sense of psychological safety in a work team, you can basically get more ideas on the table faster, and then make smarter choices as a team.

Ruth Adewuya, MD (host):

I want to reflect on what I heard from you. One is there's a component of it that is self-awareness of where you are in the different spaces that you are in, and how do you operate in the different spaces in a way that is beneficial to the entire team. The other thing that I heard was psychological safety.

And I have heard of this term before, and it's prevalent in the healthcare community. And everybody says that is what you need to have great teams. Practically, how does that happen? How do you set up a psychologically safe environment?

Michaela June Kerrissey, PhD (guest speaker):

It's a great question because nowadays, like I said, I go out, people have heard of psychological safety. And it's rare for me to find somebody that says, "I don't want to establish psychological safety." And yet when I observe teams, and sometimes I'll go do an interview one-on-one with somebody, a qualitative interview, and we'll talk about psychological safety. And then we go in and I'll observe a meeting, and you can see a gap between what someone's intention is in terms of establishing psychological safety and what really happens.

Amy Edmondson, she's one of the key person who brought this concept of psychological safety into the research world over the last 20 years. She talks about three particular areas of establishing psychological safety. One is about framing work that is new as new. So if you don't know what the answer is already, helping people understand that, stating it out loud so that it gives them permission to have maybe a half-baked idea or something that isn't set in stone.

And this one I think is really important for healthcare environments because some of the work that's done in healthcare environments is not new. It's essentially follow the script. We know how this works, and just

do not deviate from the script, and that's important. Being able to deliver with precision and excellence on the things that are, for example, major safety risks. It's important that we can create systems that do that. And yet in healthcare, we have all this other stuff that we do that is essentially an innovation task, like a process improvement or quality improvement team.

And one of the things that I see clinicians sometimes do despite really good intentions is that they don't help people shift their mindset from being this kind of execution, follow the script, don't mess up, because this is a big safety risk, to an innovation frame where you're saying things like, "Look, we don't know how to do this. We've never done it before. I can't tell you what to do."

And so you're asking people basically to suddenly change how they're relating to the work, change how they're talking about it, without setting that groundwork of this is a different thing that we are doing now. We are innovating and we don't know how to do this. And I'm not just fishing for a right answer there. I already have it in mind.

So one of the things that leaders can do in healthcare there is just to say out loud often clearly, "Let's experiment and learn. I don't know the right answer." And it's subtle, but usually powerful. So that's the first thing, framing the work as novel. The second is about inviting engagements. And there are basically two ways to do this.

So one way is the obvious way, which I see leaders do a lot, which is essentially going around and inviting people to participate. So you're doing this in rounds, "What do you think?" Or in a start of a meeting, asking people to go around, and everybody give some information that they have that's relevant to the decision at hand, certainly helpful.

But there's a second area of it that doesn't happen as often that research suggests has a more enduring impact on psychological safety. And that's about modeling your own vulnerability, essentially giving examples of when you've made a mistake, or when you've been wrong, or when you got feedback that was hard feedback. And then what did you make of it? What did you learn from it?

Because people are savvy, right? If you tell somebody, "You're free to speak up here," but then you're not speaking up about things that might make you feel vulnerable, they're much more likely to read into your behavior than they are into your words. Both are good, but it's important to not forget that second part.

And then the third one is perhaps the most important, which is responding productively. When somebody brings up a different point of view, how do you respond? What do you do? Everyone is watching. And so that moment in which you respond, especially if it's bad news, is absolutely critical to embrace the bad news and focus on fixing those problems, as opposed to blaming individuals and making it a retribution.

Ruth Adewuya, MD (host):

This is a framework that you can take and do as a leader. So thank you so much for sharing that. One of the themes that I heard around all of these three areas to build psychological safety really has to do with communication. How you frame the work, how you invite engagement, and how you respond. It's all about communication. And as such, it seems like it will contribute so much to team dynamics.

And so I'm wondering if you have any insight into some of the methods that clinicians can employ to facilitate that kind of constructive communication within their teams.

Michaela June Kerrissey, PhD (guest speaker):

A challenge with psychological safety is that it's not a quick fix kind of thing. It's not like if you just use this phrase and you bring it in, that everyone will suddenly feel psychologically safe. It's something that you have to build over time through deliberate practice, and trying to get better, and realizing when you have mishaps, and addressing them and then moving on.

So one of the things that I think clinicians can do that is really helpful is to make psychological safety a topic of conversation. Make it explicit, describe what it is so everybody has the common language to

understand it. Talk about those three areas of behavior, framing the work as novel, inviting engagement, responding productively. And then give people an opportunity to talk about when and where it's happening and why not, and give each other feedback on it.

Because right now there's this often sense of this is something that's implicit, and if we talk about it that it'll somehow ruin the thing, that you have to do it on the slide. But if you just make it part of what the team is talking about and thinking about it, then you suddenly have real time data to bring into your own practice and micro adjustments on it. Sometimes it's something as subtle as just shifting how you phrase something.

And so when you're working with a team, if you say something like, "I realized yesterday that I said this in a way that probably wasn't very good for psychological safety here, and here's how I might phrase it differently next time." That's a learning opportunity for everybody else to see like how we communicate, how we phrase things actually really matters, and we don't have to take it for granted or have it be something that we can ever change. We can make these micro adjustments. And that's something that's celebrated here and appreciated

Ruth Adewuya, MD (host):

Continuing the conversation and team dynamics. One of the things that inevitably will happen in a team is that conflicts and tensions will arise in teams. And so what are your thoughts on how clinicians can address those conflicts within the teams that they are a part of?

Michaela June Kerrissey, PhD (guest speaker):

Sure. And it's really important, especially in healthcare, to underscore that conflict is not necessarily a bad thing. Research on teams suggests that conflict about tasks, about the work is actually beneficial.

So if there's two clinicians who disagree on the course of treatment for a patient and they hash it out, we want that kind of conflict that's important. And we draw a line between that kind of conflict and what we call relational conflict.

So relational conflict is where I don't like you because we got an argument in the last meeting and now I'm bringing that grudge into the next meeting, and I'm not going to hear what you say even if it's valid because I'm just mad at you. And so when we're thinking about conflict, what we're really trying to do is to channel the conflict into task conflict and keep that relational conflict at bay.

And one of the ways you can do it, this comes from a famous organizational scholar named Chris Argyris, and he talks about ladders of inference. And basically what he would talk about is how everyone in healthcare understands that kind of scientific method. You have some data, you make some analysis of it, you make some inference, and you get to a conclusion about what you think it needs.

And the problem in teams, he said, is that basically everybody had already gone up their individual ladders of inference. And you have the debate, you have the conflict because you get stuck on the conclusion wrong, or you come in. And so Ruth, you've decided we should do A, Michaela has decided we should do B, and then we just go around and around, and get the sense of vertigo where we can't actually resolve it because you keep stating A, and I keep stating B.

And what he suggests for that kind of conflict when you're in this kind of vertigo state is that the role of the leader here is to get people to walk back down their ladders of inference to figure out what is the pool of data from which you are drawing to make your conclusions in the first place.

And often when you find as a leader, if you get people to do that, and you essentially do it by asking a series of, "Tell me how you got to that." You've probably heard the ask why five times. If you do that, it gets people down.

And what you often see is that people are just drawing, because they're coming from their own silos and expertise areas, they're just drawing on very different sets of data in the first place. And if you can do that

effectively, you can get to this kind of integrative solution. In my work, I've studied teams that do this, and we call it a joint problem solving orientation, as in contrast to an advocacy orientation where you're coming in essentially on that conclusion rung.

And it's amazing. If you go into organizations and we try to measure a joint problem solving orientation, what we find is that teams have very varied degrees of joint problem solving orientation. Some you can go in and you just immediately see this adversarial frame, and some come in and you just see they're walking right up and down the ladders of inference, and they just keep walking up and down and figuring it out together. That is something that you can capitalize on in health systems more than we do. Much like psychological safety, you can create it right deliberately.

Ruth Adewuya, MD (host):

Yeah. One of the things that you mentioned earlier is the reality that a lot of leaders feel that they might be a leader in certain spaces, but they're not leaders in all spaces. And yet, in the spaces where they might be the lower one in the hierarchy, they're still representing the team that they bring in, and they have to adapt how they show up to those spaces. What are some ways that clinicians can adapt their leadership styles to meet the needs of the teams that they are a part of?

Michaela June Kerrissey, PhD (guest speaker):

For years, all of the research on establishing psychological safety and creating conducive team environments were really focused on what the capital L leaders would do, like the people with the stated team leadership role, the boss. But we've really expanded that sense of what's going on in teams. And we just had a paper out a couple of years ago looking at what team members can do for each other, even if they're peers, in order to help their ideas be heard and make it to fruition.

And so what we were doing in that paper is we are actually studying process improvement teams in healthcare, and it was amazing. We tracked every idea that was brought forward in the team. Sat in on every meeting, categorized every idea, and then saw what happened to the idea over two years.

And the first stylized fact from the paper was that about 75% of ideas that were brought forward by people in that room who were in higher status were basically immediately accepted and moved forward by the team. And then for people that were lower status on the team, they had medical assistants, front desk patients. Their numbers were basically the opposite of that. So about 75% of their ideas were immediately discounted, and 25% were carried forward.

And what we did in this paper, and this is relevant to your question about what do you actually do in the room, is we tracked the 25% of ideas that did make it from those lower power people. And we were trying to figure out, why did those ideas make it?

And what we found was that there was this basically collective and public process in which team members were supporting one another's ideas to move forward. That is what enabled those small minority of ideas to make it forward over time.

So they were doing things like... We have all these names for the different strategies in the paper, so there's multiple strategies you can use, but an example would be bringing somebody else's idea back up. So let's say we had a meeting, and Ruth, you brought up a really good idea for a process we could improve. So if the faculty member rejects the idea, then you go into the next meeting and somebody else might say, "Hey, I thought Ruth had a really good idea last time that we put on the table, and I want to bring it back up." Strategies like that where people were actually helping each other to have their ideas be heard even when they weren't the most powerful person in the room. It's an allyship essentially.

Ruth Adewuya, MD (host):

Yeah. Hearing that data, it's sad that only 25% of those ideas were moved forward, but it's helpful to hear that there's a process in which we could increase that number. What are some tips that you would offer clinicians who are transitioning into leadership roles for the first time, and they're now responsible for establishing team dynamics within their teams?

Michaela June Kerrissey, PhD (guest speaker):

Before I say advice to specific clinicians that are at that transition, I will say I think that medicine and healthcare as a field can do a lot better in supporting people early on to make that transition. I think it needs to be more part of the curriculum in medical school, better paid attention to in the residency programs. And podcasts like yours, they really matter.

Because a lot of people that get into healthcare, they care. They want to be able to run a good team. And the supports just aren't there. We're a lot better at focusing on the expertise of the technical skills of medicine and training people to do that. We need this other stuff to the side.

So I think it is a field issue, and I know there are some really amazing leaders that have been making huge progress on this, and I applaud their efforts. Catherine Lucey at UCSF and several others that are helping us to rethink how we do this and when, because it's a systemic issue. But for the individual leaders, while they wait for all of us to figure out how we'll do it at a field level, I would say two things.

One is keep doing what you are doing to be thoughtful about this, and to try to learn as much as you can by reading, and listening, and asking your colleagues for advice, and trying on new styles. It's really tempting to think, "I've always worked in the way that I have worked and I'm going to keep doing what I've been doing that has made me successful."

But often for these transitions, from technical expert roles to leadership roles, doing what you did in the past to make you successful can actually become a huge liability and ironically undercut the whole thing. So things like maybe you got to where you are because you were uncommonly brilliant and really good, and you were the best doctor around. When you step into a leadership role, suddenly people might regard that as being intimidating, and dismissive, and unrelatable. You might have been really charismatic and good with people along the way, and then you step into a leadership role and people feel like you're manipulating them.

So you have to recognize that transition, as soon as you think it's coming, spot it and start to really take stock of what needs to change in what I'm doing for the new job. It's a different kind of job. So that's one.

And then the second thing that has to go hand in hand, I really believe this, is to just be nice to yourself about this. Give yourself a little psychological safety, because these transitions are so hard and they are a lifelong journey. Scary in a way when you think about, "Now I know I have to establish psychological safety, and I just snapped at that resident who said something and I didn't mean to, and now I feel like a jerk."

It's okay. It happens. I study this day in and day out. And with my own research team, there will be days where I'm like, "I totally just blew it. I can't believe I said that." It's all about, what do you do after? What's the moment of repair? Can you make it? And judge yourself on that and what you learn from it much more than the mistakes you make along the way, because we all make them all the time.

Ruth Adewuya, MD (host):

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