AMS - CM - EP 3 - Lisa Richardson

Helen 0:10
I'm here with Lisa Richardson. Right now you are the Acting Vice Dean of Strategy at the Temerity School of Medicine, you're still carrying, if I understand it correctly, the Associate Dean inclusion and diversity as well. So you've got two jobs, why don't you tell us a little bit about what those jobs entail, many of us don't have a really good line of sight into what happens inside of a Faculty of Medicine and what these roles actually include. So I'd really enjoy hearing a bit about that.

Lisa 0:38
I'm going to speak primarily to my Associate Dean role, because I think that's where I've spent most of my time recently; I've just taken on the Acting Dean role, while my boss, Dr. Lisa Robinson, is off for a little bit before she becomes the dean of our Faculty of Medicine, which is really exciting. So in my Associate Dean portfolio, we look to create inclusive structures within the Faculty of Medicine. And I very deliberately use the word structures, because change, as I've come to know, it is not only about creating the culture in which change can occur, but also creating the structures that enable sustainability for whatever that change may be. And so we're really trying to get away from this idea of creating diverse and inclusive environments in which people may have a sense that, oh, we're favouring certain individuals, we're doing things without clarity and transparency, we actually are extremely deliberate and thoughtful and evidence based in creating the structures and structures mean things like the black student application program into medicine, because we recognize there is an under representation of black physicians. And we know from data that actually, black patients are more likely to have better health outcomes, when there are black physicians, then they're in the care of black physicians, specifically, in certain contexts, the maternal care in the US cardiac care, also trials out of the US and a single trial in the US showing that having a single black physician in a county actually increased the overall health outcomes decrease the mortality rate for black patients in that whole county.
So there's something about representation, there's that one-on-one care that's important, but something about representation. So that's a bit of a digression, but all of that to say, we use evidence, we create a strategy, and then we build structures to support that change. And the Black Student Application Program is one example of that. So you've noticed I've used the

word strategy in there, which is the other role, and I think, how one goes about building and changing and transformation actually requires a lot of strategy and thinking deliberately and carefully and engaging with people. So we always build from the ground up, I don't want to, you know, impose an idea that's come from a single person, we want to really have a collective support and commitment and input into the direction that we're taking in the faculty.

Helen 3:24
I certainly found from the perch I had during COVID. That I saw a whole lot more about, you know, some of the systematic marginalization of people and their access to healthcare and how they wanted to receive health care. And we can see it in the data that was coming across our desks in the, you know, the vaccine rollout, for example. Do you think that that has had any impact on your work, or, obviously, your work predates COVID, but certainly starting to collect race-based data and understanding what makes a successful intervention like a vaccine rollout in those communities? I think we understand that better, at least I do.

Lisa 4:07
Yeah, I think I think what happened with COVID Is it made clear what many of us were aware of based on our own practices and based on evidence, but it made that more clear to the world or to the broader community within healthcare. So it was so stark and so overt, these discrepancies both in who was getting COVID, who had access to testing who had and how to roll out vaccines, as well as outcomes from those who got COVID that it moved into the general population and group of leaders who were suddenly responsible for overseeing this

Helen 4:52
Including me.

Lisa 4:54
So I think that that was an advantage. My big concern is that we had this awakening that occurred to oh, we need, we need to do this, we need to change the way in which we're delivering care in which we're thinking about care. And yet, we're through that now. And I think we're all in this state of, still in a state of grieving actually what happened during COVID. But I worry that we will have forgotten those learnings, and those lessons and I already

see a sort of, in that move to, to get back to normalcy have, we lost a lot of the tremendous learnings that came through often painful awakenings?

Helen 5:36
I worry about that, too. And I, I tried to show the, you know, the neighborhood decile chart from the science table in every presentation I have, and not a big audience for me. But you know, still, I think there are allies out there, obviously, in the system that I think, hopefully will keep that top of mind and health policy going forward. But you know, time will tell right?

Lisa 5:58
Yeah, I do. I really, I mean, having a leader like you, who does bring that thoughtfulness was so important, and for you to continue to advocate, I think is also really important.

Helen 6:10
Well, it's my duty. You talked about engagement strategies that you use from the ground up, can you talk a little bit more about how you build partnerships in your work, because people are always trying to engage with you've been very successful in doing that. And, you know, are there any kind of tools or approaches that you use that really get people fired up and wanting to be part of what you're trying to create?

Lisa 6:35
Yeah, that's a great question. Thank you. Partnerships, for me are about relationship building. And I think we can get so caught up in the mechanics and transactions of partnerships that we forget that what underlies a strong partnership is a strong relationship. Relationships take time. And they take effort, and they require trust. I think we forget that they need to be nurtured. And we need to continue to grow and learn. I have an example right now of an informal partnership, where there was something that didn't go well. And so what do you do? You come together as you would in any relationship, friendship and say, Let's talk this through, let's work it out. And let's learn from there. So it doesn't happen again. And that openness, authenticity, trust, it can continue to make the relationship stronger, in addition to the relationship so and working together towards a common vision, which is, to me what partnership is about, there does need to be some formalization, particularly when you're looking at large institutions, forming partnerships with smaller community organizations or groups where there's a power

imbalance. And so I often speak about learnings from indigenous organizations, because almost all indigenous organizations have people who are responsible for partnerships. And this is because of understanding nation to nation agreements and treaty agreements, and what happens when treaties are broken. Partnerships also do need to be formalized in the forms of memorandums of understanding partnership agreements, in the case of research, for example, legal agreements around who owns data, etc. So I think there are two components, but always, always, always going back to relationships that underlie that to work towards a common vision.

Helen 8:36
Very wise, great advice for our listeners. How did you prepare to do this work? I mean, we all come to our jobs and our callings with, you know, sort of life experiences shape how we are as leaders. And I've tried to ask this at all the interviews on Compassionate Minds, but how did your life shape your thinking on leadership? And how you approach it?

Lisa 9:00
It's always interesting reflecting on that, when you're further along in your career, because I do often think I wasn't someone who was deliberately saying, oh, I want to be in this senior leadership role at this time in my life, things in some ways unfolded as they did in a good way as we would say, but when I look at how I was raised in it, nobody in my family is surprised that I'm involved in education or involved in health education or involved in leadership. So I guess those qualities are, are obvious from the time one is young. So my dad is of Scottish and English descent and my mom is Anishinaabe. I've always, I think, had a strong commitment to justice and equity from both of them actually, but particularly from the teachings from my mom, which I don't think she was even aware of that she was passing along just about treating people with respect and fairness and the human dignity and equality, and actually standing up for people, and I speak about, I've spoken before about how she taught us to use our voices. And so that strength of one's voice and being able to speak up for what you believe in was something that was taught to me at a very young age, and also the value of education and the importance of being able to use one's voice and be educated in what's what, you know, what you're speaking about, to advocate for change. So I did end up in medicine as a way do I think, affect concrete and change and improvement, particularly for those who don't experience the same quality of care. And I have a passion for teaching.

So teaching seemed like a really great way in to become a medical educator to actually teach for the next generation of physicians who would be able to also, you know, delay, multiply, I still love the one on one teaching their small group teaching even the lectures, but I also realized that, you know, to take that to the next level, as well involves becoming involved in policy and system change. And my work primarily now is around what does it mean to create programs for indigenous learners to actually thrive and to then be able to deliver high quality care to indigenous peoples? How do we teach all health care providers to be able to provide high quality care to indigenous peoples? This is my scholarly work really, in indigenous medical education. And how do we then create the structures that ensure that that happens across all of our faculties of health science and medicine? So what are accreditation standards that are required? What are curricular requirements that we have to see? And so it's sort of, it's at the nexus of like a health policy or education policy and, and health care.

Helen 12:01
It's an amazing, I guess, scope of work, and probably a lifetime of work ahead of you as well, right.

Lisa 12:09
So much work still to do it. You know, whenever you're doing this work, it's like you three steps back, three steps forward. Thank goodness, three steps forward, two steps forward, one step back there, there are and so you learn to really celebrate every change that you've been advocating for. And then also try not to get too dejected and not fall off the path when things don't go as you'd hoped.

Helen 12:38
I've kind of learned to seize the moment where there's an opportunity, be ready to jump on it whenever you can. Yeah, yeah. You're also an AMS Phoenix fellow, this ties into what we were just talking about in terms of your scholarly work. You're also on the EMS healthcare board for that I'm very grateful. How did that fellow experience shape your thinking? And what kind of opportunities do you think that kind of fellowship can provide for people sort of, again, our fellowships are generally sort of early career opportunities for people.

Lisa 13:11

The fellowship was literally a game changer. For me, that is not an understatement at all, because it gave me a chance, first of all, to be believed in, and to actually focus on work that I wouldn't have been supported to do in any other context. So I was studying indigenous, like creating a curriculum on Indigenous Cultural Safety over a two year period. And that was the first thing. So just the idea that, we see that this work is important. We can imagine the potential for this work, and we want to support you. So huge, huge, it was a huge opening for me. And then the second piece was becoming a part of a community of people who think in creative, innovative ways about healthcare, education, and about compassionate care, which had always been at the heart of my practice, as a clinician and as an educator, because it's grounded in seeing people with care and respect and the humanity that we all bring. And what I was seeing had been seen through my training as a provider was how we become dehumanized as providers and how our patients are objectified often and treated as not as agents and moral human beings, but as objects and that's a result of many things, but it was quite frustrating. So gave me a chance to be in a community of people who were also working towards a similar goal.

Helen 14:57
It's wonderful to hear we're trying to do that. With our current round of fellows, and build out that community, and certainly I don't know whether you have any thoughts on sort of AMS future, but really your contribution to the next generation as your own work, but also through the work of AMS trying to really equip the fellows to take on leadership roles, having had, you know, a strong orientation, and hopefully a good book of work and compassion.

Lisa 15:25
I was talking to someone the other day about how do we support the next generation of scientists and innovators. And you can have these top giant down priorities where institutions say, well, we want to fund infectious disease research, or we want to fund cancer care. But what leads to great discovery and innovation in science is actually often when funds at the grassroots level when you look at talented individuals who need to be supported. And so I think that's one of the things that AMS has done, they've funded people who have this strong interest, and desire to change healthcare to focus on to understand compassionate care, when you find people, it becomes also founded in relationships, and supporting their development, nurturing, and mentoring them, and then bringing them

together so they can support one another. And so I think that idea of allowing some of the priorities that emerge to be the priorities of the next generation of leaders, whom we choose to fund, and then try to support people and align everyone to work together towards some common goal is important. So it's a real balance, because obviously, we have, you know, strategic priorities that need to move forward. But then we also want to have that organic component of funding creative people who will may, you know, take paths that are a little bit different, right? And bring different solutions, bring differences that or slice lateral, right, yeah. And so I think that we want to find people with diverse perspectives. And I don't just mean diversity based on social identity; I mean, diversity based on backgrounds and training and areas of research and scholarly focus.

Helen 17:23
Yeah, I couldn't agree more. And it's really exciting to see some of the proposals come across, you know, the applications for fellowships and how imaginative some of them are, I wish we could find all of them. But anyway,

Lisa 17:39
That's, I mean, what you hope is that you will also as you support the next generation of leaders, as you've said, they're then mentoring and supporting others. So the work ends up multiplying, there's a there's a Michelle Bay teaching, which I've heard from elders, but also which Richard Wagamese writes about the pebble that gets dropped into the lake. And it's just a single pebble of impact. But then when one watches the ripple effect, eventually will reach well beyond that single place where it's dropped into the water. And so the idea of how any initiative can grow and multiply, I think, is really powerful.

Helen 18:19
Yeah, I'll quote Malcolm Gladwell and *The Tipping Point*, right, at some point you get to, you've actually achieved a systemic change by virtue of some of the pebbles. Yeah. Which is pretty exciting. So like many of us, you've also been a caregiver certainly shaped some of my thinking in my own life, and, at times, has created some impatience that I've had with the healthcare system, how has that shaped your thinking about what needs to be done or your approach to leadership, if at all?

Lisa 18:52

I think it's also been foundational. I mean, I remember early on when, when I was younger, I was in my early 20s. And my mom was always going to the system as a cancer patient, thinking, there's so much here that does not feel right that does not feel like she's being cared for in the way I would want her to be. And then more most recently supporting my sister who also had cancer, metastatic breast cancer and had spent years in and out of appointments, clinics, 10 plus surgeries and procedures, many different rounds of treatment, and ended up dying in our Palliative Care Unit last June. But it really did impress upon me the importance of what, you know, AMS started to focus on right from the beginning, which was compassion. It felt so often like that was missing. And the difference between and really for my sister, we are very, we were very, very close. And so I was with her much of the time during, during her care journey. And I could feel it too when she would see a practitioner who seemed to just genuinely care. And my colleagues will sometimes say, well, we don't have the time to spend. And my response is, it's not actually about time, yes, time can support that. But it's actually just about how you show up in a room with the patient across from you, and how, as a patient or family member, you really can feel that difference of a person who is listening, truly listening, not rushing off, who is introducing themselves. We forget these basic these basics of how of human interaction. And so sometimes I think, point is compassion project is really just about going back to being a good person interacting, in a way in which hopefully, we're all taught to do as children do, listen, and care. And so that has been really critical. Like, I think it's always informed how I hope to practice and, and so seen how, as physicians and other health care providers, I mean, I understand I'm being physician-centric here, but that's because I do medical education, and certainly don't want to exclude the other health professions, because we all are critical on this journey. And we all must work together towards this. But why is it that we lose that? Or why is it that that is not cultivated and nurtured in us through our training? And then, once we're in practice, what are all the reasons why we lose track of that? So how are we struggling in a system that's overwhelmed with numbers of patients to see and electronic medical records to update and forms to fill out, etcetera? So what are all of those drivers at the system level, that are undermining our well-being and hence, undermining the way in which we care for our patients.

Helen 22:27
Those are great questions. And I think, you know, compassion exists not only at the individual level, but at the sort of the system's level as well, in

some structures. You talked earlier about structures, and some structures, I think, are more supportive of compassion. My own father was discharged from the hospital, and then readmitted eight hours later and then died another eight hours later. I mean, that's ridiculous, right? And so somehow that the drive for efficiency to get him home, was completely missed the point that really, he was discharged within 24 hours of death and the whole transaction to get him out of the hospital and back into the hospital, in the room next door to the one that he had been discharged from just didn't work for anybody.

Lisa 23:19
I love that, because it's not even when I was talking about the structures that support physician wellness to enable physicians and nurses and social workers and physiotherapist, occupational therapists and speech language pathologist and all of the pharmacists, all the amazing team members because we work in a very multidisciplinary and collaborative way in my specialty. But what are this structures that allow us to practice to the win the way we want to practice? But then what are those other drivers like, wait times and physical spaces, and I feel awful when I'm caring for a patient who's been waiting in an emergency room bed for two days. It feels hard to provide care in that way. And to see them in that way. Knowing that how hard it is to be on a stretcher in emerge, imagine sleeping and trying to get some sleep in emerge. Yeah. When you're interested. Yeah. When you're unwell.

Helen 24:24
You know, even if you were it’s going to be challenging, and my empathy for sure.

Lisa 24:29
And I don't want to make this about me. It's about observe bearing witness to what's happening with patients, right, and that push on so we start to feel that push around efficiency, because we don't want our patients to be waiting to emerge. So Oh, is there someone how can we help? How can we help get this get people out of emerge? Right, but that is about funded beds and funded rehab spaces and nursing home spaces and home care and all of the other areas. I mean, I'm not my system level work and policy work is not in that space. It really is in the med-ed space. So I don't want to miss represent myself, but it's certainly something I observe and experience as a practitioner.

Helen 25:12
And we've certainly heard that as a contributor to provider burnout in some of the work that we've done at EMS healthcare as well. Yeah. And, you know, it's got to be kind of heart wrenching for providers to be in that position. Right? Absolutely. He's a witness to that. And, yeah, it's, yes, exactly. And feeling a little helpless to try and change that as well. Or focus at EMS is really about the relationship between compassion and technology, and wanting to make sure that as healthcare becomes more technologically intensive, that we're really maintaining the focus on compassion. Is there anything about tech and particularly AI and other things that require, I guess, you know, you're kind of the thoughtfulness that you've brought to your medical education work? And how do we kind of accommodate this new world in a way that still keeps our eye on the patient? And all the noise and challenges in the healthcare system today, as I've heard needle to thread I think,

Lisa 26:14
When I think about technology, in healthcare or beyond healthcare, I think about who is the technology designed for? Who are the users that we're designing around? And when you ask that question, you realize that often, it is not the person who's most vulnerable or marginalized by our system. And so when the starting point for the design of the technology and the solutions, is actually a person who can navigate our system a little bit more easily have access to cell phone has access to a private room in which they could do a medical appointment online has access to primary care. When you design a system for those people, we're missing a whole other group, many groups, in fact, and interestingly, I was involved in a Canadian digital health evaluation project. And we were taking on the indigenous evaluation component of it at the Center for waste practices where I work and we we heard actually about virtual care and remote communities. And one of the things we heard about is, yeah, it's, it's really, it's actually really hard, we have issues around Wi Fi. And we have issues around actually having the space in which to have the conversations because we don't really want to have our visit with our whole family around us in our home.

So these assumptions that get built in to what seems like a brilliant solution are assumptions that can actually make the access worse for some people in terms of virtual care. And I realized this is not AI, I'm gonna get to AI. But we've seen some amazing solutions that are driven by community,

particularly indigenous communities where there's a whole indigenous virtual care network. And what you see is that there's infrastructure that's built and developed in appropriate places for the communities, but then how that infrastructure also gets used for other needs that are also related to wellness, like, Let's communicate with our children who are off the reserve and down south in Thunder Bay at high school. So how does that technology become used in other ways by communities is really is disruptive in a good way and contributing to wellness in a good way, when we think about AI algorithms are designed based on data, right from my colleagues, who are data scientists, Junkin is chunked out. So what is the data that we're using, and who is captured in that data? And until we know that we have good race based data that's collected in respects data sovereignty for specific communities, then our algorithms will have those bias built into them. The classic example that's often cited, which was a study that came up during COVID, was about pulse oximeters, and how that technology had been designed not for light skin, right. And so those with darker skin were actually having misreadings of their oxygen level. And it was reading that the oxygen levels were in fact higher than they were. And so you had people who were being under treated with oxygen requirements, like patients specifically. So that's an example of bad data in the development of a technology that then leads to bad outcomes. at the bedside. So how do we create technology? And how do we gather data in ways that are inclusive, and that will be mindful of representation that's needed to actually create good data sets that then will give good algorithms. The second piece is around this idea of data sovereignty. And that's most well articulated for indigenous peoples because of the rights to have control access and possession of data. And so when an individual's data, let's say in First Nations person data goes into an algorithm and gets put into this collective, they no longer have access to it. And so how is that being used? How is it being shared more broadly? What does it look like to think about data sovereignty? For AI? Very complicated. People are just starting to think about this now. And we don't have good answers yet. And I mean, as with so much with AI, incredible opportunity, but so many unanticipated risks as well. And I think we need to just move in a careful and thoughtful way. So that means as funding and supporting initiatives, how are they being evaluated? What are the metrics that we're using? Are we asking to see how communities have been involved and consulted and engaged to think about these questions?

Helen 31:37

Yeah, I think there's probably a leaf in this sort of how we've approached quality, more generally, that could be helpful here thinking about base of quality, which in other parts of the healthcare system might be, you know, there's levels of evidence, there's research ethics boards, there's safety studies. And then at the other end, there's sometimes there's post market surveillance and things that actually processes that look at results and see whether there's any bias and being much more systematic about exactly cancer care, Ontario experience.

Lisa 32:08
I know, I think that evidence that careful, evidence based approach, and when I when I say evidence based, I'm mindful also of being inclusive, and what is considered evidence, because obviously, I am a healthcare practitioner, I practice internal medicine, I believe strongly in the role of randomized control trials. But I also look closely at inclusion and exclusion criteria. And often my patients were not included in those randomized control trials. So that's one piece that I'm mindful of. But I also think about indigenous knowledge is and other forms of knowledge that are not traditionally recognized as evidence in the you know, academic system in the healthcare system that we work within. So how do we hear those stories and value them in the same way we value the numbers.

Helen 33:07
So let's end on a hopeful note. And I think there's a lot of hope in what you're doing. But what do you think, is the big challenge in healthcare today? And, you know, lessons for leaders? What do you think leaders can do? To prepare to take action?

Lisa 33:22
Wish I prepared this one. There's so much there. There's so much that I am hopeful for we've spoken a few times about a couple of ideas, and one is grassroots engagement. And the second one is partnerships and relationships. And the third one is collective vision and action. So how do we bring those three together? As we're looking at the future of the healthcare system? How do we ensure that we have broad, broad engagement and input to actually really be designing policy in an evidence waste based way? That includes not just the data from the trials that I've talked about, but also the experiences of those who are moving through the system, and those who have been excluded by the system? And how do

we actually bring all of that together for a collective design of the way forward?

Helen 34:40
I think it requires, you know, a whole lot of leadership skills which you have in terms of vision, determination, ability to connect with people, I think the value that you've described around relationships, and nurturing those in a really thoughtful, good way, as we would say, is really important.

Lisa 35:01
Yeah, and understanding that these processes and the these, these journeys towards, you know, the future of an ideal healthcare system for us right now in Canada or in Ontario will have to be iterative, too. And so I think there's this, as you become more experienced as a leader, you realize, oh, not didn't quite work out as I thought it would or as we'd hoped it would. Let's not throw out the idea. Let's take a good look at it. As we've learned from the quality and patient safety movement, let's understand the process here. And let's understand what worked and what didn't work and how we can evolve and evolve this project and try again. So I think, as a leader not to be not to be so hard on on yourself either. Being a leader is really, really hard. I mean, Diane longboat is one of the elders I'm very close to hoed nashoni woman, she said, You have to have skin that seven poems that because you never know what's gonna come at you. And no matter what you do, there will be people who are not 100% happy. And so I think that's why having that grassroots collective involvement in vision means that you're not acting on a singular idea or a singular vision. This is actually acting for and with many people who are behind you and who have helped develop this vision.

Helen 36:33
Yeah, in my world, that would be the sort of archetype of a servant leader. It's been lovely to spend this time with you. Thank you so much.

Lisa 36:45
Awesome. Thank you.