Healthcare's tribalism — and how to combat it

By Paul Levy | May 15, 2017

Back in 2001, UN Ambassador-at-Large Lakhdar Brahimi led the negotiation that established a new government in Afghanistan. He was recognized for that achievement with the 2002 Great Negotiator Award from the Harvard Program on Negotiation. At an appearance on campus, he was asked how he could morally choose to negotiate with the "bloodthirsty warlords" who prevailed in certain parts of the country.

Brahmini's response was, on the one hand, pragmatic: The warlords controlled much of Afghanistan's territory, and their buy-in was essential to the new government's success. He also noted that the warlords were actually among the most nationalistic of the parties to the negotiation, in terms of desiring a strong government that would hold Afghanistan together.

But I especially remember the other part of his answer, which I imagine was disturbing to some in the predominantly liberal audience.

It went something like this: "Who was I to judge the ethical standards and behavior of the warlords? Perhaps they were bloodthirsty because they felt that their tribes were in danger and therefore were acting to protect them. It was not my place to judge them. It was my place to understand their interests and how we might satisfy those interests to include them in the new government."

Tribalism in the hospital

I've related this story often in the negotiation classes I've taught to medical students, doctors, nurses, and healthcare administrators. I've pointed out the tribal difficulties that often emerge in hospitals, leading to dysfunction at best — and danger to patients at worst.

Rosemary Gibson and Janardan Prasad Singh summarized this sociology well in their book *Wall of Science*:

> ***Even if all the day-to-day operations of a health care facility work smoothly, there's another characteristic of health care that nourishes it as a breeding ground for mistakes. The people who provide health care to patients are organized in different tribes. Members of these health care tribes are rarely, if ever, trained together while they are in medical, nursing, or pharmacy school, even though they will work side by side taking care of patients once they graduate. After that no***

> ***training exists to help them learn how to work together, so instead of learning to understand and respect one another's role, there are chasms among the tribes.***

When I was CEO of Beth Israel Deaconess Medical Center, I was often approached by the chief of one or another clinical department, asking for an allocation of resources to support some initiative that he or she thought was important. Since almost all such new programs depended upon, or would have an impact on, at least one other department, I would simply ask, "What does Dr. X (the chief of the other department) think about this?"

As often as not, the answer was, "I don't know. I haven't asked. I don't need to. I know he won't like the idea."

My main job as CEO was to recognize such teachable moments and gently introduce a form of behavior modification. I'd usually say something like, "Well, why don't you talk with him and when you two have reached an agreement, you can both come back to me."

When we teach negotiation, we often point out that people are usually pretty good at understanding their own interests. It's the other party's interests that they often forget about or don't seek to understand. A negotiated agreement isn't an agreement, though, unless both sides agree. Your job as a proponent of an idea is to help meet the other party's interests while also satisfying your own. It's like solving two simultaneous equations back in our old algebra classes.

And when tribes work together, everyone can benefit. In our hospital, a young doctor was trying to persuade the nurses in our ICUs to adopt a new five-part bundle of care that might reduce the number of cases of ventilator-associated pneumonia. VAP is fatal over 30 percent of the time, so this doctor thought it would be well worth the effort to introduce the protocol. But he had to persuade the nurses to take on this extra work.

He did so by displaying empathy for their already busy days and nights, while also appealing to their deep sense of caring for the patients. His approach was to say something like this: "I've learned about this new protocol that appears to have great potential for our patients, but it's going to require you to do a number of extra steps every four hours and keep a new set of records to document how this experiment goes. I think it's worth a try, but it is totally up to you, as you will be the ones doing the day-to-day work."

The nurses unanimously bought in, and the experimental program was huge success. It was ultimately expanded to the entire hospital, saving hundreds of lives. Length of stay in the ICUs dropped by 20 percent. And, guess what, the nurses actually had more free time — even given the extra work — because their patients were not getting pneumonia as often.

The power of listening

Why doesn't this happen more often? Perhaps because those who have risen to clinical leadership positions have often done so by being "triple threats:" excellent researchers, teachers, and clinicians. But there is little in their training or success path that rewards them for teamwork and interpersonal skills.

Yet, there are simple ways to put those skills into practice. In a recent op-ed in the New York Times, Montana Governor Steve Bullock — a Democrat in a heavily Republican state — put it this way:

> ***It's not really a secret, or all that hard to figure out. Above all, spend time in places where people disagree with you. Reach out. Show up and make your argument. People will appreciate it, even if they are not inclined to vote for you. As a Democrat in a red state, I often spend days among crowds where there are almost no Democratic voters in sight. I listen to them, work with them and try to persuade them.***

I don't know Governor Bullock, but I'd bet he would add to this by saying that he often learns things in this process, that he himself is persuaded by his constituents on certain issues. Or that if he can't persuade them with one set of arguments, he learns how to phrase his point of view in a way that's acceptable to the majority.

If we are to address the major problems that exist in improving the quality and safety of patient care, our clinical leaders need to learn that it is not their place to judge their colleagues. Their place, instead, is to respect and listen to them. Sure, they should try to persuade, but they also should be open to persuasion themselves.

Paul F. Levy was the CEO of Beth Israel Deaconess Medical Center from 2002-2011. He is the author of "Goal Play! Leadership Lessons from the Soccer Field."

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