The Patient As Team

American Indian Healthcare and the Transorganization – A Shout for Leadership

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The casualty of silos is the territory between them

"…organizations everywhere are now facing dizzying challenges, from global terrorism to health epidemics to supply chain disruption to game-changing technologies. These issues can be solved only by creating sustained organizational adaptability through the establishment of a team of teams."

– General Stanley McChrystal, 2015

"…leadership is a complex system of relationships between leaders and followers, in a particular context that provides meaning to it members."

– General Stanley McChrystal, 2018

"It is infinitely difficult to begin when mere words must move a great block of matter. But there is no other way if none of the material strength is on your side. And a shout in the mountains has been known to cause an avalanche."

– Alexander Solzhenitsyn, 1975

Abstract

American Indian health care in the state of South Dakota meets the definition of a humanitarian crisis and as such is being called a third-world country within its own borders. This dizzying challenge will require an out-of-the-box but previously successful *Transorganization*, to address a problem which will never be solved by separate organizations operating in silos. It will also require visionary leadership to shine a permanent light on this conundrum, inviting all physicians and healthcare systems to join together as a team of teams, until this situation is transformed. The urgency of this matter demands much more than the typical call for leadership. It demands a shout.

The fall of 2001 found our nation in a very tense situation following 9/11. Anthrax cases appeared for several weeks on and after Sept. 18 in Florida, New York City, Washington, D.C., and New Jersey. Locally many physicians like myself were asked to help provide consultation to state emergency planners and on Oct. 12, 2001, Gov. Bill Janklow convened an urgent conference in Pierre. There, several hundred of us gathered, from virtually every healthcare system in the state, to make terror related preparations, including the unthinkable release of the ancient scourge known as smallpox. As the ominous prospect grew, a national smallpox vaccination program was announced on Dec. 13, 2002, by President George W. Bush. Smallpox vaccine was made available to the states for distribution/administration and on Jan. 23, 2003 South Dakota received its first shipment. Answering the call, healthcare personnel from across the state volunteered to receive history's most famous vaccine. The effort that South Dakota put forth was exemplary and in fact led the nation with a 9.8 per 10,000 vaccination rate, and 62 of 66 counties being represented. A total of 736 South Dakotans stepped forward to receive the classic bifurcated needle technique, with a 96 percent vaccine "take" (protective response) being achieved. This tally

was made up of 432 staff from 51 hospitals, along with 82 emergency medical service providers, 80 volunteer nurses, 67 Department of Health personnel and 34 highway patrol officers. Nationally 37,450 individuals were vaccinated by June 24, 2003. Thankfully, however, the threat of smallpox never materialized – but what did was extraordinary cooperation, surrounding an urgent healthcare need. *For a moment in time South Dakota healthcare came together as a Transorganization*.

Beyond national emergencies like smallpox preparation in rare times healthcare systems must prioritize cooperation in normal times, for as a state we are now confronted with not just a perceived threat to *a* population but a real threat within *our* population. This was poignantly brought into view with Dana Ferguson's Dec. 5, 2018 *Argus Leader* articles, on the generational conundrum that is American Indian healthcare.[1-3] Ferguson's significant effort, which might have been a headlight to illuminate the way ahead, may turn out to be just another road flare, in a long line of road flares – burning brightly for the moment, then quickly fading as we drive on by.

After practicing in Sioux Falls for 32 years on both sides of the divide known historically, colloquially and metaphorically as "Minnesota Avenue" – and having cared for thousands of American Indian patients, treating innumerable episodes of MRSA infection, watching hundreds of extremities amputated from limb threatening ischemia and hearing countless examples of the lack of primary/preventative care, I am left struck by the obvious. How can we, who stand on the shoulders of giants such as Hippocrates Asclepiades, Edward Jenner, and Louis Pasteur – of Ignaz Semmelweis, Joseph Lister and Florence Nightingale – of William Welch, William Osler and Abraham Flexner – of Jonas Salk, Elizabeth Blackwell and Virginia Apgar – of Helen Taussig, the Mayo brothers *and* Susan La Flesche Picotte claim to "see" this – and *ever* look away?

Dr. Picotte (1864-1915), born on the Omaha reservation in eastern Nebraska, is widely acknowledged as the first American Indian to earn a medical degree. Her story as both physician and social reformer, is very compelling and largely untold. To that extent, "Her most important crusade was against tuberculosis (TB), which killed hundreds of Omaha, including her husband Henry in 1905."[4] She faced a poorly understood threat – which by 1900 had become one of the most serious health problems among American Indians – this despite the fact that streptomycin, medicine's first TB drug, was not to come until 1943. *And so must we*. The best of our tradition has never looked away no matter what the challenge – and again is on the line. This conundrum demands something better. *It demands vision*.

Better is what Dr. Donald Berwick called for in a Dec. 13, 2017 Institute for Healthcare Improvement national address – "All together or not at all."[5] The need for an all-out approach is clear because the evidence is overwhelming – and frankly, embarrassing. The South Dakota Department of Health (SDDOH) has previously published over the years in this journal – that, "The American Indian infant mortality…(is) twice as high as the white infant mortality rate…"[6] – that, "American Indian adults (are)…at greater risk of a worse health status than White adults."[7] – that, "A significant racial disparity exists…(in)…the prevalence of diagnosed diabetes in Native Americans…compared to…whites in South Dakota"[8] – and that, "The critical disparity in life expectancy is the 12-year gap between American Indian and white South Dakotans."[9]

This continually deteriorating situation represents the *epitome* of what the National Academy of Medicine, in its *Vital Directions* paper on U.S. healthcare, described as, "…structural inefficiencies, (and) fragmented care delivery…"[10] In addition, poor healthcare within the American Indian population is exacerbated by both long term insufferable socio-economic conditions and geographic isolation. To the above descriptors could be added one more – *catastrophic*. In a recent editorial, current South Dakota State Medical Association (SDSMA) President Dr. Christopher Dietrich paints an even bleaker picture stating that, "…over the last 15 years especially, Native American communities across the nation have been devastated by increasing prescription and illicit opioid abuse, addiction, and overdose…The opioid crisis has a particular hold on communities in and around the Lakota homelands. While comprising just 9 percent of our state's population, Native Americans make up almost 30 percent of the patients in South Dakota who are being treated for opioid use disorder. David Flute, Sisseton-Wahpeton Oyate Chairman, told the *Bismarck Tribune* earlier this year, 'It's growing to the point of being catastrophic. It's causing more health conditions, causing social dysfunction, family separations. It's negatively impacting our social way of life."[11]

Ferguson captured the ultimate summary of this evidence

from another of South Dakota's own American Indian leadership: "We're a third-world country, you know, a third-world country with our healthcare', former Rosebud Sioux President William Kindle said in July (2018), when he learned the Rosebud hospital was again at risk of losing federal funding."[12] All of this is deeply troubling and therefore impossible to defend a laissez-faire mentality. This is also tragic, given the potential of what could be accomplished and in light of the enormous achievements of South Dakota healthcare systems over time. We have much to be proud of – *but not in this case*. Finally this is dangerous, as an active passivity has contributed to unsafe and unreliable care in native populations. *Neglect is not too strong a word.*

While a national debate rages over the meaning of "crisis," this situation certainly meets the definition of a "humanitarian crisis." The United Nations, "...defines humanitarian crisis as 'an event or series of events that represents a critical threat to the health, safety, security, or well-being of a community or other large group of people usually over a wider area (UNISDR, 2009).' Traditionally, the UN identified crises caused by hazardous events, such as natural disasters or conflicts. However, the UN has recently been including diverse vulnerable social conditions — e.g., health, energy, security, water security, food security, urbanization, population growth, poverty, inequality, and climate change— as emerging drivers of crises, and has taken account of complex interactions among these new causes in improving and adapting its crisis management systems."[13] We therefore need to call it for what it is. Per Berwick, to assume that the seat of the bystander is available is an illusion for, "That seat is gone."[14] As "…silence is now political…,"[15] so inaction is now deafening. Rather, "Mere words…"[16] in unison can become a shout all together.

This South Dakota dilemma begs for cooperation-based solutions, to address even the very basics of healthcare within our American Indian communities. Requiring a "turn-around" mindset and based on improvement principles writ large, an out-of-the-box approach is in order with what could be an historic paradigm-changing effort, which can only be described as *the quality improvement project of our time*. This would represent true reform (South Dakota style), bearing the first fruits of what state-wide cooperation can accomplish. As in every great endeavor, transformational leadership is key. To that extent we need South Dakota healthcare-advocates in partnership with South Dakota government leaders, to go far beyond what Gov. Janklow did in 2001. We need a shout for leadership to forge a groundbreaking "summit" (placeholder for ongoing cooperation) of all stakeholders (i.e., Native leadership, Indian Health Service [IHS], state/congressional leadership, state healthcare systems [board of trustees, chief executive officers, chief medical officers, chief financial officers], Centers for Medicare and Medicaid Services, SDSMA, SDDOH) – to try something that has never been done before. To the point, *we are all accountable for the present American Indian healthcare quagmire*, which can only be solved all together or not at all. It means eschewing partisanship of all stripes, transcending healthcare entities and cooperating with each other. *It means the Transorganization.*

The concepts of transorganizational systems (TS) and transorganizational development (TD) were introduced by Cubert et al. in the early 1970s and defined as "…planned change in the collective relationships of a variety of stakeholders to accomplish something beyond the capability of any organization or individual."[17] A search of the literature yields very little on TS or TD as they apply to healthcare per se, despite the fact that medicine is certainly proud of its own "systems" and its own "development." Perhaps the best expression of TS recently is the idea of the "Team of Teams" put forward in the compelling 2015 book by the same name. Author General Stanley McChrystal states that, "…organizations everywhere are now facing dizzying challenges…which can be solved only…through the establishment of a team of teams."[18] McChrystal pinpoints the major impediment to extraordinary teamwork as, "…the wall of the silo."[19] Cooperation, per McChrystal must exist, "…across silos…" along with, "…strong lateral ties…with our partner organizations"[20] The casualty of silos is always the territory between them and so the shear complexity of American Indian healthcare now demands not separate organizational systems *within our state* but the transorganizational system *of our state*. *South Dakota must become a Team of Teams.*

Therefore, in order for this new vital direction to be become reality, Minnesota avenues all across the state must become pathways rather than barriers. The possibility of such reconstruction would be paradigmatic. In that same speech on the amazing possibilities for cooperation-based healthcare (the new paradigm), Dr. Berwick threw down the gauntlet for our entire industry stating that,

"Competition is not the answer. Competition is the problem."[21] This is not to propose the elimination of an honorable form of competition, which drives us to be the best for our patients and to be known for that – but rather to address the problem of a form of competition, which actually hinders us from working together. This will be remedied with nothing less than all physicians and systems in South Dakota coming together in partnership with our American Indian communities and in open public forum – to improve neglected healthcare affecting these original pioneers. There is simply no other way but it won't happen unless an uncommon leadership shines a (permanent) beam on the third-world country within our own borders.

SDSMA has provided a leadership perspective on this challenge with its policy statement of Nov. 3, 2017. In this particular call, it proclaimed that, "The United States Government has a treaty obligation to provide healthcare to American Indians, and the State of South Dakota has long argued that services provided to individuals eligible for both Medicaid and IHS should be eligible for 100 percent federal funding whether provided directly by IHS or non-IHS providers. The policy of the SDSMA is to support the State of South Dakota in its efforts to secure reimbursement for services provided to Native Americans by non-Indian Health Service (IHS) providers." In addition the statement, "…includes our support of Congress to enable IHS to meet its obligation to bring American Indian health up to the level of the general population (and)…efforts to improve recruitment and retention of employees in IHS…"[22] This policy prescription is commendable with transformative ideas – such as more non-federal health centers, increased involvement of private practitioners, improvement in transportation and improving recruitment/retention of employees in IHS. But it also reveals two chronic attitudes toward American Indian healthcare which must change. First, obligation, as remote duty, *assumes that the current system can actually bear this burden on its own*. It cannot. Therefore as a state we must shoulder obligation within our borders as proximate family, not as distant inhabitants. Second, calls for money, as reflexive solution, *assumes that the current system can actually improve on its own*. It will not. Therefore as a state we must shoulder improvement within our borders as engaged professionals, not as idle onlookers.

The dizzying challenge of American Indian healthcare in South Dakota is in fact more about leadership than anything else. General McChrystal in his newest book *Leaders – Myth and Reality* teaches us why our mental models of leadership are inadequate – at best. Per McChrystal, "While I enjoyed the study of history and leaders, as I matured, the concept of leadership that I had willingly accepted increasingly contrasted with some of what I read, and much of what I experienced…I found that leaders who exhibited all the right traits often fell short, while others who possessed none of the characteristics of traditional leadership succeeded. The things we sought and celebrated in leaders had confusingly little linkage to outcomes. The study of leadership increasingly seemed to be a study of myth..."[23] After profiling the lessons learned from 13 famous leaders, McChrystal defines three prevailing myths which require rethinking if not rejection – The Formulaic Myth (leadership cannot be reduced to algorithms but rather is contextual and dynamic) – The Attribution Myth (leadership is less about any single individual but rather is an emergent property of a complex system) – The Results Myth (leadership is less about specific results and is more about symbolism/meaning/future).

Out of these real examples from history, McChrystal proposes a more accurate definition, that, "…leadership is a complex system of relationships between leaders and followers, in a particular context that provides meaning to it members."[24] This sounds strangely like what we do in healthcare, for we are vast numbers of medical leaders and followers working in complex relationships for the needs of patients, within the complexities of illness and suffering – providing great fulfillment for all of us along the way. South Dakota healthcare therefore has more than the necessary leadership to address this challenge but we currently exercise it within siloed organizations. So the question is called or in this case shouted – *In the context of American Indian healthcare can our complex systems break down walls, develop relationships with each other and form a team of teams?*

Transformational cooperation and leadership like this will require the ultimate public/private effort and become the BHAG – "Big Hairy Audacious Goal" – for our state. Per author Jim Collins, "A true BHAG is clear and compelling, serves as a unifying focal point of effort, and acts as a clear catalyst for team spirit. It has a clear finish line, so the organization can know when it has achieved the goal; people like to shoot for finish lines."[25] To pursue this South Dakota BHAG would be to show the industry

how healthcare delivery is possible with *a first-in-the-nation-transorganizational-system* aimed at addressing intractable healthcare challenges, which none of us can solve on our own. As the highly partisan healthcare debate slouches forward in 2019, models to solve this Rubik's Cube are urgently needed. Ironically an answer may lie in the crucible of American Indian health, for this is territory where healthcare's overuse, underuse and misuse all converge – where contexts of history, culture and reality all reside – where philosophical debates over privileges vs. rights all fade – and where obligations to our fellow immortals all emerge. *South Dakota, while one of the least in population, could be one of the greatest in population improvement.* We can be exemplary once again.

This initiative needs to be radical in the following ways – cooperation-based, innovative, transparent, accountable, sustainable and humble – *in other words how most of us care for our patients every day – as a team of teams*. For any hope of achieving transformational ends, it must not primarily be about money (the cart) but rather primarily about improvement (the horse). This trailblazing journey together should be covered by the major news organizations – and an annual press conference, for decades to come, should be convened with each stakeholder at the table exposed and engaged over this need.

But how might exemplary begin? History is our teacher. The shoulders we have stood upon are now looking over our shoulder, as we face ourselves in the mirror. The leader of our state in 2001, Gov. Janklow, issued a call to form a South Dakota Transorganization. Now 18 years later Gov. Kristi Noem must do the same, except this time *it will require a shout*. As stewards of a great tradition, we must not look away.

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