Tribalism and Organised Medicine

by A/Prof Lee Kheng Hock, President, 23rd Council, College of Family Physicians Singapore

A Cautionary Tale

At about 8.20pm on 6 April 1994, a Dassault Falcon passenger jet descends to make the final approach to Kigali International Airport in Rwanda. Unknown to the VIPs on board who are looking forward to a routine landing and a swift ride into town escorted by the Presidential Guard, two surface-to-air missiles were locking on to the plane. They were launched almost simultaneously. The missiles streaked through the night sky. The first struck one of the wings splintering it. Just as it began to spin out of control, a second missile struck the tail and transformed the plane into a massive fireball in the sky. All twelve passengers in the plane were killed instantly. Among them was Juvenal Habyarimana, President of Rwanda who was working to end the simmering civil war between the Hutus and the Tutsis. The flaming smithereens plummeted down from the night sky and ignited a conflagration of hatred on the ground that had been sown and simmering for the last 78 years. What followed was known now as the Rwanda Genocide. An estimated 1 million people or 20% of the population were slaughtered within a period of just over 3 months. The killings were exceptionally chilling because of its direct and personal nature. People were killed in the most painful and brutal way imaginable. The preferred method of murder was by hacking with a machete, often perpetrated by neighbors and friends. They were killed in or near their homes and often in churches where they sought refuge. They were killed by people who shared the same religion and spoke the same language. The murders were often preceded by unspeakable acts of torture and abuse.

What hatred can drive members of the same community to turn on each other with such violence and cruelty? It took many years to fester and it started with the registration of people into categories in 1916 by the Belgian colonial masters of Rwanda.

Roots of Intolerance

Before the Europeans came in search of empire, Rwanda was a stable and prosperous kingdom. There were three informal classes of people in the society who lived in relative harmony. There were cattle herders, farmers and the hunter-gatherers. In a society that measures wealth by cattle ownership, the cattle owners were called Tutsis and formed the aristocracy. The farmers were Hutus. The original people of the land, the Twas, were hunter-gatherers. The Twas were the poorest and despised by both the Tutsis and the Hutus. The division of the people into different castes was not mandated by law. Intermarriage between the groups was not restricted and there was social mobility. An upwardly mobile Hutu who become rich can buy himself a herd of cattle and become a Tutsi. A down and out Tutsi who lost all his possession, falls from grace and becomes a Hutu.

When the Europeans arrived, one common strategy used to control the natives was to "divide and rule". It is hard to believe today but in the early 20th century racism was the politically correct ideology in many parts of Europe besides Nazi Germany. There was a belief that some races are superior and the imagined genetic closeness of the inferior races to the master race created a hierarchy of superiority. They imagined the Tutsis to be taller and fairer and a tad more European looking than the Hutus. They are therefore considered to be more highly evolved and intelligent. A lethal combination of racism and imperial pragmatism lead the colonialist to start classifying the people as Tutsis and Hutus. The Tutsis were placed in positions of power and leadership to help the colonialists control the country. In practice it was difficult to define who is a Tutsi and who is a Hutu as they were really one people with different stations in life. They therefore created a register of race through the issuance of identity cards. Henceforth the old social mobility was gone, one's registered identity determined the things you are allowed to do and your position in society. A person's fate is cast in stone based on registered race. In an effort to bring legitimacy to this arbitrary classification, they brought in "scientists" from Europe, experts in the pseudoscience of phrenology. They made elaborate but nonsensical measurements of the heads of people and then relegated them to either an inferior or a superior race.

After the registration of the races was completed, the systematic oppression and disempowerment of the Hutus began. The fortunate minority who were registered as Tutsis were understandably flattered. They were quite willing to be persuaded to collaborate as they were rewarded with things that were taken from the

Hutus. Hutu chiefs and tribal leaders were deposed. Only Tutsis were allowed to take on civil service jobs and leadership positions. They were given preferential treatment in education, business and had better access to public services. The tragic thing was that over time, the Tutsis came to believe in their superiority and the Hutus developed a deep hatred of their former brethren.

The Rwanda Genocide teaches us that categorising people into rigid groups for expedient purpose can have far reaching and sometimes, catastrophic unintended consequences. Autocratic and insecure leaders often like to exacerbate distinctions between tribes as a way of staying in power, often to the point that it boils over.

Tribalism and the Medical Profession

So we know tribalism is nasty. What relevance is there to medicine? Surely an idealistic and noble profession such as ours is above such social aberrations. However if we reflect on our day-to-day activities as doctors, the way we are registered into caste systems and the incessant conflicts between the various guises of tribal councils, we will realise that all is not well. The constant turf war sometimes makes me see some resemblance between organised medicine and organised crime. You may think I am too harsh on the medical profession but I am not alone. Sir Irvine Donald, former President of the General Medical Council, thinks that tribalism is deeply rooted in our profession. He wrote the following: "In our professional institutions, inappropriate autonomy, manifest as divisive tribalism aggravated by the fragmentation caused by specialisation, has resulted in a profession less and less able to act creatively as a coherent entity."[1] "Tribalism has a profound impact on the profession — we are a dysfunctional profession at that level right through the system, and it is hurting us."[2]

The tendency to tribalism is similar to ethnocentricity. It is hardwired into all of us. It is believed that such instincts evolved because it is a pro-survival adaptation. The benefits of loyalty to a socially constructed group is evident if we imagine early man coming together for mutual protection and greater efficiency in hunting larger animals. Group conformity keeps people together and allowed co-operation towards the common interest of the tribe, even when personal antagonism between individual members would have otherwise prevented co-operation. Therefore tribalism is not always bad if it brings order and allows division of labor towards a good cause. However if the leadership of tribes loses sight of common goals, negative tribalism often ensues.

Specialisation is necessary for us to cope with the increasing complexity of healthcare. However it is a double-edged sword as it can veer towards tribalism when intra-group cohesiveness is achieved through intolerant group identity and turf wars.

Dysfunctional Tribalism in Medicine

The strong intra-group loyalty of tribes can be maladaptive. The dynamics of what is apparently a primitive instinct to form social groups is actually a complex adaptive system. If the rules of the tribal membership evolve towards rigidity, the negative pressure on non-conforming members increases to the point that it limits the diversity of the group. Non-conformist are bullied into submission or exiled from the group. Consequently the group increases its effectiveness in a static niche and the expense of loosing its ability to adapt to changes in the external environment. An even more sinister tendency is when rules for intra-group cohesiveness are defined in terms of antagonism towards other tribes. This causes non-cooperation, confrontation and eventually, open warfare with opposing tribes. In extremis, it leads to genocide, when one tribe re-defines its existence towards the annihilation of another.

Specialisation is necessary for us to cope with the increasing complexity of healthcare. However it is a double-edged sword as it can veer towards tribalism when intra-group cohesiveness is achieved through intolerant group identity and turf wars. If tribalism exists in organised medicine, then we must take heed to limit its negative tendencies. We should remember our common goals and the raison d'etre of our existence as a profession. Medical tribalism

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aggravates care fragmentation and hinders the collaboration of inter-professional groups. A recent study found that "professional tribalism" is a strong influencing factor in professional decision-making processes that results in unplanned re-admissions.[3]

Preventive Medicine

While we accept that organising health care along tribal lines is unavoidable, there are things that we can do to limit its excesses. Awareness of the negative consequences is important and conscious effort must be made to instill this awareness in the formative years of the education of health care workers. In addition, work environment and processes should also be designed promote inter-professional collaboration.[4]

Leaders of medical tribes should be constantly reminded of their responsibilities towards promoting inter-professional collaboration and limit the negative tendencies of their tribesmen's hostility towards members of other tribes in the healthcare landscape. They should consciously resist the urge to appeal to jingoism as a quick and dirty way of strengthening their leadership position. Instead they should recognise the benefits of diversity and seek common platform for collaboration with other groups.[5]

When we register healthcare workers ostensibly for the protection and well being of our patients, we must ensure that we are true to our ideals and not let our personal prejudice and self-interest get in the way. Pragmatism towards patient centered care must trump social constructs of purity of ideology. We should be reminded of the wisdom of Deng Xiao Ping who saved China from the excesses of the ideological pursuits of the Great Leap Forward and the Cultural Revolution.

"不管黑猫白猫能捉着老鼠的就是好猫"

As he famously said, "regardless of whether a cat is white or black. It's a good cat if it catches rats."

Registers should be based on training and competencies. It should not be an extension of turf wars or ideological conflicts within or between tribes. Within our College we must work to accept doctors who are committed to the values of family medicine and the advocacy of higher standards in family medicine, regardless of whether they are in or out of the register. We must remember that the Family Physicians Register is a means to an end and not an end in itself. Until the day comes when we have sufficient resources to ensure that all graduating doctors have access to formal family medicine training, if they so wish, we must accept that the register is still work-in-progress. Registers whether family physician or specialist should not be used as tools of medical tribalism. We must constantly resist any tendency to impose our narrow and legalistic definitions of tribal specialisation on our colleagues who may work in different settings or descend from different training pathways. We should instead focus on developing competencies that enable us to fulfill our common calling, which is to use our family medicine training to provide patient centered care to our patients, in accordance to the higher values of our discipline.

References:

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4. What is your management plans?

- Relief of itch with oral antihistamines and mild TOPICAL steroids if necessary.
- Reassurance that it is not a contagious rash and is self-limiting.
- No need to keep patient from work or school (for children).

5. When would you refer to a dermatologist?

Referral to dermatologist in the following instances:

- Atypical presentation/distribution of the rashes.
- Duration of rashes beyond 3 months or recurrences of rashes.
- Involvement of palms, soles and mucosa.
- Systemic symptoms.
- Patient very concerned over the prolonged rash.

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