We Need to Use Our Instincts to Help Us Continuously Improve and to Help Us Solve the Very Real Problems That Our Instincts Create

As I began to look at all of the countries that I could find that were either at war with themselves or at war with other countries, it became clear to me very early in the learning, study, and discernment processes that there were very definite and very consistent patterns in the negative intergroup interactions that were happening with obvious regularity and with very predictable consistency in a very wide range of settings.

The patterns were so obvious and so clear that it was obvious to me that there must be an array of common and universal factors and functions that were creating, shaping, guiding, and perpetuating those consistent packages of intergroup behaviors in all of those settings.

I have had a long history of looking for both behavior patterns and consistent processes that affected important outcomes in my work life as a health care executive. I have served as the CEO of one health care organization or another for more than three decades. The organizations I served treated millions of patients in a wide variety of care settings.

I knew from that experience that problematic health care situations that happened in multiple settings often had common causes. I also knew that health care outcomes were heavily dependent on the basic processes that create the outcomes that happen in each health care setting.

In that health care world, I had become a believer in the science and the practice of systematic process improvement.

My experience in my work settings has been that we can make a number of significant improvements in health care outcomes by looking at care from the perspective of the actual functional processes that are involved in delivering the care that exists in each setting.

I applied that same basic process and analytical perspective to looking at the issues of the intergroup interactions that I had begun to study back in the early 1990s. It was clear that there were very similar intergroup problems and conflicts happening in settings across the planet. I could see nearly 200 of those conflicts in various settings almost immediately after beginning my search.

I could see very quickly that there were intergroup conflicts in a high number of settings — and I could see that those settings — like the health care situations that I knew fairly well — seemed to have some basic patterns of facts, circumstances, and behaviors that had similarities across multiple sites.

I looked at both books and news media reports about all of those intergroup conflicts, and I built files containing what information I could learn about each conflicted situation. As I gathered that information, I could see that there were a number of factors that seemed to occur with some regularity across multiple sites where conflict was happening.

I began an assessment process to figure out what common causes or common factors existed in various settings that could be creating at least some of those conflicts.

My work on functional process improvement in health care taught me that getting better results from any process requires understanding clearly what the key factors are in each health care situation and also figuring out what the key steps are and what the key component parts are for each of the relevant health care process in those settings.

That combination of approaches had given me great results when it was applied to health care outcomes. It was an extremely useful process to do.

To reduce pressure ulcers from 5 percent of our hospitalized patients to less than than 1 percent of our patients — to some of the lowest levels in the world — our approach involved understanding every single patient interaction and every single functional process element that created, triggered, activated, enabled, and reinforced those ulcers.

Once we understand the specific process reality that was functionally relevant to those ulcer-related issues, we did what we needed to do to put in place and deliver the explicit steps in each setting that could actually make outcomes better for those patients.

We improved the most relevant key processes for both the diagnosis and the treatment of those pressure ulcers. Care was significantly improved for our patients as the result of that work.

That way of thinking is, in itself, a very systematic, structured, and entirely intentional process for solving problems and resolving problematic situations. I know from direct experience that systematic process improvement work can make complex and important health care outcomes consistently better when the work is grounded in actual analysis of the key factors and problems in each setting and when the work involves a basic understanding of each problem's most significant causes in each setting where those problems occur.

That approach has worked for several areas of health care. It has also worked very well for many other people in many other industries. I believed, as I began looking at the intergroup interaction behavior patterns that were causing conflicts in all of those settings, that the same approach had a lot to offer to help us resolve and prevent issues and problems relative to intergroup interactions in those areas of problematic interactions.

Process Improvement Cut the HIV Death Rate in Half

The formal process improvement model works well and creates real value when it is well done.

The care system where I worked literally cut the HIV death rate to half of the national average.

We shared our improved processes with the world relative to our HIV care steps and approaches. You can look at what we did for those patients in the national HHS care support systems database because we gave those improved processes as a gift to other caregivers. The staff at HHS is now sharing that information with the rest of the care delivery world.

We also cut stroke deaths by 40 percent. We cut hypertension by half. We did all of that work using the science and the thinking approaches that are embedded in systematic process improvement.

I love those processes and I love that way of thinking about problems.

As I looked at all of the consistent sets of basic intergroup problems and intergroup conflicts that I could observe in all of those settings, it made sense to me to try to apply those same kinds of process analysis, data review, and process engineering approaches to intergroup conflicts that had cut death rates for us in several key areas of health care by half or more.

That systematic and process related approach to those problems turned out to be a very good and useful thing to do. As I put basic paper files together on hundreds of conflicted settings, I could see that most of those patterns of negative intergroup behaviors clearly did have discernable and consistent processes embedded in them.

History does repeat itself. There are definite patterns in intergroup interactions that showed up in setting after setting.

I concluded after relatively brief review that it was going to be very useful to use basic systematic process improvement thinking and process improvement

approaches to think about solutions to the issues of racism and intergroup conflict in our country and in other intergroup settings as well.

You Need to Identify Both Process and Consequences

The process of doing process improvement for any key area or function is pretty basic.

When you do process improvement in a work environment or in a health care setting, you take the time to figure out initially exactly what your problems and challenges are. Process improvement advocates and practitioners base their thinking on the belief that the outcomes for any function or situation are all created by processes — and if you want to improve the outcomes, you need to improve the specific processes that create that outcome.

Each outcome, process zealots argue, is simply the natural and inevitable result of the process that creates it.

Once you figure out the outcomes, you need to take the time to figure out what set of factors, functions, or processes are functionally creating those outcomes.

Once you understand those key processes, improvement experts can generally figure out how to have an impact on those factors and those processes in ways that will improve the product or enhance the service you are delivering.

Each step in that process is fact based. Data is important. Facts are highly relevant. Analytical science is extremely useful and critical to the success of those efforts.

Process improvement is, at its core, a fact-based, reality grounded, purely analytical process. I am a believer in that theory and that process and I have found it to be very useful in a purely functional way in both health care delivery and health care coverage.

I believe that the outcomes that exist in any setting are each created by the specific processes that exist in that setting. I believe strongly that if you want to

improve the outcomes that exist in any setting, you can do that by systematically improving the actual processes that create the outcome.

I Needed Information About the Functional Process Factors That Cause and Exacerbate Intergroup Problems

As I did my process improvement centered research into intergroup interactions, I could clearly see that there were, in fact, consistent intergroup outcomes and behavior patterns in many settings.

My goal was to figure out what the functional pieces and "impact factors" were that set up the processes in all of those settings in ways that created those consistent intergroup outcomes.

That search process then structured my learning processes for intergroup interactions. I looked at a very wide range of settings and circumstances to see what "input" factors might be relevant and common to all of the places where those sets of problems existed.

As I categorized the factors that seemed to exist in patterns with some frequency, I could see that language differences were often a factor linked to groups being conflicted with a high degree of consistency, the people shooting at each other tend to have different languages. That was true in World War II and it seemed to be true in most of the current conflicts I saw in Asia, Africa, and Eastern Europe. I could also see that in areas like Quebec where part of Canada speaks a different language than the rest of Canada, that language difference seemed to be a source of intergroup tensions.

I could also see that in a very large number of settings, the groups at war with one another inside countries tended to be different tribes.

That was true in almost all of the conflicted areas. I defined tribes as being people who had a different group name, a different group language, a different group culture, and, in most cases, a sense of their own group turf.

When groups met those criteria, they were often in a state of conflicts with other tribes who also met those criteria.

Instinctive Behaviors, I Concluded, Had to Be a Key Factor

All of those factors existed in settings where group were at war with other groups — but all of those factors also existed in settings where groups were in a state of Peace with other groups. Those various factors all seemed to have some relevancy, but they clearly were not the reason why some settings have people killing people from other groups.

It was very much like the problem that we faced relative to central line infections in our hospitals. When we started to focus on that problem, it was clear that most patients never had one of those infections, but a number of patients were actually being killed by those infections. We decided to use systematic process improvement approaches to reduce the number of people who were being killed by those infections and that required us to figure out what the differences were in the settings where there were no infections.

To reduce and end those infections in our care sites, we needed to identify each of those various factors that were relevant to each patient that created the infections when they happened. Then we needed to invent, design, implement, and systematically refine and continuously improve focused processes that were directed at those specific causation factors in ways that had a consistent, relevant, beneficial, and positive impact on mitigating or eliminating each causality factor for each relevant patient.

Good Intentions Are Not Sufficient to Improve Care

We identified those problematic causality factors, measured and tracked them, and then took systematic steps to reduce or end them. Our overall goal was continuous improvement — not just doing things situationally better to resolve a circumstantial issue or an incidental problem.

As our process reengineering steps systematically improved care in our care sites, our continuous improvement mind set and commitment caused us to figure out ways to enhance the steps even farther to improve care even more.

We ultimately had some hospitals that went more than a year without one single infection. That was only possible because we were dealing with those factors consistently in every site and because we were continuously improving our approaches to delivering that care across all sites.

Many caregivers in a wide range of care settings have very good intentions about those infections. Good intentions are not enough.

Good intentions were not sufficient to end those infections in any site. It took analytic processes and systematic, focused, and structured process improvement work to achieve those results.

I looked at those success levels in care delivery and made the commitment to figure out how we could create a similar systematic approach to ending intergroup conflict in all of those conflicted settings — beginning with a clear sense and an accurate diagnosis of what factors and which functions were the consistent factors, functions, triggers, reinforcing processes, and causality links that were feeding and creating the conflicts that I saw happening in so many places.

InterGroup Problems Clearly Stemmed from Consistent Triggers — Not Conspiracies

As I read my first sets of books and articles about intergroup issues and about racist behaviors, I ran across multiple references to conspiracy theories as a major possible factor that might be behind that consistency of negative behaviors.

I learned that some people believe strongly that those consistently negative intergroup behaviors are the result of overarching conspiracies — with people conspiring with each other to create those behaviors and then reaching out somehow to transplant those specific negative behaviors to other people in all of those settings where those particular negative behaviors now exist.

As I did my initial research into specific problem settings and issues, I looked carefully for those conspiracies. Conspiracies clearly had the potential to be a

relevant factor with broad negative impact on intergroup interactions if any conspiracies existed.

My search for a core conspiracy for those sets of problems failed. I could not find any overarching conspiracies that had the leverage, the power, and the logistical connectivity components that would be needed to influence intergroup behavior in all of those very consistently negative ways across that very wide range of settings.

My Personal Analyst Pointed Me to Instincts

So I continued my search for an underlying causation factor that could be triggering the specific conflicts that were happening in so many settings. Using the context of process improvement thinking — with the intent to re-engineer relevant processes as needed to improve our outcomes in our key intergroup areas — I looked for basic trigger factors that could be catalytic in creating that wide range of negative intergroup interactions that were happening with such regularity and such consistency in so many places.

I was personally doing some counseling at the time that I wrote those first drafts of this book with a Jungian psychoanalyst.

One of the things I personally like to do is self-analysis. I find the process fascinating. I have done Freudian, Adlerian, and Directionalist analysis and coaching at different points in my life. I have also done some human potential theory linked personal analysis processes, some self-awareness exercises, and I have participated in some life choice education sessions.

Each of those processes and all of those counseling approaches have taught me interesting things about human nature and about my own behavior and thought processes. I haven't done any counseling for a few years now, but for a while I had almost a mild addiction to periodic, professionally assisted, personally focused levels of self-analysis.

My Jungian Analyst Pointed to Instincts

So at that particular point in my life, as I was trying to figure out for the purpose of the book I was writing what the underlying factors might be that created the intergroup equivalent of those central line infections in so many of those multi-ethnic and multi-tribal sites, I happened to be working on my own self-awareness with a Jungian analyst.

He was a gifted and insightful practitioner and he was helping me develop a focused understanding of some of my own personal life challenges that I was finding very useful. I enjoyed our conversations and I appreciated his counsel. He was very good at what he did.

I changed the direction for one of our analysis sessions from talking about me and my personal issues to talking about me and my current writing challenge and issues.

I talked to him very specifically and explicitly about my group conflict trigger problem and about the fact that I was looking in a process improvement mindset and continuous improvement analytical context to find common causes of some kind for all of those troublesome and damaging intergroup behaviors that were happening in so many settings in our country and around the world.

I asked him if he had any idea about the specific consistent intergroup discrimination issues that were at the heart of the book that I was trying somewhat unsuccessfully to write.

I also asked him why we had consistent negative intergroup behaviors in our own country that paralleled the tribal conflicts that existed in other countries in many ways without us having the kinds of actual tribes in the picture here that were obviously creating those kinds of intergroup problems in most of the other conflicted settings.

I was very focused on tribes at that point in my research and thinking. So, part of my question was to ask him if he had any sense of why those same basic negative intergroup behavior patterns clearly existed both in those purely tribal

settings in other countries and in our non-tribal, but clearly diverse and also internally conflicted country.

He provided me with an insight that stemmed — not surprisingly for a Jungian analyst — from Carl Jung. He pointed me to instincts. Instincts, he said, were the most likely trigger for those behaviors.

In response to my question about finding and identifying a common cause for all of those problems in all of those settings with all of those people, my very thoughtful and frequently wise analyst pointed me very directly to instincts as the missing link that probably, he said, connected all of those behaviors for all of those people in all of those settings.

Jung, he told me, believed in instinctive behavior as part of his understanding of the mind. Carl Jung believed, he told me, that anytime we see a universal pattern of behavior across the planet, there functionally has to be an instinct at the core of that universality.

Instincts Made Functional Sense as a Trigger for Consistent Behavior

I loved that answer. That answer made immediate sense to me. I had failed in my initial search for conspiracies as the common cause for all of those negative behaviors. Macro conspiracies did not seem to exist. But universal instincts clearly did exist. They were everywhere.

We all have instincts. I knew that already. So his answer made operational sense to me and it also made functional sense to me that many of our key behaviors could be both triggered and choreographed by our instincts.

As a focused and almost obsessive process analyst, it immediately made both functional and practical sense to me that the consistency that I saw across all of those key areas of behavior across all of our intergroup settings could actually, very logically, be created by the undeniable fact that we humans all have the same sets of human instincts and that those instincts could very easily create a very real process component and set of functional factors that consistently affect the way we think and the way we behave in every setting we are in.

The functional realities are clear. The logistics are irrefutable. We each bring our instincts to each setting we are in. We do that because our instincts are a key part of who we are. We can't go anyplace without them.

That linkage of our universal behaviors to our universal instincts had a great sense of intellectual legitimacy to me as a belief system. It made clear functional sense to me as a process related causality formula factor because it explained major pieces of our collective behavior in the context of clear functional processes that I could both see and understand.

I believed in that exact moment that he made that statement that he was right. I can still remember the couch and the cushions I was sitting on in that tiny office in East St. Paul when he gave me that lovely piece of wise and clarity-inducing insight.

I Had Suspected That Instincts Were Relevant Before

I had actually believed that instinctive behaviors were a probable partial factor for at least some of our behavioral consistencies before he made that statement, but that primary level of full linkage at a base-line causality level between instincts and those overarching patterns of behavior made great sense at a higher and more complete level when he suggested it to me in that session.

I realized immediately that it probably was the best functional answer for why we have so many absolutely consistent and universal intergroup behaviors in all of the places where we have those behaviors.

There have been a number of excellent authors who have done some really good work on instinctive behavior in people. I read some of those authors and I learned significantly from them. E.O. Wilson, Richard Wright, Francis Crick, and Edward Dawkins had written great books that I devoured and deeply appreciated. Anne Moir wrote an amazing book on instinctive thought processes with a gender-related context that I have given as a gift to several people.

Wilson, in particular, was and is a hero of mine. He clearly has one of the best minds on the planet.

Each of those authors added layers of insights to my thinking on those issues.

Instincts Can Choreograph Complex Behaviors

After that session with my analyst, I immediately read as many articles and books about instinctive behaviors as I could find. I read about human instincts and I read about instincts in a wide range of other species that we share the planet with.

The power of instincts to influence and choreograph behavior in other species in amazingly complex and consistent ways very directly reinforced my sense that instincts could and did directly influence us and that the influence of instincts on us could also involve consistent complexity.

The Question Is — How to Use Instincts to Improve Processes?

None of those authors had, however, reached the same specific sets of conclusions that I was in the process of reaching about the impacts of our instincts on our intergroup behaviors.

The books and articles that I found to read at that point in time tended not to deal in a direct or explicit way with the specific set of intergroup issues and intergroup problems where I was focusing my own attention and my own thinking from a process improvement perspective.

But all of those materials were extremely reinforcing to my belief that all of those problematic intergroup interactions had to have a set of instincts as both triggers and guides for our behaviors and our thought processes.

Because I am functionally and fundamentally both a continuous improvement process analyst and a reengineering practitioner, but I am not an academic or a scientist, I looked at those sets of issues from the perspective of a person who is figuring out how to use that set of information about our behaviors to make important relevant process improvements in our lives that

are relevant to Peace and relevant to resolving intergroup tensions, anger, and conflict better.

My approach to that set of information about intergroup interactions was more like a carpenter or an engineer than a physicist or even an academic theorist. I decided to do experiments in real life settings to see how our instincts affected our thoughts and behaviors.

My goal was to create pieces of processes we could build with to make our intergroup interactions better. I wanted to build tools that I could use to cause some sets of problem behaviors to change. My goal, very quickly, became to build tools that I could use to help take our very best, most caring, most inclusive, and most enlightened instinct-related behaviors and to use those positive instinctive behaviors in very intentional ways to help spread functionally beneficial behaviors to a wide range of people.

Even as a carpenter, however, I need to get some sense of the relevant science about instincts to make the building process that used our instincts as tools to work.

I Began to Track and Study Instincts

I knew as I began that work that instincts are clearly universal and that instincts clearly influence behavior. I very intentionally focused my thought processes and my research efforts on looking for specific ways that instincts had an effect on our intergroup behaviors.

I wanted to know where instincts were relevant and I wanted to know both how the truly relevant instincts were triggered and how they influenced our behavior.

I began to do a series of experiments and tests at that point to figure out ways that I could use my knowledge of instincts to have an impact the work that I did in health care management settings and on the people I worked with in my various job and public policy settings.

My job as the CEO of a fairly complex and large health care organization gave me a great context to do that work at a very practical level. I looked to find ways that instincts affected our work force and I looked at how instincts affected the patients we served and influenced as patients and customers.

I looked very directly to see how instinctive issues affected the customers for the services we sold.

Because my day job for more than 30 years has been to be sequentially the CEO of half a dozen different organizations — involving tens of thousands of employees and a wide range of resources and component parts — I have actually been able for a very long time to use my day job as a learning laboratory to create and test multiple theories and approaches to instinctive behaviors.

I Used Instinctive Behaviors to Create Cultures, Hierarchies, and a Sense of "Us"

I have used what I learned about instincts in that process very directly to build cultures, design hierarchies, create and motivate teams, and to create a clear sense of internal alignment for each organization that I led as CEO.

I used instinct-related approaches to cause each group I worked with to identify with itself in a positive, aligned, and self-reinforcing way as an intentionally designed category of organizational "Us."

I also had some useful ideas at that point in an entirely unrelated series of thoughts from a very functional care delivery perspective about how we might be able to use comprehensive and targeted medical information in computerized formats to improve both the delivery of care and the science of care.

I worked on those systems related care improvement approaches and systematic care support issues at the same time as I worked on the culture of care approaches and issues.

I have been blessed with the opportunity able to use my day job as a functional laboratory to test those computerized care support theories and

approaches as well as testing instinct related behavioral impacts for the behaviors and values or our care teams.

It turned out that those concepts and those function-related theories about using a wide range of computerized tools to help improve care were, in fact, accurate and useful ideas. It turned out that care actually did get better when caregivers had the right electronic tool set that gave caregivers real time and meaningful information about their patients as well as giving the caregivers computerized access to best practice care protocols and computerized access to what might currently have become the largest electronic care library in the world.

A Culture of Caring and Continuous Improvement Can Improve Care

That electronic library that we built as a caregiver support tool contains thousands of books and articles about the science of care in a format that is easily accessible to each physician and each caregiver on that Kaiser Permanente care team.

Because I worked in a resource rich environment, I was able to have us invest more than $4 billion of our financial assets to test that particular set of care support tool theories. We worked hard to create both the right set of care tools and to simultaneously create a culture of patient focus and continuous improvement for our caregivers that would cause the tools to be used well in the interests of our patients, once those tools existed.

Making the science of care better is a good thing to do. Making the culture of care better also adds major value.

Getting those infections in our hospitals down to zero can't be done by science alone. Great care requires a culture of great care. Achieving those quality levels in those care sites takes a functioning and self-reinforcing culture of caregivers who care deeply about the care outcomes for every single patient.

We built our systems and we built our culture in close alignment with one another and the results in many areas of care for patients and for medical science have both been spectacular.

Four billion dollars is a lot of money — but that money spent was a good and solid investment. The higher levels of care and the better care outcomes that result from that significant system functionality more than repays that entire cash investment every couple of years.

The Approaches Worked in Care Delivery

The instinct related work that I was able to do in those settings as the chair and CEO for the organization helped make that care improvement agenda a success.

On that wisdom-triggering day with my Jungian analyst in East St. Paul, I began immediately to look very specifically at all of the universal intergroup behaviors and problems that I could find and identify to see which of our relevant universal behaviors might have an instinct of some kind at their core.

It was clear to me that if I was going to use our instinctive behaviors as part of my functional process improvement tactics and process improvement strategies, I needed to know both what our instincts were and I needed to know how they, themselves, actually did what they did.

If I intended to use instincts in an intentional and structured way to make real things happen, I needed to know how instincts, themselves, actually made real things happen.

Instead of assuming that instincts used magic or some kind of generic and invisible biological or magical interventions to do their actual work, I spent time figuring out what tools were actually being used in the instinct tool kit.

That turned out to be less mysterious or complicated then I thought it might be when I first started trying to answer that question. Some of the key tools that our instincts use to guide us toward out to be fairly easy to identify and find.