Leadership in the Midst of Heath Care Complexity II:

Coaching, Balancing and Moving Across Multiple Cultures

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We identify specific challenges and specific models of leadership in this fifth in our series of essay regarding adaptive complexity in contemporary health care systems. Our exploration of leadership begins with a consideration of ways in which health care leaders can benefit from not only receiving coaching services but also serving in a coach-like role when working with others in their organization.

We suggest that coaching to a team rather than an individual might be particularly appropriate in health care given the complexity of challenges being faced and the need for multiple perspectives in addressing these challenges. We also focus on the empowerment that comes with effective team coaching and with the way(s) in which health care issues can be added in an "emergent" manner.

In the second half of this essay, we turn to the fundamental nature of the challenges that a coaching and team-oriented health care leader is likely to face in the middle of the 21st Century. While there are many challenges (such as those related to volatility, uncertainty, complexity and ambiguity: the so-called VUCA conditions), we focus on two additional challenges that are closely related to and exacerbate the intensity of the VUCA conditions.

These two additional challenges are turbulence and contradiction (yielding a VUCA-Plus environment). Leadership in a VUCA-Plus environment requires balance and agility in a world that is turbulence and contradictory, in part, because of the varying conditions of change in contemporary health care and because of the presence of six sub-cultures in health care that each contains its own version of reality and its own set of needed.

Coaching the Leaders

The authors have long believed that teamwork in healthcare will struggle to manifest until a sufficient and sustainable coaching bench is developed. When we look at the world's most successful teams, we often find a pattern of outstanding coaches who travel to develop one remarkable team after another. In basketball, one can trace the careers of Phil Jackson and Gregg Popovich. We find dynasty after dynasty moving right along with both of them.

College basketball has seen many coaches with truly stunning lifetime records of national championships year after year after year. One of us (JF) was a varsity oarsman for the University of California Lightweight Crew in the 1980's. With amazement, he watched first-hand the career of Steve Gladstone who established dynasty-level National Championship crews at Cal (6), Brown (5), and Yale (3) throughout his 50+ year Coaching Career.

What was Steve's secret sauce? Helping young oarsmen find their sense of purpose and passion for rowing and bring their full measure of effort each and every day they are on the water (Gladstone 2024). Where are the Jacksons, Popovichs, and Gladstones of Healthcare? Likely they are there, under-

recognized and overstretched trying to instill deep trust and teamwork into their workplace teams, developing small islands of teaming that must engage with otherwise siloed and splintering contexts.

Coaching in healthcare

Much as is the case in most sectors of American society, coaching initially focused on health care executives, who were provided with 1:1 coaching. This coaching was likely to be provided with substantial success as these senior executives adapt to rising levels of rugged and ever-changing healthcare landscapes (Miller and Page, 2007). However, middle management and frontline team level coaching has received little attention, resources, or effort to date.

There are some signs of a rising tide around clinicians educating each other using coaching principles as we see in Branzetti *et al* (2023). Branzetti points out that despite the robust supportive evidence for coaching in business literature, it remains rare in the context of healthcare. Yet, in medicine, they indicate evidence has emerged that in an academic medicine context, coaching has demonstrated:

1) Improving faculty well-being, quality of life and resilience
2) Help faculty attain professional goals
3) Increase faculty academic productivity
4) Improve overall clinical learning environment of the institution

These four (4) areas of improvement are vitally important to today's healthcare environment in which the majority of physicians are now struggling with burn-out and face rising expectations for clinical productivity, with greater challenges sustaining positive emotional energy, a connection with each other and the deeper meaning of their work.

The Accreditation Council of Graduate Medical Education (the ACGME which regulates all Physician Residency training in the United States) has been so concerned about erosion of the Clinical Learning Environment that they created a completely new Institutional oversight around 2015 in order to specifically focus attention on improving the institutional learning environments for Resident Physicians across the USA. Healthcare is experiencing the greatest challenge to work and learning environments since the Flexner Report upheavals in the 1910 – 1920's period.

Yet, a quick search for "Coaching" and "Healthcare" turns up a scant though rising array of articles to help leaders and clinicians in healthcare to increase the role of coaching. One of the few articles was written by one of us in association with Michael Cassatly (Cassatly and Bergquist, 2011).

Using a 1:1 Coaching Model also does not appear to be the right framework for healthcare given the vast number of healthcare workers and the enormous variety of healthcare workers---although physicians in executive positions now often have some level of access to such coaching, whether in-person or virtually based on their leadership role in the healthcare system.

Team Coaching

Shifting our focus from 1:1 coaching toward 1:Team coaching may begin to increase our ability to improve teamwork across the spectrum of healthcare environments and professions. There is a growing body of Team Coaching literature that indicates this approach may take longer to establish yet improve teamwork across a variety of professions, including healthcare. Leaders in healthcare have been calling for silo-busting, team-building transformations for decades, yet may not realize that may not manifest

fully until enough Health Team Coaches are developed in the model of great coaches like Jackson, Popovich and Gladstone.

Yet, even amongst international leaders in Team Coaching, we find we are early in the process of fully understanding the best approaches and competencies required for team-coaching: In an extraordinary Podcast including David Clutterback, Marita Fridjhon, Jennifer Briton, Ruth Wagament, Peter Hawkins and Phil Sandhal—godparents of Team Coaching—we find even our thought leaders feel we are 20-30 years behind our understanding of 1:1 coaching (Clutterback, et al, 2016). A simple search of Google for Team Coaching reveals 9,000 articles, demonstrating an explosion of research indicating our understanding is accelerating and the impact of Team Coaching is likely to be lasting.

In this Team Zone Podcast, Cultterback and his associates also point out the vital importance of Team Coaching leading to Self-Coaching Teams---a concept that aligns well with Complex Adaptive Systems in which Self-Organizing Groups / Teams / Communities are the engine of emergent phenomena and behaviors that push an organization into a future state over time (Fish and Bergquist, 2024b)

Self-coaching teams appear to have 4 key components (Walsh, 2021). Two of these components concern "what a team is doing." The other two concern "what a team is being":

2 Things Self-Coaching Teams are doing:

1) Uses communication to deepen relationships and connections
2) Lives in commitment to collective and ongoing learning

2 Things Self-Coaching Teams are being:

1) Creates a space of deep trust and psychological safety
2) Aware of what's not being expressed in the room and brings it to light.

The challenge is to create the scale and scope of initiatives necessary to spread Team Coaching throughout the complex environment of healthcare. We likely need external coaches to develop internal coaches throughout the healthcare system, including physician leaders. Some in other industries are looking to shift from a "manager" to a "coach" role for middle management to achieve this aspiration for self-coaching teams:

In 2015 one of the top priorities of senior executives in the business community was the transformation of managers into coaches In this important Harvard Review, author Keith Ferrazzi (2015) describes six (6) ways organizations and leaders can lead this important transformation:

1) Encourage peer-to-peer coaching
2) Create coaching mentorship partnerships
3) Tap into coaching already present in managers
4) Prioritizing learning and daily learning activities
5) Use 1:1 check-ins to support coaching efforts
6) Provide or seek formal coach training for managers

There are indications in many industries that positive manager-employee relationships are essential to employee engagement, well-being, productivity, and desire to stay in an organization (Better Works; Dennibis, Doug, 2023) Yet, in one large study across US and UK, the authors found 49% of employees feel their own manager lacks skill in providing important feedback to the employee.

Since over 70% of America's Physicians are now employed by an organization—rather than serving as independent operatives—their collective well-being, engagement and alignment are likely to be well served by increasing their supervisors and managers skills in coaching. Physician alignment and engagement remains a top-tier priority across America's healthcare sector. Team-coaching and self-coaching teams may just be the right pathway to achieve that crucial physician engagement and alignment.

Leader as Coach: From Drama to Empowerment and Emergence

We turn now to a closely related matter. Not only should physicians and other health care leaders receive coaching services these leaders should also be coach-like in their own leadership role—a perspective that is gaining traction more broadly in the domain of leadership strategies (Bergquist, Sandstrom and Mura, 2024).

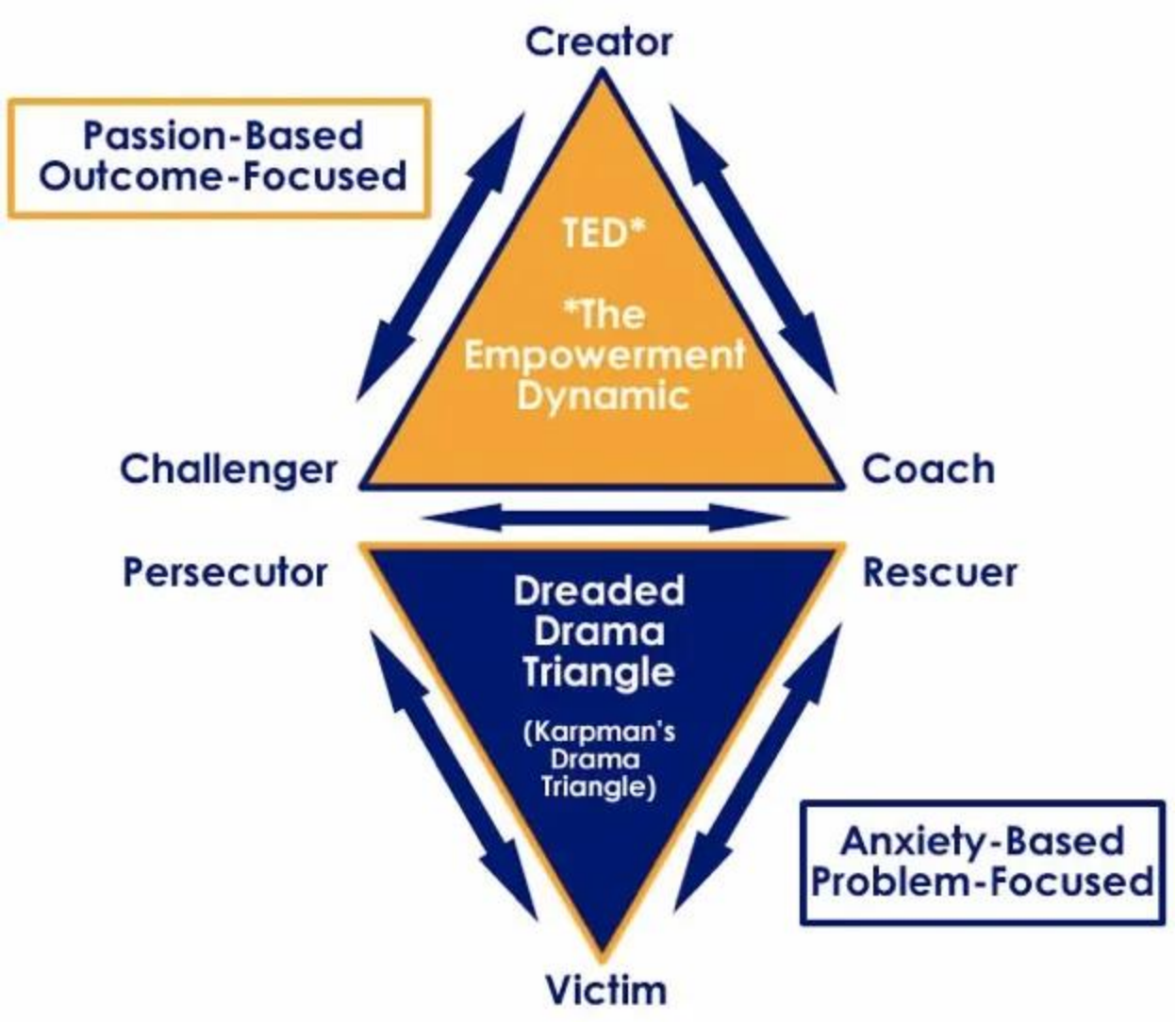
Transforming Drama Triangle to Empowerment Triangle

One of the great challenges of working in human systems, particularly complex adaptive human systems in the often dysfunctional ways we humans attempt to address conflict. The Drama Triangle was first described by Stephen Karpman in the 1960s [Karpman, 1968].

It is a model of dysfunctional social interactions and illustrates a power game that involves three roles: Victim, Rescuer, and Persecutor, each role represents a common and ineffective response to conflict. We might call the Drama Triangle a cognitive-rut, a pattern we humans use to explain when things aren't going our way—a fundamental attribution error common within the context of teams.

Simply put, when things don't go our way, most of us first seek out someone else to blame "our persecutor" and then turn to someone we hope will save us from the bad place we find ourselves in, the "rescuer" to save the day. While such dramas sell well in the media and make for wonderful novels, most of us seldom benefit from its daily use in our home and work lives. You'll notice the lack of any sort of "coach" or "mentor" role in the Drama Triangle.

Thankfully, David Emerald (Emerald and Zazonc, 2013) re-imagined the Drama-Triangle into The Empowerment Dynamic (TED*) as seen below:



Emerald's model describes clear role shifts for each player in the drama:

Victim	→	Creator (Some also use Learner)
Villain/Persecutor	→	Challenger
Hero/Rescuer	→	Coach

Emerald (Emerald and Zazonc, 2013) also describes very specific ways to begin to learn to shift out of whatever role we find ourselves in under new conditions: We turn to Emerald for guidance given our focus on increasing the use of coaching among health care leaders. Emerald recommends the following shifts from "telling to asking" to achieve this important transformation (adapted from above link):

RESCUER	**COACH**
Thoughts:	
• I must save others	Creative people can save themselves
• Pity for Victim	I trust others and their abilities
Feelings:	
o I fear not being needed	Compassionate, fulfilled and reflective
o I am superior to the Victim	Supportive yet "not-attached"
Behaviors:	
o Jump in to save the day	Starts with questions, self-reflection
o Fosters dependency	Empowers and develops others
o May sacrifice truth to protect others	Encourages w/ positive reinforcement

This shift from Rescuer to Coach role is one that likely requires some level of outside or internal coaching as it requires internal work and reflection to understand the temptations and satisfaction gained through rescuer role that must be let go of in order to grasp the healthier and likely more successful role of coach.

We suspect that healthcare would undergo a profound transformation into high-performance teamwork if every manager, supervisor, and leader in healthcare took steps to move from rescuer toward coach over the next decade. Such a shift would take enormous combinations of courage, curiosity, and resilience—for the world of health care is filled with what we identified in a previous essay (Fish and Bergquist, 2024a) as anxiety-provoking conditions of volatility, uncertainty, complexity, ambiguity, turbulence and contradiction (VUCA-Plus).

Yet it is likely that a shift from rescuer to coach would enable health care leaders and managers to more effectively navigate the rising tide of VUCA-Plus realities. Coaching toward empowerment enables a health care leader to lead a more fulfilling life at work and to achieve better outcomes for all of us. There is a further upside to which we are about to turn. A coach-like role enables healthcare leaders to embrace and engage a dynamic organizational phenomenon that we call "emergence."

Fostering Emergence

Emergence is a term that is used in many ways. It was originally employed by those engaged in process-oriented philosophy. It referred to the emergence of a new form that could not have been anticipated from the elements that went into the creation of this new form. The classic example of emergence is the creation of water from two gases (oxygen and hydrogen). No one could have anticipated the presence of something so very different from a gas than an entity called water.

New Forms: In human systems, we find that new forms emerge from most revolutions—be they scientific or political. At a less dramatic level we find emergence when a cluster of puzzles (complicated state) suddenly become tightly interwoven and interdependent (complex state). Together these puzzles become an elusive and multi-tiered problem or even a "mess" made up of several intractable problems.

We even see the emergence of several problems that require completing solutions. They become dilemmas and often form a condition of polarization. (Fish and Bergquist, 2022).

The "complexity and adaptive leadership lens" offered by Lichtenstein, Uhl-Ben, and Marion (2006) may provide insights regarding leadership within the context of emergence. Insight might also be found regarding surprises inherent in the dynamics of complex adaptive systems—as are often found in healthcare. Lichtenstein, Uhl-Ben and Marion reframe the traditional model of leadership. They shift their focus from an individualistic, charismatic, leader who acts "on" an organization toward relational leadership that is distributed throughout the organization. This distributed leadership stimulates purposeful tension to create adaptive outcomes and changes in the organization.

The shift of focus from individual leaders (traditional) toward distributed leadership relationships provides us with a new lens. It is a lens that yields important insights regarding important interactions in an organization. These are interactions that generate novel, emergent and innovative ideas and behaviors that might not otherwise surface. The authors point out that leadership itself is an emergent event.

Outcomes emerge from the relational interactions among agents in the organization. They don't emerge just from a single person at the top of an organizational hierarchy. The capacity of leadership in an organization to create just the right relational tension and harness a series of positive emergent changes is critical. The successful engagement of this relational lens of leadership will eventually lead to a new and more adaptive organization. The organization will be able to navigate whatever VUCA-Plus external and internal realities emerge.

Surprise: Emergence might also require a lens (and heart) that is open to Surprise. A colleague of ours had the unique opportunity to attend a session led by Michael Polanyi, the Noble-winning biologist, who was speaking of the false divide between the humanities and science. Polanyi mentioned that all significant learning is attended by surprise.

We are surprised when water emerges from the combination of two parts of hydrogen to one part of oxygen. Those hanging around early years in the formation of our planet would have been surprised to find that a bunch of chemicals and some light produces a living being. (We of course would have been surprised to find someone hanging out in this hostile environment in which there were not yet any sentient beings).

One of the attendees at Polanyi's seminar spoke up as Polanyi was describing how scientists get surprised by major new findings in their field. The attendee indicating that this sense of surprise and even awe seemed like the Hebrew experience of encountering Yahweh. Polanyi was startled (surprised/). He had never thought of this comparison. Though he grew up in a Jewish culture (and had to escape Hungary in part because of this heritage), Polanyi had abandoned this heritage many years before leading this seminar. Suddenly Yahweh reappears and offers new insight about surprise and emergence (in this case the new insight-generating merger of Polanyi's scientific background with his Jewish background).

Dither: There is another important characteristic of emergence that is often not considered. An insight regarding this characteristic comes from another seminar that was led by a noted scientist. In this case it was Karl Pribram, a major neuroscience researcher and theoretician from Stanford University. He was speaking about the way our nervous system operates like a holograph (Hampden-Turner, 1981, pp. 94-97). As a side note, Pribram talked about something he called a "dither." This is the vibration that tends to occur in an individual neural cell before it fires. Pribram suggested that this same "dither" effect might operate in any system just before it undertakes a major shift in state (its own "firing").

Pribram's speculation might readily be applied to the dynamics of any emergence. We might expect to see some "dithering" just before the new emergent form is "born." There would be the "birth pains" represented in vacillation of the pre-emergent forms. Properties would change rapidly in character and form. State of affairs would swing back and form—from hot to cold, belligerent to peaceful, orderly to chaotic. Entities would move rapidly from side to side.

We would witness the reign of Volatility--the first (V) condition of VUCA-Plus. Under such conditions, we must be nimble of cognitive foot—we must find an adjustable lens. This lens must be altered in scope and focus based on rapidly changing conditions. Or we might have to be patient and wait for the new form to emerge and then assist with the raising of this new child—our lens becomes one of nurturance and care (Bergquist and Quehl, 2019).

New Learning: Emergence can also be viewed from the perspective of new forms of learning that are demanded when new elements are added to an existing condition. We return to Michael Polanyi, who proposed that all significant learning requires the integration of something new with an existing body of knowledge. The form in which this new learning takes place can never be fully specified for this form itself would be new and would have to be integrated with what already exists—thus necessitating yet another level of learning and integration.

Unfortunately, most of the work on emergence and learning concerns the emergence of new learning in an established setting rather than the learning that must occur when there is emergence in the setting—producing a new set of challenges. In turning to the insights offered by Polanyi, we would have to push back on those who advocate emergent learning.

We would suggest that the "rules" and "procedures" of emergent learning will need to be integrated with the content of that which is being generated via this process. This new integration of process and content requires a higher level of learning—and the potential of an emergence in the setting. It might even be when the emergent learning process is being fumbled or when participants rebel against this process that "real" learning occurs—filled with surprise, a whole lot of dithering, and eventually a new form and new insights.

Reflective Inquiry: The central question at this point becomes: how do we learn in the midst of surprise, dithering and new forms? Polanyi would suggest that there is no easy answer—for any answer we might offer would have to be newly integrated with the challenging, emergent setting we now face or even live in. Keeping Polanyi's cautionary note in mind, we can suggest that there are processes of

reflective inquiry which can be thoughtfully engaged when confronting (and seeking to lead) in an emergent setting.

First introduced by Donald Schön in *The Reflective Practitioner* (Schön, 1983) reflective inquiry concerns the ability to consider actions to be taken based on critical consideration of one's own attitudes, perspectives and existing practice. Along with this self-critical practice comes flexibility (agility) and continuous adaptation to the changing conditions that come with VUCA-Plus—and emergence. It is not enough to learn from one's experiences; one must also learn about the very process of learning from one's experiences.

In other words, experience alone does not necessarily lead to learning; deliberate reflection on experience is essential. Together with his colleague, Chris Argyris, Schön would differentiate between the learning from a specific experience (what they labeled "single-loop learning") and the learning that takes place regarding the learning from multiple experiences ("double-loop learning') (Argyris and Schön, 1974; Argyris, 2001). Effective reflective inquiry is based on this second order (Double loop) learning.

Fundamentally, this process of reflective inquiry is about the integration of theory and practice. Schön was always critical of the split between the education of theatricians and practitioners—and from the isolation of practitioners from those who were engaged in scientific studies regarding the issues that the practitioners were facing. Schön would suggest that a successful practitioner should also be a thoughtful scientist. They should test their perspectives and assumptions against the reality they face in their daily work.

Schön identifies this everyday process as reflection-on-action and reflection-in-action. The reflective practitioner is responding to problems, messes, dilemmas and polarities – not just single-dimension puzzles. Building on insights offered by John Dewey, Schön is not only unafraid of venturing into the world of complexity and emergence, he believes that valid and useful knowledge is only gained from this "dirty" involvement in real life issues.

Given this push toward active engagement in and reflection on real-life issues, what type of questions might be asked. We can be guided by the experiential learning cycle proposed by David Kolb (Kolb, 1984) -- who was influenced by Donald Schön:

Inquiry Series One (Divergence: Taking in Immediate Experience)

Description: What happened? What would a "neutral" observer have seen and what fundamental observations would they have made?

Feelings and State of Mind: "What were your reactions and feelings? What made you most happy, anxious, mad or confused?

Reflections: What biases might you have brought to this experience? What were you expecting and where were you surprised?

Inquiry Series Two (Assimilation: Making Sense of Immediate Experience)

Evaluation: What was good or bad about the experience with regard to your own welfare? What about the welfare of other people? What about sort term consequences? What about long-term consequences? How might your own opinions of good and bad influenced the judgements you have made?

Analysis: What sense can you make of the situation? What was really going on? What do you think were the causes and barriers (If any)?

Reflections: How is this similar to and different from other experiences of a similar nature? Were different people's experiences similar or different in important ways from your own?"

Inquiry Series Three (Convergence: Learning from Experience)

Conclusions: What can be concluded, in a general sense, from these experiences and the analyses you have undertaken? What can be concluded about your own specific, unique, personal situation or way of working?

Reflections: What alternative conclusions might be reached if a different perspective is taken on what occurred? This there “another side to the story”?

Inquiry Series Four (Accommodation: Taking Action Based on Analysis of the Experience)

Personal action plans: What are you going to do differently in this type of situation next time?

Single-Loop Learning: What steps are you going to take on the basis of what you have learnt?

Double-Loop Learning: What have you learned in this situation that you can take to other situations? What did you learn about yourself as a learner?

Multiple Lens: There is a second approach that can be taken when engaging in reflective inquiry—especially when confronting the surprise of a newly emergent phenomenon. This approach involves a “whole body” response to the challenges inherent in the emergence of a new form. Stephen Brookfield (1998) proposed that critically reflective practitioners constantly research their assumptions by seeing practice through four complementary lenses.

Each of these lens moves us further away from our own personal (proximal) perspectives and practices to more distant (distal) perspectives and practices. We would suggest that we need all four of these lenses to complement the lens we have already identified: (1) the lens of complexity, (2) the lens of surprise, and (3) the adjustable lens.

Lens 1: Our autobiographical eyes

Our autobiography is an important source of insight into practice. As we talk to each other about critical events in our practice, we start to realize that individual crises are usually collectively experienced problems, messes, dilemmas and polarities. Analyzing our autobiographies allows us to draw insight and meanings for practice on a deep holistic (cognitive and emotional) level.

Lens 2: Our eyes as a learner.

Learning about ourselves as leaders (double loop learning—and even learning about how the setting in which we operate influences how we learn (triple loop learning). We compare ourselves to other learners (and the differing way in which they engage Kolb's experiential cycle) We are open to testing our own assumptions as a learner and the assumptions and biases we bring to the learning process.

Lens 3: Our colleagues' eyes.

As we mature, there is an important development step that takes place. It is called "a theory of mind" and involves our capacity (and willingness) to acknowledge that other people may see the world in a quite different manner from how we see if. Our primary narcissism breaks down and we acknowledge a world that exists outside our own cognition (and affect).

Respected colleagues can serve as critical mirrors reflecting back to us images of our actions. Talking to colleagues about problems and gaining their perspective increases our chance of finding some information that can help our situation—especially if the perspectives they offer differ from our own (Miller and Page, 2007; Weitz and Bergquist, 2024). Cross-cultural dialogue is especially helpful in bringing about successful reflective inquiry.

Lens 4: Our theoretical and conceptual eyes

Theory is especially important in the engagement of assimilation (Kolb's second series). We can learn (vicariously) from the experiences of other people (case studies) as well as from the numbers and diverse insights offered in books. As Frederick Hudson (1999) notes in describing the process of making major life changes, it is important that we can "name" what is happening to us and to our perspectives and practices. Theories help us focus in on what is important (challenging in a world of volatility, complexity, and ambiguity). Theoretical structures and guidelines can also help us address the contradictions we find in our analysis of issues we are facing.

A 5th Lens: Collective eyes

In moving beyond Brookfield and addressing the unique challenges associated with Emergence, we turn to the notion of collective learning and to the role of collective eyes in discerning the elusive "truth" to be found in the swirling VUCA-Plus environment. As Ken and Mary Gergen (2004) proclaimed, "truth is only found within community." More specifically, they would suggest that truth is found in trusting relationships: "constructivism favors a replacement of the individual as the source of meaning with the relationship."

Even more to the point, truth is found in dialogue – and disagreement. There is an insistence that we respect and learn from other people: "one is invited into a posture of curiosity and respect for others." Of greatest importance is the respect we show for the distinctive perspectives and practices which people from all backgrounds bring to the dynamic construction of a desirable future.

A constructivist framework enhances the possibility that old, outmoded assumptions will be challenged, and new realities and values will emerge. Diversity thrives with the encouragement of collaboration and absence of rigid judgments ("the one right way"). Participants in constructive dialogues are not confined

to traditional sources of expertise and authority because the relationship and the discourse is itself reality and the primary source of expertise.

Organizational Learning: we can take this fifth eye a step further. There are distinctive (often cutting edge) lessons to be learned and insights to be offered by individuals who are collaborating with one another. This is Ken and Mary Gergen's dialogue toward truth. In addition, there is the occasional breakthrough learning and the insights gained by a team or task force in the organization. We find the acceptance and use of collective advice that is "out-of-the-box."

However, existing alongside this learning and these insights is the intensive resistance to new learning. We find repetitions of old, outmoded behaviors. Nothing has been learned from history. Invalid assumptions are being made and reinforced by those in power. Most importantly, self-fulfilling beliefs are rampant. We identify an "enemy," treat them as an enemy, and soon find that they are defending themselves against our threatened attack. They become our enemy precisely because we treat them as an enemy. Nothing is learned. Everything that is invalid is validated. The organization is "stupid", as are its leaders and experts.

*Single and Double Loop Learning***:** How do we make sense of the challenging contradictions between organizational learning and organizational resistance—especially when these two conditions can exist within the same organization (which is often the case in health care systems)? We look once again to some of the wisdom and guidance offered by Chris Argyris and Don Schön as they address the issue of organizational learning. These two highly collaborative colleagues from Harvard (Argyris) and MIT (Schön) offered an important perspective regarding a concept we offered earlier in this essay regarding single-loop and double-loop learning.

Chris Argyris (2001) offers the following important distinction:

> . . . learning occurs in two forms: single-loop and double-loop. Single-loop learning asks a one-dimensional question to elicit a one-dimensional answer. My favorite example is a thermostat, which measures ambient temperature against a standard setting and turns the heat source on or off accordingly. The whole transaction is binary.
>
> Double-loop learning takes an additional step or, more often than not, several additional steps. It turns the question back on the questioner. It asks what the media call follow-ups. In the case of the thermostat, for instance, double-loop learning would wonder whether the current setting was actually the most effective temperature at which to keep the room and, if so, whether the present heat source was the most effective means of achieving it. A double-loop process might also ask why the current setting was chosen in the first place. In other words, double-loop learning asks questions not only about objective facts but also about the reasons and motives behind those facts.

The challenge is that users of information want the message they receive to be single loop in nature. They want simplicity, clarity, calm and consistency (the opposite of VUCA-Plus). They also want their leader or an expert to tell them that they need to do more or do less of what they are already doing—rather than something new and different. Unfortunately, a large portion of truly valid and useful advice

coming from health care leaders requires that the recipient of this advice do something different (double loop) rather than more of the same (single loop).

As Argyris and Schön (1974, 1978) have repeatedly shown, this type of learning is difficult to achieve and is often associated with equally-as-challenging double loop change. The second level of learning and change often requires broad-based support from those leading and working in the organization. This collective support is based on a dynamic associated with organization character and culture. A Learning Organization must be created and sustained.

The Learning Organization: As the name implies, an emphasis is placed in this organization on collective learning. Mistakes will inevitably occur in a VUCA-Plus world. We can't avoid making mistakes. The key goal in a learning organization is to not make the same mistake a second or third time. We might not be able to live without mistakes—especially if our organization is seeking to be agile and creative. However, we can learn from our mistakes. If there is no learning from mistakes, then a "stupid" organization has been created. Mistakes are repeated. Nothing is learned from history.

We wish to move beyond Argyris and Schön at this point by taking a more appreciative perspective. In a learning organization, we can learn not just from our mistakes but also from our successes. It is not enough to celebrate when we happen to get it right in spite of uncertainty. In addition to celebration, we must reflect on what has occurred that produced successful outcomes. In other words, we should "catch them [us] when they [we] are doing it right!"

Working in a challenging health care system, we must spend time reflecting on what has occurred and what we did that influenced the desirable outcomes. We need to slow down our thinking (Kahneman, 2013) and engage in Double loop learning if we are to learn from both our failures and successes. Those with expertise in appreciative inquiry can be very helpful in this regard (Srivastava, Cooperrider and Associates, 1990; Bergquist, 2003; Cooperrider and Whitney, 2005).

We wish to extend and expand our exploration of the fifth eye even further. A successful engagement of the fifth eye and an accompanying engagement of organization learning requires that we gain a fuller understanding (and appreciation) of an organizational dynamic called "collective intelligence." We must be smart not just as lone health care practitioners but also as members of a team—guided by those who are coach-like in their leadership and appreciative in their encouragement of and support for shared ideas and insights.

Collective Intelligence

Important collective dynamics are associated with the shared framing and reinforcement of distorted insights and false learning that pervade many health care organizations – especially those faced with the anxiety-provoking challenges of VUCA-Plus. Single loop learning or resistance to all learning is prevalent when we are anxious, overwhelmed or simply exhausted. By contrast, there are collective dynamics that operate when an organizational culture of learning has been established. These dynamics are to be found in a learning organization even when VUCA-Plus anxiety is prevalent. All of this can be brought together in an analysis of what has come to be identified as *Collective Intelligence* (CI). For us, the critical question concerns the interplay between CI and the creation of a learning organization.

In recent years, the concept of collective intelligence has gained considerable traction. While much of the attention is directed toward the way collective intelligence is enhanced through the use of Artificial Intelligence (AI) and specific digital applications, there is some attention being devoted to the psychological aspects of collective intelligence (Arima, 2021). There are even several research projects demonstrating that performance by a well-functioning team on a specific problem-solving task is often superior to the average performance of team members or even the most "intelligent" member of the team.

We know that for collective intelligence to be successfully engaged, the team members must be able to communicate effectively with one another. Information silos clearly hinder collective intelligence, while emotional intelligence enhances CI and team performance. Furthermore, a team must discover or create a sense of purpose. Team members must accept one another and there must be a shared perception that the team is a distinct entity. Team members are sharing commitment, pride, clarity about roles and responsibilities, and a history of successful resilience (Hughes and Terrell, 2007).

Collective skills related to these ingredients include forming team identity, finding appropriate motivation, emotional awareness, interpersonal communication, tolerance of differing views, resolution of conflicts, and creation of a positive mood. Elsewhere, one of us [WB] has offered an appreciative perspective regarding these collective skills, suggesting that an *Empowerment Pyramid* must be created and maintained. Empowerment requires that a team move from effective communication to skillful conflict management, and then on to creative problem solving and appropriate decision making (Bergquist, 2003). Empowerment is an antidote to close-minded serenity. It is not an accident that our use of the term "empowerment" complements that offered earlier in this essay by David Emerald.

Beyond the ingredients and skills needed for a team to become collectively intelligence is the creation of a supportive environment. Team members must forgo their competitive spirit (at least with one another). A culture of individualism and individual gain must be discouraged. On the positive side is the critical role played by a culture of collaboration.

Members of the team must be willing (even eager) to work with one another. They must find gratification in the relationships established with other team members and enjoy the collegiality that comes with "winning" as a team rather than as an individual. Most importantly, as conveyed in the portrayal of the Empowerment Pyramid, team members must appreciate the strengths shown by one another as well as the moments when they are effective at communicating, managing conflict, solving problems and making decisions. We once again introduce the appreciative motto: "Catch them [us] when they [we] are doing it right!"

Turbulence and Contradiction in Healthcare

What does emergence look like in a healthcare setting? When do several things that seem separate begin to dance to life and create new and surprising outcomes that might baffle and un-nerve traditional healthcare leaders? Covid-19, of course, represents just such a surprise. We see viruses all the time, they are ubiquitous in our lives through colds, the flu, herpes, HIV, etc. We generally see contagious

epidemics on the TV, happening in other countries and have world-renowned experts who advise them on how to manage their epidemics.

We might get a little scared when one flies to our country like Ebola, yet most of the suffering and death happens “out there.” We normalize the deaths of our endemic contagions---yep another flu season, yawn. The emergence of Covid-19 is still hotly debated, was it a Chinese Death virus created in a lab and unleashed on the world to cripple the west? Or was it because of climate change and development into previous bat-lands leading to unprecedented mixtures of species and natural mutations that formulated this devastating pandemic.

A pandemic is an emergent phenomenon that likely requires thousands of things to all fall in place in a certain way that, thankfully, doesn’t happen all the time. Like a 100-year storm, some high-turnover, high-mutation-rate, moderate-killer virus is created and suddenly our entire world is shoved into a new and unstable, VUCA-Plus reality for everyone on the planet. Just looking at the DNA sequence of the virus, no one could predict how it would fundamentally alter reality for years, perhaps decades. This microscopic virus emerged and traditional healthcare, traditional public health, traditional life was not ready.

Nor were our leaders, surprised, baffled, we dithered and dithered. Yet we also acted with lightning speed to create the most effective, rapid vaccination development response to a pandemic virus in history. With emergence came polarity---mask vs no mask, social distance vs no social distance, conspiracy theories vs best evidence, truly effective treatments vs quackery. Entire societies dithered and squabbled about the right pathway forward.

Some societies, particularly Eastern societies, had clear, direct actions, often draconian and severe---that, at least based on publicly released data, provided the greatest protection for their population around deaths from Covid. Here in the United States, we came out worse than most other countries---with death rates far surpassing those in most European countries and much poorer countries without access to vaccines even. Yet, healthcare leaders learned we can change our systems in the blink of an eye---something that seemed impossible pre-Covid-19.

Within weeks of the epidemic, new tele-health tools were fired up across the United States and we were able to provide healthcare access to millions of people from the comfort of their homes. Home-based testing became normalized as the Federal government sent out free supplies of Covid-19 test-kits, often more accessible than they were in primary care offices event. People learned they can do their own home-based testing which now is rapidly growing in the United States with new “home test kits” spreading into women’s health, trauma-informed care, men’s health, longevity health, etc. We have seen an explosion of new telehealth opportunities, home-based test kits, and pro-active health websites emerging out of the storm.

Healthcare transformation was called for during many decades before Covid-19. Yet, in truth, the greatest disruptive innovation in modern healthcare history has been Covid-19. This deadly teacher taught us lessons we will continue to benefit from for decades into the future---at great cost of so many

lives it is depressing to think of it. Dithering in the face of emergence is natural. Getting stuck at dithering, paralyzed by polarity of opportunities, is a leadership failure.

Taking stock of lessons learned requires self-reflection, accessing multiple lenses into the events and outcomes that unfolded, and learning from the experience through the double-loop as well as single-loop process. We begin that reflective process by looking at Turbulence and Contradiction as forces that disrupt our leadership lives and how we might better adapt in the future.

Turbulence: Leadership and Personal Balance

Peter Vaill (2008), the organizational theorist who first introduced the idea of a "white water" world, wrote about the need for balance in navigating this world. This is a matter not only of finding balance in the moment-to-moment shifts in the dynamics of the system one is navigating (the volatility in VUCA-Plus), but also of preparing for the radically different patterns of change (or non-change) that is operating in the white-water system. (uncertainty and contradiction in VUCA-Plus).

Many of today's health care organizations must survive highly turbulent and unstable conditions. The white water is all around us at this point in the 21st Century. Some things in our life and work are moving rapidly, while other things are moving in a cyclical manner. We are also likely to find that some things are not moving at all—even if we would like them to move. Perhaps, most importantly, some things in our life and work are moving in a chaotic manner—they are swirling about in an absolutely unpredictable manner. We might be able to adjust temporarily to one of these four conditions, but soon find that we are facing a different set of conditions that require a quite different manner of planning and leadership.

Before identifying the nature and challenges associated with each of these four subsystems, we offer the positive side: there is nothing more beautiful and variable than a mountain stream, with its falls, whirlpools, rivulets, and quiet pools of water. The stream is beautiful in part because it is always changing. Like the flickering flames in a fireplace, the crash of waves on an ocean beach, or the fall of snow on a winter evening, there is always something new (emergent) evolving from the unpredictable interplay of various subsystems in the mountain stream.

The whole is always something more than the sum of its parts. If one looks more closely at this extraordinarily complex system, one finds the four subsystems operating in the stream. These four subsystems interact to produce increased complexity and they, in turn, produce a phase change (tipping point) which becomes the magical white-water world of the flowing stream (the positive side), as well as the VUCA-Plus challenges of unpredictability and contradiction (the negative side).

What is the negative (or at least challenging) systemic Impact? Four subsystems are all operating at the same time—and they are often bumping into one another. There is another important factor that we must add to this complex equation. We know that any system will grow chaotic when it moves faster. Thus, in a world where accelerating change (the first subsystem) is becoming more prevalent, then we are likely to find that chaos (the fourth subsystem) will also become more prevalent. The cyclical changes—that are more predictable—will become less prevalent.

These four different environments require quite different approaches to leadership.

Rapidly Changing Environment: There is the rapidly flowing subsystem of the stream. The movement in this subsystem is very rapid and highly predictable. When we watch a leaf being carried by this subsystem we can readily tell where it will be two seconds from now. The flow of water in this subsystem resembles the flow in a large river: powerful, constant and quiet. This subsystem of the stream exemplifies the orderly subsystems in an organization.

While rapid change has long been identified as the major challenge facing our organizations and societies – beginning with Alvin Toffler's *Future Shock* and *The Third Wave* (Toffler, 1984)—it is actually not the most challenging sub-system in our white-water world. In fact, we can get addicted to this rapid change. There is an adrenaline rush when we turn around turning knobs and changing polities in the face of a rapidly shifting external environment. In this state of addiction, we can even envision change when it is not actually present—or it is change that is predictable because of seasonal shifts or recurrent patterns in our society. These changes fit with our third sub-system.

Cyclical Environment: A second kind of subsystem of the stream is also orderly, though it is much more complex. This is the whirlpool that is formed when the water hits an impediment (such as a submerged rock). The water in a whirlpool keeps changing directions; however, one can predict the change in directions since the water is moving in a predictable spiral formation. We know where the leaf that enters a whirlpool will be two seconds from now. However, we may not be able to predict where it will be in five seconds—since the whirlpool is likely to pull the leaf down below the surface of the water and throw it off into some other subsystem.

In an organization, this whirlpool-type subsystem is represented by the predictable changes in the life cycle and seasons of the organization. Change is occurring in the organization, but it is change that has occurred before in the organization (seasonal change) or it is change that one can anticipate given the experiences of comparable organizations as they grow larger or older (lifecycle change). There are the unknown aspects of the change—as the organization (like the leaf) is pulled into the vortex of the compelling change. Even if they don't know where it will all end up after the predictable cycle, seasoned leaders can be relatively confident regarding the pattern of organizational change that will unfold in the cycle. Budget preparation times in companies are typically whirlpool occasions: intense, dizzying but ultimately predictable.

Stable Environment: a third environment stands in stark contrast to the first two. This environment often takes the form of a quiet pool located near the shoreline. This pool often contains water that is stagnant and undrinkable: White water streams usually include this subsystem. The quiet pool is tucked away behind a large boulder in the stream or at the edge of the stream beside a large sunken tree trunk. It is remarkable that a stream with rapidly flowing water also inevitably contains many subsystems that are not only very quiet but also often stagnant. We can usually drink from the rapidly flowing water in a stream--but are warned (by the smell) to avoid drinking from the stagnant pools.

Yet, these pools are often the sources of nutrients for the ecosystem of the stream. Our leaf floats into the stagnant pool and remains there. It eventually sinks and joins with other rotting leaves to form a

richly nutritious biomass for the living organisms of the stream. The quiet pools represent yet another form of order in the turbulent stream. Nothing changes. Everything eventually sinks, rots and contributes to the ongoing revitalization of the bio-system.

The quiet pool is represented in the organization by those subsystems that never change or change very slowly. These are the subsystems that provide what Talcott Parsons (1955) calls the latent pattern maintenance functions of the organization. They preserve the continuity of the organization, while other subsystems are rapidly changing. These subsystems include the rituals, ceremonies, norms, values, and narratives of the organization—the deeply embedded and often invisible (latent) patterns of behavior in the organization (to which I turn in a later chapter).

The quiet pool is also represented in the formal bureaucratic processes of the organization: those rules and regulations that are slow to change and that seem to have a life of their own. They are reinforced even when no longer appropriate and are followed even when no longer formally in force. These are the bureaucratic ways represented in the phrase, "that's the way we have always done it around here." We might also include those people and departments who represent the old ways of doing things in the organization. Sometimes called the "remnant," Everett Rodgers (1995) identifies these people as the "laggards" of an organization who forever struggle against change and innovation.

This quiet pool may at first seem to represent a deficit in an organization and a source of resistance and consternation for those seeking to improve and adapt the organization for a changing world. We must recognize, however, that a quiet pool is the primary source of nutrition for the stream—and that in a comparable manner the quiet pool in an organization is the primary source of its distinctive character, traditions and culture.

Without this core patterning, the organization will fall apart. It will lose its integrative glue and its sense of abiding values and purposes. In the VUCA-Plus world of health care where boundaries are often falling away, the quiet pool in an organization contributes in a profound way to its clarity regarding organizational intentions and to its sense of continuity and commitment. Alternatively, these organizations may operate in heavily regulated settings. Many modern health care systems are increasingly fitting into this category,

This environment that we have identified as stable tends to decline in size or magnitude as the stream increasingly is dominated by the other three subsystem —or it will become more isolated from the other subsystem. While reduction in the size of this subsystem might initially seem to be a positive outcome, we find that this is not always the case--for the third subsystem is often a source of stability for any system (especially a human system)—providing Parsons' latent pattern maintenance.

Furthermore, nutrients in a natural system (such as a mountain stream) reside primarily in the so-called "stagnant" portion of the stream. This is where leaves eventually end up and where they sink to rot (convert into new forms of nutrition for other living beings in this stream). We might find that this same nutritional function is being served in human health care systems. But simply, this third subsystem is just

as important as the other three. Overly rapid change damages everything in a system and makes this system hard to manage. We need some form of a stable environment in our life and work.

Chaotic Environment: There is finally a fourth type of subsystem in the stream. This is the subsystem that resides on the boundaries between the three other subsystems. When looking at a stream, one sees this type of subsystem in the area that exists between the rapidly flowing section of the stream (subsystem one) and the stagnant pool (subsystem three) or between the whirlpool (subsystem two) and either the rapidly flowing or stagnant water. Unpredictability is endemic to this fourth type of subsystem.

A leaf that floats into this subsystem begins to move in a highly erratic manner. One cannot predict from moment to moment where the leaf will be. It bobs and weaves, darting from one point to another in a seemingly random manner. Eventually the leaf will end up in the stagnant pool, the whirlpool or the fast lane (subsystem one). Meanwhile (to borrow from the movie All About Eve) it is in for "a bumpy ride!"

The fourth subsystem is common in contemporary health care organizations that are filled with uncertainty resulting from the complex and unpredictable dynamics inherent in this subsystem. Typically, the participants in these turbulences not only have differing priorities, they also move at a different pace from each other and in different directions. This is at the heart of the complex conditions in which many contemporary health care leaders find their life inside an organization.

Living and Working in a White-Water Environment: Given these characteristics of a "white water" world, we find that the personal impact is likely to be great for any of us who are living and working in this environment. The white-water environment requires a search for balance and direction which in turn requires ongoing attention.

Apparently, we need a kayak when navigating the white water. A canoe will just tip over, for it doesn't' have the flexibility of a kayak. Furthermore, we must find our center of gravity when steering our kayak through the white water. Peter Vaill (2008) goes so far as to suggest that this center of gravity is often found in our embracing of a core set of principles and values—even operating from a spiritual perspective on life and work.

One might wonder if this core can't be found in basic religious beliefs and in an alliance with some authoritarian figure. Don't we find balance when we find guidance in a set of firm religious tenants? We would suggest that this rarely is the case, for these beliefs, alliances and tenants are much too rigid. They operate like canoes that can only move in one direction (forward). Furthermore, the person operating the canoe has a one-bladed paddle that must be moved from one side of the canoe to the other side.

Counterbalancing and adjusting to changes in the water's direction is difficult—as is also the case in a white-water organization or society. By contrast, the person navigating the kayak is provided with a two-bladed paddle that makes counterbalancing and shifting directions much easier. The term agility can readily be applied to the successful operations of a kayak—and to the successful leadership of a mid-21st Century organization. This term does not readily apply to someone or some organization that is caught up in the vice-grips of authoritarian rule.

Leadership in Turbulent Environments: Many mid-21st Century health care organizations do not, at least on the surface, appear to be as fortunate as the more stable organizations. They exist in an environment that is unstable and highly turbulent, hovering on the brink of both order and chaos. VUCA-Plus is swirling all around the operations of these organizations.

Along with a potential loss of mission, contemporary organizations that exist in unstable environments are often vulnerable to a loss in any sense of commitment on the part of those working in the organization. The unclear boundaries, the shifting values of workers and the newly emerging emphasis on knowledge as capital make it hard for organizations to elicit commitment from their employees.

We are likely to find that mid-21st Century health care organizations are becoming less top heavy or that communication across the levels of existing hierarchy is becoming more important and, as a result, the focus of considerable training and review. The knowledge worker who resides at the "middle" level of most organizations will have much to say in the future about the success of their organization if it is operating in a turbulent environment.

Contradiction: Leadership and Cultural Agility

Leadership in contemporary health care systems is challenged not only by the turbulence caused by the confluence of multiple environments, but also by the contradictory forces that operate within these systems. Specifically, these contradictions reside within the multiple sub-culture that operate in these systems. For instance, it is interesting and informative to note that one half of the documents cited in the Scoping Review of complex leadership came out of Nursing publications. This is quite understandable since nurses stand at the crossroads between two dominant cultures in contemporary health care—the professional culture and the managerial culture (Bergquist, Guest and Rooney, 2003).

Along with the Alternative Culture and Advocacy Culture in health care, these two organizational cultures play a major role in determining how complexities (and other VUCA-Plus conditions) are interpreted and made meaningful (social complexity perspectives), while offering contradictory ideas and instituting polices and actions that make the system that much more complex (mathematical complexity perspective).

Together with turbulence, contradiction rages uncontrolled and often uncontrollable when these six cultures are fully in operation. While we will be devoted an entire set of essays to these six cultures, we provide a brief review of the way in which anxiety builds organizational culture and the way in which each of these cultures operates. This brief review provides a glimpse into how health care leadership is being challenged by the diverse perspectives and operations that attend each of these cultures.

Culture and Anxiety: Culture provides a container. It establishes roles, rules, attitudes, behaviors and practices. In terms of the illness experience it describes ways for people to begin feeling safer after they have experienced themselves as vulnerable, unsure or threatened. Many people, for instance, feel comfortable and comforted when they place themselves in the hands of a physician. The patient can depend on the physician's allegiance to the Hippocratic oath and the pledge to do no harm. Culture places boundaries around the illness experience. It provides predictability.

Culture says that when you take on the sick role you are not alone. There are specific people to see. There are tests to be performed. There is assurance that you are a long way from dying. Culture provides meaning. In some parts of the world illness and injury are expected to be an opportunity for transcendence and personal growth. In North America and many other technologically dominated societies it is something to be endured and gotten past as soon as possible. We know that the illness or injury will soon pass or heal, because he has faith in medical technology. In all these ways, culture helps to manage anxiety.

Psychologists tell us that when we become anxious, we tend to regress to a more primitive state of mind and feeling. We become more like we were as children. In particular, we are likely to become dependent, and look forward to being taken care of by a person who in certain respects is superior to us. This anxiety and resulting dependency often serve us well. Our anxiety encourages us to seek help. It provides an incentive for us to turn to other people, to rely on their expertise or at least their caring attitude, and to recognize our own need for change.

Yet, anxiety is also a source of major problems regarding health care. Anxiety not only keeps people from addressing major health-related problems in their lives, this emotional state also contributes to the wounding of healers and blocks the fundamental changes required in our contemporary health care delivery systems. As we come to understand the nature and effect of anxiety in health care, we will begin to unravel many of the Gordian knots associated with our current health care crisis.

The Containment of Health Care Anxiety: We base our analysis of health care cultures on this fundamental interplay between the experience of pain, the containment of anxiety, and the formation of organizational cultures. This interplay was carefully and persuasively documented more than forty years ago by Isabel Menzies Lyth (1988), who wrote about ways in which nurses in an English hospital cope with the pain and anxiety that is inevitably associated with issues of health, illness, and injury—issues of life and death. Menzies noted how the hospital in which nurses worked helped to ameliorate pain and protect the nurses from anxiety. She suggested that a health care organization is primarily in the business of reducing pain and the attendant anxiety and that on a daily basis all other functions of the organization are secondary to this pain and anxiety-reduction function.

It is specifically the culture of the organization that serves as the primary vehicle for addressing the nurses' anxiety and stress associated with ameliorating the pain. The culture of an organization is highly resistant to change precisely because it directly threatens the informal system that has been established in the organization to help those working in it to confront the anxiety and make sense of the pain inherent in health care.

Menzies Lyth' observations have been reaffirmed in many other organizational settings. Anxiety and pain are to be found in most contemporary organizations and efforts to reduce this pain and anxiety are of prominent importance. Hospitals and other health care systems, however, may be particularly saturated with pain and anxiety, given the unique problems they confront. It was not coincidental that

Izabel Menzies Lyth, in studying a health care institution, was among the first to identify pain and anxiety as central issues in organizational life.

Somehow a hospital, or any other institution that must address the issues of pain and that is inclined to evoke anxiety among its employees and customers, must discover or construct a culture that creates a context for the pain and contains the anxiety. At the same time this institution must addresses the realistic, daily needs of both its employees and customers. How exactly does pain and anxiety get addressed in organizations?

Menzies Lyth suggested that pain and anxiety are addressed through the social defense system, which is a pattern of interpersonal and group relationships that exists in the organization. Other organizational theorists and researchers similarly suggest that the rituals, routines, stories, and norms (implicit values) of the organization help members of the organization manage pain and anxiety inside the organization. Yet, these rituals, routines, stories and norms are not a random assortment of activities. Rather, they cluster together and form a single, coherent dimension of the organization. This single, coherent dimension is known as the *culture* (small "c") of the organization.

Isabel Menzies Lyth proposed that health care workers create the culture of a health care institution to contain anxiety. These institutions are to be neutral containers with the ability to absorb anxiety. But what happens when the container is cracked or acts in ways that intensify pain and anxiety—as seems to be the case in contemporary health care? What happens when pain is introduced into this equation, as it must be when we are considering organizations that tend to people who are ill, injured or even dying.

A tripartite dynamic is created. As pain increases, anxiety also increases for both the patient and those attending the patient. Culture is then created which helps to reduce the anxiety and provide comfort or reassurance if it is successful. As Edgar Schein (1992) has noted, the culture of an organization is the residue of the organization's success in confronting varying conditions in the world. To the extent that a health care organization is adaptive in responding to and reducing pervasive anxiety associated with pain, then the existing culture of this organization will deepen and become increasingly resistant to challenge or change.

The pain also impacts directly on the culture. While health care professionals are often reluctant to address the troubling issues associated with the meaning of pain, they must eventually confront these issues, even if this confrontation requires, as in the 1990s movie *The Doctor*, that they confront their own pain and mortality. At the same time, patients are trying to make sense of the pain and try to find meaning in the attendant suffering.

Together the professionals and patients create additional cultural artifacts. These artifacts include stories, rituals, symbols, language, dress, and decoration of physical space, as well the rights, privileges and responsibilities associated with certain culturally based roles in the organization. These artifacts give further meaning to the pain and suffering, and to the work of health care professionals. Artifacts often

cluster and form powerful, coherent images. We call these images the *archetypes* of health care. These archetypes become particularly powerful and persuasive under conditions of anxiety and pain.

Organizational Anxiety and the Six Cultures of Health Care: Health care organizations must always address the anxiety associated with current or potential pain illness, and injury—and, more generally, the fear of dependency and death. Health care organizations are successful in part, and perhaps in large part, because they can reduce anxiety, or at least provide a context for understanding the meaning or purpose of the pain and anxiety that is experienced by patients, clients, citizens and people working in health care.

Organizations have created or embraced cultures that help them address the pain and anxiety that inevitably accompanies the provision of health care. We identify six primary cultures that currently exist in North American health care systems, as well as many other health care systems in our world. These cultures influence the ways in which we interpret the nature and purpose of health care, as well as the ways in which we confront, reduce or find meaning and purpose in the pain and attendant anxiety associated with health care.

The Professional Culture: Medical, clinical and scientific professionals populate this culture. Most of this culture's members hold death as the ultimate but inevitable foe. The scientific and medical professions gave over the task of understanding the meaning of life and death many years ago to religious and spiritual practitioners and the alternative culture, while they focused on the disease processes that happen to bodies.

In this they have been hugely successful. As a result of the efforts of health care professionals, countless numbers of people have been cured, had their lives extended, and had mobility stabilized if not returned fully to them. Exciting new answers emerge from the problem solving done by the professions that make up this culture. Practices improve. Harmful quackery is questioned and eliminated. A host of competent people labor in richly textured jobs. Health care professionals are proud of the work they do.

In managing pain and anxiety, this culture has very much organized itself around the need to control, at all cost, the experience of death by deferring it as long as possible for themselves and their patients. Pain is to be tolerated. Death is to be resisted and overcome no matter what the cost. Professional practitioners have invented models and organizational structures and put systems in place that try to contain pain and defer death.

Nurses have played a particularly active role in establishing these structures. Pain is a valuable source of diagnostic information. Life is a by-product of the struggle against the death of the body. In this sense, the absence of pain and the continuation of life have no meaning for the professional medical practitioner other than as symbols or signs of success. Death calls into question the very nature of and meaning of life, which is the unexplored aspect of the professional culture's reality. As long as one is

focused on the fight against death, then one never has to confront the purpose of this fight, which has something to do with the purpose of life.

We have effective systems, and successful treatment programs because patients have always come first in the professional culture. People from the professional culture have theories about how to organize for maximum effectiveness that have to do with putting patient care first, which in turn ultimately has to do with the prevention or curtailment of death. The patient comes first because it is through the patient that professional health care providers receive repeated reassurance and all kinds of support for the good job they do in thwarting death. This, paradoxically, becomes the central ingredient in the provider's own sense of life purpose. Members of the professional culture look for strategies of organizational change that hold the promise of increasing their control over and opportunity to influence the quality of health care they provide. Ultimately, they support organizational changes that enhance their ability to heal people and delay the inevitability of death.

The professional culture has been the dominant culture in health care since early in the history of North American health care. It is now being attacked from all sides and must share power with the other three cultures of contemporary health care. The professional culture finds and takes its meaning primarily from the professional memberships and associations of its members.

Members of this culture value technical expertise and specialized technical language. They are fully committed to the preservation of professional autonomy and have established quasi-political governance processes to insure this autonomy. These processes have enabled health care professionals, over the past hundred years, to strongly influence or even dictate the policies, procedures and missions of the health care system. Members of this culture hold assumptions about the dominance of rationality and technically based procedures in hospitals and other health institution.

Health care professionals have the rights and hold the responsibilities associated with physically touching people. This is not a trivial point, for these are among the only people in contemporary society, other than hairdressers, masseurs and a few other members of the *touching professions*, who hold the power to physically touch another person with whom they are only professionally affiliated. The capacity to touch and comfort may be one of the most powerful and even magical ways in which people help one another in coping with the anxiety associated with physical and psychological pain.

Cure (amelioration) is highly valued in the professional culture. Prevention is also important. Any nurse or physician would prefer to prevent an illness or injury than treat it; however, professionals must often assign secondary status to prevention. These health care workers are often overwhelmed with the demand for treatment and are usually being paid primarily to cure rather than prevent. This emphasis on cure is intended in part to reduce the anxiety of both providers and patients. When the emphasis on cure is dominant, there is a tendency for members of health care systems to defer or deny issues associated with death and dying and to collude with patients in the avoidance of pain.

The professional culture also highly values competency. This emphasis helps to reduce the anxiety of both providers and patients. This emphasis, unfortunately, also tends to perpetuate the myth of medical infallibility and can block public access to the *secrets of the inner temple* of professional health care. Members of the professional culture value hierarchy and believe that a clear and stable hierarchy can effectively reduce the anxiety of both providers and patients.

This does not mean that the professional culture values bureaucracy—a hallmark of the second, managerial, culture. Members of the professional culture instead value clarity regarding whom is in charge in any given instance. Physicians, nurses and a host of other players in a busy Emergency Room often are dealing with highly chaotic and emotionally charged situations. They value hierarchy from the perspective of identifying power and responsibility so that effective decision making occurs. This emphasis on hierarchy can, in turn, lead to major status differences among health care providers—and is a source of considerable wounding among many members of the health care community.

The Managerial Culture: This culture also brings much that is of value. It builds on the dichotomy between control and chaos. Members of this culture fear their loss of organizational control and are anxious about organizational chaos. They resolutely hold theories about how to organize for maximum effectiveness that have to do with predictability regarding the outcomes of any change effort. They look for continuity and for planned change.

Just as members of the professional culture live with the hope of thwarting the physical death of their patients, members of the managerial culture live with the hope of thwarting the death (chaos and unpredictability) of their organization. They look for organizational strategies that will reduce their anxiety regarding organizational chaos and delay the inevitability of organizational decline and death.

There is another important artifact of the managerial culture. People from this culture are not allowed to touch patients, but they are allowed and hold the rights and responsibilities to touch the organization and its resources, especially money. By touching and controlling the resources, health care managers believe that they can directly benefit their patients as well as society in general. Over the years, health care managers have primarily focused on the provision of resources for the amelioration rather than prevention of illness and injury. These managers have traditionally believed that they could reduce both their own anxiety and the anxiety of their customers (patients) by demonstrating that they could provide healing services at reasonable costs to their customers.

Today, we find a greater emphasis on prevention among some health care managers and in some health care systems. In some instances, this shifting priority is quite real and tangible. Typically, this new emphasis on prevention is occurring because prevention has been found to be more financially viable, under certain conditions, than effective but often costly treatment programs. In other cases, the increasing attention to prevention is more a matter of rhetoric and appearance than a sign of real shifts in attention. *Prevention* is often added to the vocabulary of health care managers and the plans of health care systems they administer primarily in order to make their services appear more attractive.

The same is often true of alternative health care options that are covered to attract members. These alternative health care options are usually inexpensive, even though they have often not been proven to be effective. By contrast, health care managers often refuse coverage of bone marrow transplants for cancer treatment because this treatment modality hasn't been sufficiently proven. One suspects that expense, rather than patient welfare, is the real reason for refusal of coverage for many bone-marrow transplants.

We would suggest that prevention still has being given secondary attention in most sectors of the managerial culture, despite the rhetoric and verbal commitments. Furthermore, we propose that when an emphasis on prevention does occur, this shift in priorities might tend to reduce the anxiety of the managers, but it is not likely to reduce the anxiety of those who are receiving health care services. They are accustomed to treatment plans and dependency on health care professionals. Prevention requires a shift in responsibility back to the patient. This is not very reassuring for most patients. Thus, the rhetoric of prevention might not even be an effective marketing strategy.

Members of the managerial culture have also traditionally valued access. In the past, this emphasis on access helped reduce the anxiety experienced by both manager and clients. Managers could count the number of patients being served and take pride in the provision of maximum service at minimum cost. Citizens could feel assured that treatment was at hand if they needed it.

Today, this assurance is no longer warranted. Americans can no longer trust that they will receive adequate treatment—unless they are wealthy. Health care managers also no longer can feel comfortable in counting numbers of patients served. They now must take costs more fully into account and often seek less rather than more patient-contact. When access is valued, it is sometimes presented in a very condescending manner on the part of the health care managers: "be glad you're getting something!"

Accountability is also valued by the managerial culture. This emphasis is intended to reduce anxiety for both manager and clients. Taken to the extreme, however, this emphasis on accountability can produce a bean counter mentality. Furthermore, for many members of the managerial culture, accountability primarily relates to another managerial value, namely profit. This emphasis on profit and efficiency, in turn, is intended to reduce only the anxiety of managers.

Patients typically could care less about profit. In fact, they often take great offense when they discover that their illness, injury or health is a source of profit for another person or institution. The managerial culture's emphasis on profit creates a climate of indifference when taken to an extreme, People in the managerial culture sometimes lose touch with the real reason for engaging in the business of health care. A dominant concern for profit leads eventually to indifference about the primary customer: the patient. Many people from the management culture, including accountants, information services technicians, insurance agents, and members of the human resource staff, have little contact with patients.

The Advocacy Culture: Representatives of this culture view their world primarily through the prisms of revolution, war and peace. This is the orienting dichotomy of the advocacy culture. We propose that advocates are primarily anxious about disruption in the social system. Just as members of the managerial culture are fearful of organizational chaos, advocates are fearful of societal chaos. In the United States, advocates try to thwart societal disruption by placing a great deal of emphasis on individual rights. They defend the rights of the underdog, ensuring that each citizen receives his rightful access to health care services.

In devoting their primary attention to individual rights, American advocates are sometimes inclined to forget or downplay the other half of the equation: collective responsibility. In their attempts to avoid the death of their society, advocates often fail to recognize the responsibility that all members of society must assume in sustaining this society. On the other hand, advocates provide an invaluable role to the social systems they serve by seeking compromise and by ensuring that there is equitable distribution of those resources that are most central to the pursuit of life, liberty and the pursuit of happiness.

Members of the advocacy culture find meaning primarily in the establishment of equitable and egalitarian policies and procedures for the distribution and use of health care resources within the system. Members of this culture firmly hold assumptions about how to organize for maximum effectiveness. They emphasize negotiation and compromise, the establishment of solid power bases, the forging of alliances, and the provision of convincing evidence for their point of view. Any organizational strategy that is to be accepted by this culture must address the anxiety associated with social disruption and must consider politically based strategies. As in the case of the alternative culture, the advocacy culture has served usually as a counterpoint to the managerial culture, and to a somewhat lesser extent to the professional culture.

Members of the advocacy culture tend to value both confrontation and compromise. They encourage fair bargaining among constituencies with vested interests that are inherently in opposition. These conflicting constituencies may be management and staff, or, at a broader level, the healthcare institution and potential health care consumers. Advocates tend to hold assumptions about the ultimate role of power and the frequent need for outside mediation in a viable health care system. People from this culture have the authority to touch the whole of the health care system through social policy development.

Historically, prevention has been of primary concern to advocates. Beginning with the attempts to clean up city streets and continuing through the recent efforts to clean up our global environment, the attention of most advocates has been focused on prevention rather than amelioration. Prevention is intended to reduce anxiety for both advocates and citizens. Anxiety is also reduced through this culture's emphasis on access. Political rhetoric tends to dominate the advocacy culture and this rhetoric sometimes substitutes for tangible improvement in the health care system. When misdirected, this rhetoric also can lead to a proliferation of health care legislation and policies.

Advocates value electability, which specifically reduces the advocate's own anxiety. A climate of expedience is created when the advocacy culture is taken to an extreme and when this emphasis on electability moves to the forefront. Eventually members of the advocacy culture may begin to do anything and say anything to get elected or appointed.

People who take this culture and its values to an extreme can forget why they got into the health care arena in the first place. The electorate, whether this be the voting public, members of a union, or representatives of a community association, collude through their skepticism and cynicism. Trust is lost and with it an ability to easily take actions that are meaningful. The media treat advocacy as a political game, ignoring the importance of the outcomes. Politics becomes personality.

The Alternative Culture: Members of the alternative culture tend to view health care as a process for sustaining and enhancing life rather than deferring death. This perspective is represented in the old Chinese tradition of paying a physician for every day of health and not paying the physician when one gets ill. Unlike members of the professional culture, those who are most aligned with the alternative culture tend to think of disease in direct contrast with the well-lived life. The alternative perspective concerns not the fact that death is inevitable—but that dis-ease inevitably comes with a life that is out of balance.

Members of this culture are most afraid of being seen as quacks or judged crazy, wicked or foolish. They spend a considerable amount of time thinking about the meaning of life and often devote themselves to alternative health care precisely because of this life commitment. Therefore, when their work is criticized or discounted, they are particularly wounded. What if there is no spirituality? What if these models of health are found to be inadequate? Voice, confidence, and credibility are important. Members of the alternative culture often find themselves on the defensive. They are often being defined by what they oppose rather than by what they support.

The alternative culture touches communities of believers. Whether this is a Tai Chi club, a group of people dedicated to eating a particular diet, or an institution formed around a set of spiritual beliefs, there is a clear set of beliefs and a community that provides support. As in the case of professional health care providers, alternative practitioners assume the authority to touch people. However, they touch people not only in order to heal their body, but also to heal their soul. They seek to heal the whole person. This authority to touch is given to them by both the individual and the community to which they belong. Prevention and amelioration are equally important. The emphasis on both prevention and amelioration is intended to reduce anxiety for both providers and recipients.

Members of the alternative culture have strong theories about how to organize for maximum effectiveness. These theories often focus on the retention of flexibility and promotion of continuing dialogue and innovation, while also demonstrating thoughtfulness and credibility in a still-skeptical outer world. Members of this culture would welcome a strategy for organizational change—if it helps reduce their anxiety regarding non-acceptance and the ultimate meaningfulness of their work in the life they have chosen to live.

This culture has always played a marginal role in the North American health care system. It has been populated by faith healers, herbalists and foreign-trained practitioners of ancient healing arts. Alternative healers have operated spas, provided massage and offered televised instruction regarding new models of health and happiness. Some of these practitioners have been charlatans, while other have been visionaries and insightful innovators.

Alternative healers and their often-controversial methods have usually served as counterpoints to the dominant medical orthodoxy of their time. Alternative medical practices have often been set against those medical practices that are represented in and by the professional culture and, to a varying extent, are also represented in and by the managerial culture. When we move past this theme of contention and anti-establishment opposition, we discover that alternative practitioners find meaning primarily in the creation of programs and activities for comprehensive health care that cross over traditional health care boundaries.

Alternative healthcare practitioners also find meaning in fostering the personal and professional growth of all participants in their health care community. They are inclined, in particular, to view their patient as a partner rather than an object of care. Members of the alternative culture hold assumptions about the inherent desire of all men and women to attain and sustain their own personal health and maturity, while helping others in the community become healthier and more mature.

Representatives of the alternative culture seek to alleviate anxiety among those whom they serve. In seeking to fulfill this function they provide a unique understanding and possible treatment of illness, pain, and death. They say: "you are a whole person, and you need to understand that your dis-ease is part of your spiritual being." It is assumed in this culture that a patient's community and support systems can be engaged to make a difference in how the patient copes with illness and creates health. Members of the alternative culture suggest that they can provide competent treatment, for they are skilled in new or very old ways of doing healing work. This culture focuses on empowering each individual to find and understand what illness, death, and pain really mean. Alternative practitioners encourage their patients to listen to their own voices and create their own healing and good health.

Virtual Culture: accompanying VUCA-Plus (and accelerating its presence and power) is the technological revolution that has impacted all sectors of 21st Century societies—including health care. Those in health care systems who are aligned with the virtual culture conceive of their responsibility as am engagement and use of knowledge and expertise that is being produced and modified at an exponential rate in our postmodern world. Philip Rosinski (2003, p. 54) notes that someone who embraces the virtual culture "values a dynamic and flexible environment, promotes effectiveness through adaptability and innovations, and avoids routine which is perceived as boring".

Those aligned with this culture tend to value a global perspective and make extensive use of open, shared, and responsive learning systems. They are participants in what Thomas Friedman (2007) describes as a "flat world" which has abandoned organizational and national boundaries. Furthermore, with the exponential growth of Artificial Intelligence (AI) in the field of medicine, these health care workers are likely to be fully wrapped up in

this new technology. While AI might be threatening in many regards, it is also “here to stay” and holds the potential of vastly improving the quality of medical diagnosis and treatment.

Leaders who are aligned with this culture speak about learning organizations. As Peter Senge (1990, p. 4), one of the early proponents of the learning organization, has noted: “The organizations that will truly excel in the future will be the organizations that discover how to tap people’s commitment and capacity to learn at *all* levels in an organization. Learning organizations are possible because, deep down, we are all learners.” Furthermore, as learners, we should not avoid taking risks and making mistakes, yet we should avoid repeating the same mistakes and taking the same unsuccessful risks. We learn from our mistakes (as well as our successes).

Members of a health care system who are aligned with the virtual culture not only tend to be increasing in numbers, they also tend to embrace many untested assumptions about their ability to make sense of the fragmentation and ambiguity that exists in the postmodern world. (Bergquist, 1993; Bergquist and Mura, 2005) They typically are quite wise and skillful in making use of digital technologies. They are likely to be frustrated in working with other members of their health care system who are not readily accessible via some portable digital device. These members of the virtual culture are inclined to work quickly and decisively with clients via many different media.

Health care leaders who are oriented toward the virtual culture are likely to conceive of the development of those working for them as a matter of “just-in-time” linking of learning needs to technological resources that enable access to a global market and learning network. Mobile devices are the new classroom. A virtually oriented leader will be actively engaged in setting up their own network of leaders from other health care organizations who share a similar perspective regarding technology and global sharing of information.

The health care leader who operates out of this particular frame of reference is involved in a balancing act with regard to the creation of meaning and reduction or elimination of organizational anxiety. On the one hand, the leader is often in the business of challenging those reporting to them with new information regarding the postmodern world or with new points of access into a dynamic network of relationships—these challenging inquiries can shake up existing patterns of meaning and can certainly increase anxiety.

On the other hand, the virtual leader is trying to be supportive of their colleagues, providing them with some sense of coherence in a world that is filled with VUCA-Plus. (Bergquist and Mura, 2005) A global network that can introduce new anxiety-producing perspectives and practices can also be the source of support and reassurance: “this challenge has been faced elsewhere and has been met successfully!”). The organizational cocktail is shaken up, but then stirred (to borrow from James Bond movies). The shaking up produces chaotic change, while the stirring produces cyclical change (“this is just another of the interesting challenges we will be facing and overcoming. . . “).

The virtual leader faces a difficult task in helping others (as well as herself) make sense of this world. It is not only a matter of digesting a large amount of information and managing anxiety> It is also a matter of thinking and acting at a very high level. Kegan (1994) suggests that we, of the postmodern era, are “in over our heads” (certainly a challenge to existing patterns of meaning and a source of profound anxiety). It would seem that

these virtual, postmodern leaders are particularly needed to help others in their organization address these major 21st Century challenges.

The Tangible Culture: While this sixth culture has always been present in the health care system, it has become more salient (and even strident) with the emergence of the virtual culture. Those in health care systems who are aligned with the tangible culture conceive of their most important role as a leader in their system as the identification and appreciation of their organization's roots. They are in the business of building community that is grounded in traditions and symbolic representation of critical values.

This organizational perspective resides at the opposite end of the continuum from the virtual culture. Labeled "stability" by Rosinski (2003, p. 54), it is a perspective that "values a static and orderly environment, encourages efficiency through systematic and disciplined work, and minimizes change and ambiguity which is perceived as disruptive". Those aligned with this culture tend to value the predictability of a value-based, face-to-face process of interacting with other members of their organization—as well as interacting with those seeking health care assistance. Their anxiety is reduced through the establishment and maintenance of these value-based interactions, as well as preservation of traditions and history (often distorted) in the organization.

Those aligned with the tangible culture like to work with people they can see and "touch" (tangible) and work in relationships that are long-term and grounded in reality (tangible). There is nothing better than seeing their patients mature over the years or of honoring a fellow employee for their 30 years of service in the local hospital. Leaders who are aligned with this culture also are inclined to turn for guidance to others in their system who focus on deeply embedded patterns (traditions) in the organization. Cultural change is either considered impossible or unwise. A strong emphasis is placed on the full appreciation of existing and often long-standing dynamics of the organization—this emphasis being most fully articulated by those embracing an "appreciative approach" to leadership (Shrivasta, Cooperrider & Associates, 1990; Bergquist, 2003; Cooperrider and Whitney, 2005).

If one is oriented toward the tangible culture. then they are likely to be concerned about the desire of their patient (or fellow worker) to interact via a phone of mobile device. The patient or fellow worker might declare that they have "no time" for an in-person meeting. A health care worker who is inclined toward the tangible culture doesn't feel like they really "know" this person and would much prefer to meet in person for at least a short period of time. Much more could be accomplished. As a physician or administrator, she would be much more comfortable in picking up subtle clues at a later time when interacting by phone or mobile device. If she at least has an opportunity to work with her patient/co-workers in person once in a while, then she can more effectively interact with them virtually.

Health care leaders associated with this culture embrace many untested assumptions not only about the value of personal relationships, but also about the ability of organizations to "weather the storm" of faddish change. They conceive of the developmental enterprise in their health care system as primarily the honoring and reintegration of learning from existing sources of distinctive wisdom located in their specific organization. These leaders tend to be appreciative, loyal (and sometime a bit narrow-minded and resistant to new ideas): "the new

technology is fine—but let's remember what really heals people and how organizations really navigate the turbulent waters of contemporary health care!"

Given the postmodern challenges facing contemporary health care leaders, it is obvious that the tangible coach is potentially of great value—for leaders long for reassuring strategies that are directly aligned with the tangible culture. They want to be able to meet with other people face-to-face; they seek out a time and space that is safe. When effective, the leader and health care provider who is aligned with the tangible culture will help create a "sanctuary" in which her patient can talk about anything and feel deeply. This patient may have no specific agenda, nor does he necessarily want to change his health-related habits. He mostly wants to find a safe place where he can "be himself," "talk to someone who holds no agenda other than being there for him," or "simply be listened to by someone who cares about his personal welfare."

These tangible needs are aligned with a holistic perspective regarding health care. They are not easily captured in a formal statement regarding the health care workers responsibilities. However, as in the case of the alternative culture, the strategies associated with the tangible culture may be immediately effective in helping to create (or sustain existing) patterns of meaning and reduce postmodern anxiety. Unfortunately, this type of health care service is often reserved only for those with sufficient power, wealth or opportunity to meet over an extended period of time or to meet frequently with their health care provider. Thus, the tangible culture – more than any of the other five cultures – is often associated with health care services that are reserved for the elite.

Conclusions

The two of us are committed to constructing bridges between the professions of psychology, coaching, primary care, complexity science, and leadership. We have offered a series of insights and several summary statements which reflects on the many complex topics that confront those leading mid21st Century health care institutions. We believe that an interdisciplinary bridge provides a roadway for effective leadership, creating a caring health care system, and nurturing a "safe" environment for innovation and collaboration. Hopefully, this series of essays has produced some of the piers and beams for this bridge.

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