The Lens of Leading Causes of Life:
Working in living systems

Note: This review was requested by Gary Gunderson at the working session of the Leading Causes of Life Initiative in Winston-Salem in February 2015.I have added an extensive bibliography to this paper in order to place the work of LCLI in a context. The case histories are derived from existing published papers and attendance at various sessions. I do not feel I had enough descriptive information on the work in Africa to include it here. The lessons from turnarounds were also requested by Gary as a reflection on change. I wish to give particular thanks to Dr. Paul Laurienti who has been of outstanding help in both the writing of this paper and in explaining the nuances of work with complex adaptive systems. Jim Cochrane has been a sensitive editor whose comments greatly enhanced this work.

Overview of the Fundamentals

> **"***The useful creative work is not ordering diseases, conditions or pathological determinants. We need a far more useful grasp of what we have to work with—the assets. But an asset is only useful in the context of a change theory. … assets in service of a change theory aimed at improving the life of the community."*
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> *Gary Gunderson: What's really worth knowing about the community? IRHAP Consultation2014*

How can we improve the life of our communities? How can we bend the arc of the healthcare universe toward justice? How can we engage those who serve health and healing but who work within institutions that commodify both health and service? The Leading Causes of Life Initiative is a direct attempt to answer these questions by shifting the healthcare conversation from death and dying to life and living. Part of this new conversation is the sharing and exploration of an entirely new healthcare vocabulary—new words that guide decisions and interventions to improve well-being and vitality. Among the words in this new vocabulary are *connection, coherence, agency, intergenerativity and hope*. Each of these "causes of life" will be defined through successful implementations of the Leading Causes of Life.

Complex Systems and the Leading Causes of Life

Caveat: It is very common in healthcare and medicine to use the word *system* in the sense of "an assemblage of parts forming a unitary whole." We say "the digestive system," or "the reimbursement system," or the "fuel injection system" describing discrete units of understanding. In discussing living systems, we mean complex adaptive systems: *complex* in that they are diverse and made up of multiple interconnected elements, and *adaptive* in that they have the capacity to change and learn from experience.

It is important to remember that complex adaptive systems are:

Dynamic: there is constant discontinuous change.

Massively entangled: the interdependent variables and network relationships are context-dependent.

Emergent: these are self-organizing networks, constantly altering themselves.

Robust: the adaptive nature of these systems means that as externalities change, so do the relationships among the elements change.

Indeterminate: the focus is on variation, local control, and sensitivities to co-evolution with the environment, unpredictable.

Although healthcare systems are themselves complex adaptive systems and as such messy, unpredictable, and fraught with multiple and diverse relationships and meanings, it is common to discuss them as designed institutions: predictable and serving efficiencies. In an institution dedicated to preserving itself, predictability and resource allocation will seem dependent on a precise knowledge of averages and aggregations. In the complex system, averages and aggregations may be meaningless because of the interactions and relationships of the parts. Thus the neuroscientist Paul Laurienti has described the need to understand the "outliers" of a healthcare system as these have the greatest impact on the entire system. This has enormous implications for research, and for the meaning of the "data-information-communication-understanding" continuum of learning.

The Leading Causes of Life Lens

The roots of medicine lie in the mediating role between science, knowledge, wisdom and the complete journey of life in all its complexity. The current professions of medicine and institutions of health care have limited themselves to a set of tools defined by the languages of morbidity, mortality and pathology. Most of healing takes place in *complex adaptive systems:* in community, in relationships to our environments and to each other, independent of the institutions of medicine and professional care. Despite chronic diseases, socially complex challenges, and multiple reasons to despair, life finds a way: people the world over manage to care for each other and to express their own vitalities.

In order to better understand how Life finds a way, we use the perspective of the Leading Causes of Life framework to reflect upon the current work in living systems, faith and health initiatives in differing locations, and on the challenges such a perspective engages within institutions and communities. All life organizes into relationships and networks. "All living is meeting" (Martin Buber), so in order to better understand how connection, coherence, agency, intergenerativity and hope are expressed in healthy communities we will look at the networks which have been fundamental to this work.

Margaret Wheatley admonishes that "To create a healthier system, connect it to more of itself," expressing the belief that living systems contain their own solutions, that somewhere within the system, the solutions to problems are known and implemented. What would this mean if applied within the LCL framework? What does it mean as we think of change within the communities now served?

In the monograph developed for Stakeholder Health, the values of this work are eloquently expressed:

> "Health care is first and foremost a matter of love and service, grounded in mission, purpose, and values. Some of our institutions make their religious identity and

spirituality explicit, while others do so implicitly. But all provide significant opportunities for their employees and physicians to live lives of meaning, good work, respectful community, and recognition of the transcendent.

Health care should never be reduced to a commodity. Healthcare disparities are the clearest expression of the need for these missions to continue.

We believe that every person is deserving of compassionate health care that attends to the needs and the resources of the whole person. No one is left out; everyone counts. And our communities cannot experience their full potential when glaring health disparities continue to be inadequately addressed. These glaring disparities within the United States become even more challenging when the needs of persons in the developing world are considered. For them healthcare begins with core needs for sanitation, clean water, and vaccinations."

Health Systems Learning Group Monograph, page 80

Faith and Health—A Brief History

At the recent working session of LCLI an ICU physician stated that if he shed tears with the parents of a dying infant, his peers might admonish him for being unprofessional and for "losing his objectivity." This comment illustrates the past two centuries of the development of medicine as a profession and the distortion of human wholeness, dignity and creative freedom imposed by that professional but constraining role. Only recently has there been movement away from constricting rules, roles and relations for both the healthcare professional and the person seeking medical treatment.

Critical to that movement toward overcoming disparities and restoring dignity, is the work begun at the Carter Center in Atlanta as the Interfaith Health Program. Understanding that faithful congregations could be critical to the development of healthy communities, the IHP worked across disciplines and the public, private and volunteer sectors to align energies in support of community health improvement. Perhaps best summarized in the "Appreciating Assets: The Contribution of Religion to Universal Access in Africa" Report of the African Religious Health Assets Programme to WHO, this work took gladly to the challenge of returning health to the context of life. Especially because of the work in Africa, aligning faith and health has focused on the assets provided, or that may be provided, to public health and communities by the religious institutions in those communities. The HIV pandemic provided the impetus to better understand the realities of how communities and congregations deliver care to their most vulnerable and stigmatized members. The Leading Causes of Life perspective may provide a new way to integrate and accelerate this work.

Language as an Intervention

Linguistic scholars as well as social development experts have written extensively regarding how changes in vocabulary change the perceptions, expectations and social constructions of a given group, so affecting practice and action. Equally extensive, those working in the field of resilience explore the use of new language to reframe experience, as positive psychology also explores the dramatic impacts on behavior after introducing a vocabulary which emphasizes strengths rather than deficits (*Resilience and Vulnerability*, Luther). Building on the history of work in faith and health, the Leading Causes of Life vocabulary is an intervention in itself, engaging its audience in the exploration of a perspective which is constructive of greater meaning and purpose.

As others introduce concepts such as the Capability Approach, (Nussbaum) or social contagion through connection (Fowler), the introduction of the Leading Cause of Life language enables a new symbolic system around possibility which inspires, clarifies and enables the work to overcome health disparities. Underpinning the five causes are cognitive and moral drivers of the human spirit such as imagination, mutuality, generosity and courage which warrant further exploration.

It is especially important to see how the LCL perspective is strengthened by, and strengthens, the understanding of complex adaptive systems as the reality in which the work is being accomplished. Creating a symbolic system around which people can better comprehend the energies of networks and their own lives is a huge step toward greater shared vitality. Edward Goldsmith wrote “To sanctify something is the only cultural device that has ever succeeded in preserving it.” The LCL language sanctifies, and nurtures, the capacities for reverence among those who use it.

Case Histories

I. Memphis

Just as the work in Africa was precipitated by the HIV epidemic, the work in Memphis was precipitated by the recognition that in an area rife with disparities, a chronic disease epidemic among the young was developing in ways which could not be addressed by hospitals. Rev. Bobby Baker put together a network of congregations to better educate the community about health issues and resources. Identifying that 70 percent of the people using the Emergency Department had been in a congregation in the last thirty days, the pastors recognized that their own faith network could become the basis for real engagement in patients’ lives outside the hospital and beyond acute care needs.

The two priorities of the group were to elevate the health of the community and to create better access to health care for the community by aligning community assets with formal healthcare providers. In addition the system was designed to address the four critical areas of health disparity in Memphis: the frail and elderly, mental health, chronic disease, and maternal/child health. The Congregational Health Network is structured as a web of trust, with Navigators within the hospital and liaisons in each covenanted congregation, so that there are two large supporting institutions, and infrastructures, working together to bridge the gaps in resources and knowledge.

Connection

The CHN amplifies the connections of individual members of congregations not only to the health care resources and sponsoring hospital, but to the other covenanted congregations. Using the various tools for mapping assets and *hotspotting* needs, these connections are strengthened and extended to address the scalable needs of population health in a disadvantaged community.

In addition, the CHN connects the congregations to the hospital system in a dynamic learning relationship which expands the impact of hospital care and medical resources through the network. From the individual to the level of the huge healthcare system, connection and interconnectedness cultivate the network of trust by reciprocities which further nurture and extend possibility. The sustainability of the network is a property of the connections across the network, not a property of any individual effort.

Coherence

CHN's founders recognized that the search for meaning, even in desperate circumstances, linked individuals to each other, to their neighbors, and to representatives of the faith traditions in the community. With profound effort, CHN has brought coherence to that search by creating covenant relationships of the congregations to the network, and thus to the spiritual as well as physical health of the community. This is a differentiating commitment, and although it may be embedded in the largely African-American churches in Memphis, the emphasis on cultivating covenanted relationships elevates the LCLI understanding of coherence in a community, and further resonates with what we know of complex systems. Coherence is directly related to the capacity to self-organize.

In both faith and health, coherence is founded in intimacies—of need, of imagination, of vulnerability, and of yearning. Resilience can be described as having a sense of being, a sense of belonging, a sense of belief, and the will to benevolence. All of these bring coherence to the individual seeking faith or seeking health, to the relationships through which that individual finds both belonging and community, and to the systems in which this system of meaning is

embedded. Coherence through the CHN helps build resilience for individuals and for the networks of support themselves. The interdependence between coherence and network resilience is a classic example of a self-organizing complex system. As coherence increases, trust is allowed to flourish and network ties strengthen. The stronger the network ties the greater the trust amongst network members, resulting in more coherence. The more flexible and adaptive these ties, the greater the capacity for an increasingly stable and inclusive network.

Agency

The CHN began with the sense from founding President, Rev. Bobby Baker, that chaplains and congregations must **act** on behalf of the health of members. His sense of agency permeates the network and has strengthened the self-organization as well as the willingness of large organizations, such as the hospital, to partner with CHN. The Navigators within the hospital, and the trained Liaisons within the congregations, are constantly facilitating change and creativity. Although I know of no narrative archive of the stories of patients affected by CHN, the connections and resources facilitated through it are designed to increase the self-efficacy of health management.

In addition, a greater sense of agency can grow over time as the CHN web of trust attracts new covenanted relationships, and extends its work by becoming a framework for community imagination. This cannot be overemphasized in importance, for the agency appreciated and applied by the community reinforces it as a living system, dispersing authority and responsibility widely, and expecting innovation from its participants. Agency becomes a protective aspect of the work, against both instrumentalism and controls imposed by other institutions.

Intergenerativity

Frequently efforts to reach the vulnerable by healthcare institutions focus on the frail elderly, in part because of the costs of care for those with compromised function and chronic illness, and in part because the aging population is visible. CHN began with an understanding that young people in the community are at risk, and the congregations could mitigate those risks. As faith leaders help develop, and exemplify, moral skills, they become the conduits of intergenerativity on behalf of a tradition and on behalf of the future. This intergenerativity in CHN is made evident through its ability to attract and sustain new members, and enroll increasing numbers in its training sessions.

There is a further aspect of intergenerativity made possible by the work of CHN, and that is the inspiration and engagement of the greater Memphis community (beyond CHN and Methodist LeBonheur Hospital), as well as beyond Memphis. Through the encouragement made possible by the web of trust in action, other resources, institutions and communities gain the

perspective of possibility and mutually beneficial engagements. Intergenerativity is critical to sustained life within the networks over the course of time. It is this spreading legacy that allows continued adaptation and resilience to emerge as agency and coherence strengthen.

Hope

The CHN brings hope as well as teaches the practice of hope by anticipating possibility and willingly undertaking responsibility for making new possibilities real in the lives of the community. When a liaison helps an individual gain access to care, the action generates hope, increases knowledge, and frees the imagination to see beyond immediate needs. Since the work is done in and through congregations, the shared experience reinforces as well as generates greater confidence in the agency of the group, the skills being developed to do the sacred work, and the courage and reverence to apply these shared skills to the unknown.

CHN helps its members bring to its partners and to the community at large an imagination of possibility that we can construct the lives we want to live, the health we strive to enjoy, and the legacies we want to leave. Energizing agency, the work of CHN is thereby contagious of hope and life.

Complexity and CHN

The structure of covenanted relationships is especially important in the framework of a living system, for it emphasizes the nurture and cultivation of interdependence nested in shared responsibility. From this foundation, CHN can work at multiple levels of scale, engaging in variously resonant and reciprocal systems which it can influence as it is being influenced. CHN can and must change the hospitals and medical systems with which it partners by making evident the assets and the existing wisdom and social intelligence within the communities served by those institutions.

CHN facilitates relationships, it does not control them, but it does expect that from its climates of trust and exploration, new commitments, ideas and spheres of action appropriately adapted to the living systems it embraces will emerge. Complex systems cannot be effectively controlled from the top down. The late Donella Meadows once wrote that you must dance with the complex system rather than trying to force them to change. CHN now possesses capacities it did not have at the time it was established, and those capacities will change and create change as they are applied. What remains critical is that the changes are connected to and articulated through the network, and that the network can constantly transcend itself by learning.

Reflection

The data and reports on the remarkable impact of CHN have to date largely been presented in terms of hospital-based information. Because of the innovative work of LCLI, it is critical that

the narratives of CHN's work be collected, analyzed and archived, and that the qualitative nature of that work be better described and understood. Cost savings to the hospital and increased access to medical care are necessary to the work as "proving" its value to its sponsors, but this is not sufficient knowledge on which to understand why CHN works, and the ways that it works as a living system.

II. Winston-Salem

The Supporters of Health Initiative of FaithHealthNC engages long-term employees of the hospital who are trustworthy reporters, energetic advocates and brilliant field workers. These individuals can discover and coordinate resources in the community which mitigate the risks and suffering of those patients identified as costly "outliers" of the Wake Forest Baptist Medical Center (WFBMC). Using sophisticated analyses of their service area, Wake Forest staff members Paul Laurienti and Teresa Cutts, have understood that most of these outliers live in a specific area of East Winston which the Supporters of Health know well.

The team of pioneering Supporters applies the perspective of LCL by:

- Establishing *connections* on behalf of their patients, and among community entities serving the vulnerable
- Creating *coherence* for those whose illness or vulnerability have challenged their sense of meaning by accompanying them on their life journeys
- Advocating self-reliance as awareness of *agency* both for their patients and for service providers who may not be aware that they are part of a network of care
- Reinforcing *hope* by their daily presence, and by the intimate actions they take on behalf of a future of health and engagement
- Identifying and exemplifying *intergenerativity* by seeking out the lessons to be learned from those serving and being served by community efforts and by expanding the impact of each of those efforts.

This Initiative was founded to reduce the reactive costs of care for the uninsured patients of WFBMC and create a smarter and more effective way to use those charity dollars to prevent and ameliorate acute needs. Although some of its founding ideas (such as reducing readmission costs by community support of the patient) derive from the Congregational Health Network's accomplishments in Memphis, because the Supporters work is markedly different from CHN's, the discussion of LCL's application will be comparative.

Connection

CHN exists as a network of over 500 churches partnering with Methodist LeBonheur Healthcare and associated clinics to address the needs of the Memphis population. Fundamental to its

work is the commitment made to covenant relationships through which the congregations share responsibility for improving access to medical care and alleviating preventable acute needs. The trained liaisons in the congregations have the support of both the CHN network and the medical institutions.

The Supporters of Health in Winston-Salem are at present creating a network of resources, although without covenant or tangible commitments to the network itself. Their work is an extension of WFBMC, but through that work they are connecting community resources in ways which have not been done before. However, at present this dynamic learning and trust building is not within any existing web of relationships and trust. The work is not as yet supported by a network of congregations, in part because there is a different attitude toward membership in a congregation in Winston-Salem than there is in Memphis. The Supporters state that asking about a patient's church or faith affiliation can be taken as intrusive and invasive, whereas in Memphis the congregational liaisons are already embedded in both a church and the network.

Connection for the Supporters of Health is not yet scalable, but is an iterative process directed to the needs of each individual client, and with the changing staff in existing community service agencies. Their priority is establishing a web of trust among the community service agencies in order to improve accountabilities for the continuum of care and reduce duplication of services.

"Not Alone" is the fundamental principle of FaithHealthNC, and chaplains do accompany patients at WFBMC and within their own congregations, but not as yet in a distributed web. The Supporters themselves need a better sense of connection to their sponsoring system, but as builders and pioneers they do not concentrate on what they lack, but on what they are creating.

Coherence

Each of the Supporters of Health is articulate about the moral and philosophic aspects of their work in bringing a sense of meaning and caring to the very fragile people they serve. The Supporters speak eloquently of the failures of the current health care systems to convey a sense of caring, a sense of love, and a sense of dignity to their patients. Further, as they identify, evaluate and engage community service entities, they speak of this greater meaning and bring attention to the consciousness of service within those entities.

CHN brings a different sense of meaning to its members by articulating, in its covenant, the shared sense of purpose and responsibility which it strives to elevate. This appears to be a unique emphasis made possible by the faith traditions in Memphis. The Supporters of Health have invited greater activity in the coordination of services by the congregations, but their experience as yet is that the congregations in their area want to serve their own members and the ongoing sustainability of their own church, rather than extending or expanding activities in

connection with other churches. Coherence between the hospital and the community resources extending services to patients and the community would create a significant infrastructure of trust, respecting the work of the Supporters, and would reinforce the strength of the complex network.

Agency

The Supporters of WFBMC emphasize to their patients the capacities for self-determination and control of their own agency, but find that this is in some cases a daunting task because of the learned helplessness and various dependencies within this population. They stress their own work and vigilance to act on their own behalf and transform their circumstances, and their clients see the Supporters as both examples and leaders of possibility. This is an individual, case-by-case, effort.

CHN first established a sense of agency among its congregations, and then identified the individuals who could become advocates and workers for the care of others. CHN has not been limited in its own agency by its partnership with the hospital, and has through its success, expanded that sense of capacity beyond its initial hopes.

As yet, the agency of the Supporters and the lessons about effective action are not being spread across the various service resources. There is as yet no framework similar to CHN through which this can be accomplished, but a resource network, sponsored by WFBMC, is both necessary and seen by the Supporters as a hopeful way in which their work can become scalable.

Intergenerativity

CHN began with a focus on the young, and what risks to the young meant as risks to the whole community. The Supporters of Health see the unaddressed needs of children and the young to be significantly neglected in their area. They feel that any effort to use charitable dollars in a proactive rather than reactive way should begin by attempting to break the cycles in which so many young people feel locked. The Supporters are deeply aware of the cost to the community of “losing” a generation to substance abuse, or remaining blind to the stunting of development caused by inadequate physical, emotional and spiritual nutrition. Since their jobs are at present to focus on reducing the costs of the outliers, who are mainly the chronically ill and the elderly, they do not have an institutional means to bridge these pressures.

CHN builds a sense of intergenerativity through the attractions of its network. The Supporters must do so through their own attention and presence. This they do every day for their clients, but with a clear awareness that they are limited.

Since both the Supporters and CHN are creating a dynamic body of knowledge about their communities, it would be deeply generative if this learning could be captured and available to others. In the living systems work, attention to such knowledge could help establish the standards of practice and evidence of efficacy, as well as the feedback loops necessary to learning.

Hope

Both the Supporters of Health and the liaisons in the congregations of CHN bring a sense of hope as an awareness of possibility through their active compassion and their comprehensive attention. CHN has spread this sense of informed hope across its members and more broadly into the community. The Supporters of Health feel that community-based prevention and education efforts would bring hope to neighborhoods that feel they are, and must remain, invisible to the larger community.

Since in both regions, the hospital systems are very large employers and economic drivers, they convey a sense of overwhelming power, as well as a sense of opportunity within that system. This power can be a vehicle for hope, just as it can be perceived as indifferent to all but the financial aspects of delivering care. Changing the institutional language to include the LCL vocabulary might help change the perspective as well as the perceptions of these large medical systems. To begin, the Supporters of Health must be valued as the vectors of hope and protectors of dignity that they have become.

Complexity and WFBMC

The Supporters of Health are creating something new, and they are doing so with an awareness that their work is in a massively entangled, dynamic, wholly unpredictable environment of needs and resources. They have a great deal to teach, and if WFBMC learns from them to apply LCL perspectives, real adaptation and robustness may emerge. It is important to remember that such self-organization may be slow initially and early markers of success (or failure) could be misleading. Self-organization often starts as a single drop in a pond but can propagate to a great ocean wave. The system must be nurtured early and short-term evaluation based on "quarterly earnings" should be avoided. This nurture must take place in a dynamic, safe, environment of trust and learning, avoiding the short-term language of performance and measure.

III. Stakeholder Health

The Stakeholder Health affiliation of faith-based hospitals began as a learning group in order to shift their organizational perspectives and priorities to better serve their communities. Although the group calls itself a movement, so far it does not seem to describe itself as working in living systems, in part because the participants are also the field workers who rarely have the

time to reflect on such theories, and in part because it is not clear that these different entities are learning through the same lens. Members are conscious of the need for change, and work to educate other members regarding new efforts.

Some of these educational offerings are project or program descriptions, and most are still preoccupied by a focus on a particular hospital system rather than on the interconnectedness with other systems in which that hospital is embedded. Frequently members speak of having to justify to their institutions their engagement in Stakeholder Health, which would indicate that there is as yet no real coherence between the participants' efforts and their sponsoring groups. When members use "complexity" it is frequently as a descriptor of challenges rather than a reference to the powerful generativity that can be found in complex systems.

If members were to examine the goals of the learning group through the lens of LCL,

> The nature of the connections they are establishing might well become clearer;
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> Connection between, and coherence among member institutions, the group itself and individuals could be inspired as well as expanded;
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> A sense of agency to act together could be defined beyond the focus on existing institutional priorities and resources;
>
> Intergenerativity across participants could not only better understand the traditions and mission of social change, but mentor participants as they apply their own energies to work on behalf of a more just future;
>
> And in a time of volatile fear and constraints, the group could become a sanctuary as well as a driver of hope.

It might also be fruitful for the participants in Stakeholder Health to attempt to

- Discern the various theories of social change from which they are working, and how these impact their expectations
- Evaluate their work as living systems work rather than as organizational development activity or professional performance
- Examine how complexity theory could help them better overcome their default perspectives on predictability
- Focus on how their initiatives can illuminate as well as facilitate understanding of how the LCL perspective is already present in the communities they serve.
- Apply the LCL lens both to their own institutions and to their communities, better to understand if and when they are limited by a deficit perspective, and when they are working to strengthen a living system.

Work in Organizations and Work in Communities

I. Who, What, Where and How

Much of the work of the nonprofit and public sectors has been driven by attempts to identify predetermined solutions. Funders have wanted to know what their money is buying and what impacts will be achieved and short-term gains often trump long-term success. Business entities rely on predictability for planning, monitoring, evaluating and investing. Nonprofits have been urged to become more like businesses at the same time that businesses are finding their models and perspectives no longer apply to the changing contexts of their activity.

Often the creation of a "model" also creates an expectation of predictable replication even when the interdependent factors and circumstances are different from those in which the model was developed. A greater understanding of complex systems can help organizations learn that prediction is great, until it fails. Rather than focusing on predicting what will happen, it may be more useful to focus efforts on predicting when things will become unpredictable. That is, we may benefit more from understanding when the systems is becoming unstable than try to predict what will happen next during periods of stability.

In our work in living systems, as with work in most businesses, it is rare that there is a shared, and accurate, understanding of who does what, where and when they do it, with whom they accomplish what, and how they in fact *work*. The tacit and dynamic knowledge that is being accumulated every day is not captured, and thus must be acquired repeatedly, or lost.

Even within relatively small entities buzz words, jargon and management terms rarely clarify and more frequently create barriers and false assumptions. The labels and titles—the finance guy, the visionary, the maverick, the hero—placed on individuals are barriers and constraints to comprehension of our interconnectedness and interdependence in all aspects of work and performance. Exit interviews with retiring staff members rarely recognize that this person maybe the trusted carrier of vast institutional knowledge and mores, and that passing on that knowledge is essential to the institution's integrity.

In the conditions of complexity, knowledge of who does what becomes critical because it is the interconnectedness and relationships which matter, not the title, role or place in a hierarchy. Work in living systems is work in discovery, alignment, learning, reflection and emergence. In the case studies of CHN and The Supporters of Health, it should be clear that what is now known is not what was planned or predicted, but rather what has been discovered and this will not be what is yet to be learned. A vigilant and consistent attention must be paid to the feedback from every level of the living system.

Especially in the dynamic pioneering work of the Supporters of Health, their feedback must be valued as *constructing* the possibilities of community work, and must be both sought and archived as well as disseminated. The narratives of daily work both in CHN and Winston-Salem will become tools for change, evaluation and broader coordination of resources. Using the LCL framework to look at this work can be provocative as well as precipitating of the continuous adapting of skills to new circumstances and newly acquired understanding.

II. Lessons from Turnarounds

A turnaround specialist is generally engaged when the pain of an acute crisis (of leadership, financial need, or some perceived failure) becomes intolerable to the entity. The turnaround may appear to be concerned with the acute crisis, but the primary task in a true turnaround is the restoration or creation of vitality, and the LCL perspective can be deeply helpful in this work. When a corporation or community seeks help for troubles, the focus is frequently on symptoms—declining revenue, staff turnover, disruptive information systems—rather than on the resources and assets, not to mention the knowledge and skills, within the corporation. Such a troubled entity may not see itself as a living system, let alone as a complex adaptive system, and as change occurs, change is defined as "trouble."

One fundamental and very common reason for institutional crisis is the misuse and misunderstanding of the existing talents present in the entity. In part, this often develops over time as a calcification into vertical accountabilities and within the labels on roles which are internalized by individuals to their own detriment as well as to the significant loss to the institution.

A person may be labeled by others as a hero because of an incident of action or performance, and become locked into that sphere of action, even though the individual may be frustrated, fearful and resentful of the one-dimensional view of their potential. Another may be called "the conscience of the company," or "our moral compass," and then become reluctant to innovate beyond that role, thus becoming marginalized in a negative feedback loop which began as praise.

Discussions of necessary change in healthcare, and especially population health, often become obsessive rants about systemic constraints: the insurance system is broken, we must change medical education, uninsured people do not want to comply with life-style change, government systems cannot address local needs, there is always more demand than we can deal with and so on. In this atmosphere it is also common that the positive deviants, those who have figured out how to leap beyond these constraints, may be dismissed as not replicable, unsustainable, or not credible because they did not share customary measures. These preoccupations are indicators that the living system is not perceived as such.

Mandated community health assessments may show particularly dire needs in the population to be served by healthcare institutions—as suicide rates among young people, or severe food insufficiencies among military dependents—and these may remain unaddressed, or given no priority because there is no obvious medical intervention, or because community agencies do not perceive these issues as within their mission or sphere of service (the perspective of "not my job"). Labels and descriptions are usually anachronistic to the crisis which has provoked the need for turnaround and irrelevant to the work going forward.

The lens of LCL and living system work can have profound impact in realigning perspectives, and thereby placing emphasis on the patterns of interaction and relationships rather than on roles and rules and measures of incidents. In any atmosphere of crisis, especially when there has been a perceived loss of mission, or a sense of betrayal of the mission, trust and the vectors of trust, becomes essential to movement out of the crisis.

Further, examining any shared effort with the LCL lens will help to remove the harmful assumption that positional power is the only form of power which matters in an organization. There are many forms of power:

- The power of connection, inclusion or resonance, shared interest
- The power of language, shared tacit, implicit and explicit communication
- The power of coherence, shared values, mission and purpose
- The power of intergenerativity, shared traditions, customs and aspirations
- The power of hope, shared imagination and creativity
- The power of agency, shared actions for mutuality and transformation

Within any corporation, or effort, identification of these kinds of power and those who use them is an important step toward building cohesion and stability. An effective executive in a living system will humbly seek out those who understand and wield these differing kinds of power and reinforce the continuous learning possible, and which builds stability in the complex system. During those times in a community effort or in a corporation when austerity measures are necessary, using these many types of power to support, encourage and realign practices is especially vital.

Lack of resources, even at crisis points, must not become an excuse for lack of discipline or lack of rigor in hiring, training, supervising, promoting and mentoring staff. The wisdom applied to the hiring of the initial Supporters of Health in WFBMC is exemplary of what needs to happen in most of the nonprofit sector. Often this sector has abdicated responsibility by saying that dependence on volunteers means that "whoever shows up is the right person," compounding this irresponsibility by providing minimal, and neither ongoing nor rigorous, training of these volunteers. Continuous training is an essential aspect of the continuous feedback necessary to

the stability of the complex adaptive systems in which this work takes place. The Clemmons Food Pantry is a very good example of ongoing training for volunteers which makes their service both proficient and deeply accountable to their community.

During volatility, or times when new tools, methods and goals are introduced into an entity, the LCL perspective can support patterns of interaction among participants as equal students, removing the stagnation of vertical authority and roles, as all those affected grapple and struggle together. One of the most significant lessons from development work is that the necessary wisdom exists within the community, so that facilitating a sense of agency can evoke and release energies restricted by any view that the community is a passive receiver of actions or work on its behalf. This is also true in large organizations, departments and congregations where it is sometimes assumed that the visionary or "guru" alone has imagination.

No matter at what level in a living system a visionary is working, implementation depends upon the nurture of trust and dynamic relationships with those who share responsibility. Since the society or community or institution is already undergoing changes which may challenge its existence, visionary leaders must be vigilant as they introduce new frameworks and new projects. The person who cautions that the pace of change is too fast or the numbers of changes has become inconsistent may be appropriately protective of the relationships and commitments of staff. It is of critical importance to any truly innovative leader that they have a strong partner who is trustworthy to advocate for existing staff and existing contractual obligations, and who is trusted to be a truth-teller to the visionary in the living system. This is essential to coherence as well as agency.

LCL language promotes the asking of questions, the inquiry which reveals as well as discloses much that has been hidden or invisible. It is this aspect of the LCL lens which may be especially important in revising habits of thought about measurement and data. Data represents a fact or statement/symbol of an event without relation. Information and knowledge place the data in a context of relationship and patterns. Currently, we present the data of transactions or medical measures in reference to the measuring tool or scale used. LCL's language would prompt us to ask about the interconnectedness of the data presented, probing until there are no clear answers. LCL language as a basis of query can lead to discernment of fundamental questions.

Particularly during crises which require radical change, truth telling must be protected, and cultivated, because avoidance, denial and fear have usually prevented exposing known truths prior to the crisis. Leaders must recognize that within any entity the truth is certainly known, despite concerted efforts to deny or conceal that truth. This is even the case when top leadership is confident that "no one knows" how bad the situation is. Denial usually comes at the cost of agency and coherence which brings about the loss of intergenerativity, hope and eventually, withdrawal from connection. An alert leader will seek those known to be the

"listeners" within an organization, and elicit from those persons the guidance necessary to find the truth. Indeed, an alert leader will also be a "listener" in the first instance, and then repeatedly again and again over time. It is also imperative in any turnaround that when the truth is known, it is revealed, unless (and only unless) there are legal reasons to keep it from the community.

For instance, in several instances in healthcare organizations, it was known that substance abuse issues compromised top leadership, but after the removal of those affected individuals, their privacy had to be protected. This does not mean that the consequences of such problems are not openly discussed in order to build the connections and the trust which will revive commitments. In turnarounds following dire financial crisis, most workers already know that the hospital, clinic or community is in trouble, and will share in the work of transformation more readily if the leadership discusses the crisis openly. Finding out how such crises came about usually means seeking the tacit, invisible and pragmatic knowledge within the entity, and the LCL language can create such a climate of discovery.

In work with living systems, we need evidence that matches their emergent, adaptive, dynamic and entangled yet always partially indeterminate complexity (think of a detective weighing clues) rather than data derived from tools designed for nonliving systems. Sorting evidence rather than data is important especially when we recognize that interconnectedness means that there will be increasing variation in any living system. Evidence includes narrative, reflections and deep searching for tacit knowledge beyond instrumental measures. Evidence-based medicine tells us what to do not how to do it. To evaluate the effectiveness of the Supporters of Health Initiative, or of CHN, a hospital system may seek measures of financial impact, or indices of increased health literacy, and these measures will serve short-term goals, but real evaluation will only be valid in a perspective of long-term emergent change and the learning which has resulted. This takes patience and courage, as well as a profound and humble willingness to abandon what is comfortable and challenge what is denied. Then, we can learn from ambiguity within the realization that we must remain uncertain out of our respect for the life in the living system.

Final Thoughts

How do we formulate the questions which can lead us forward to better understand what is the quality of life?

If the LCL lens invites us to be more alive, how does this translate to our institutional practices?

What are the cross-cutting themes and behaviors in a (human) living system, such as imagination, mutuality, generosity, curiosity, and how do these relate to what we know about the five themes of LCL?

What concrete tests can we suggest that will drive further adoption of this perspective?

If there is a language of life, is there also a grammar, and how can we discover that to translate concepts into actions?

Can we now use the LCL perspective to inspire, revive and redirect current efforts which may be floundering as our society and communities change?

Transformation is a process without an end-point, and the Leading Causes of Life language can be a catalyst of transformation. What are the consequences of the use of this language? In initiatives like CHN and the Supporters of Health which bring LCL to challenged neighborhoods, what changes over time, and what bonds become resilient?

Perhaps we will never know, but the search, like the language, is compelling, and the possibility that we can begin to answer questions like those raised above excites us to greater effort.

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Bibliography

African Religious Health Assets Programme (2006). Appreciating Assets: The Contribution of Religion to Universal Access in Africa, Report to The World Health Organization, University of Cape Town.

Barlow, Julie, Chris Wright, Janice Sheasby, Andy Turner, Jenny Hainsworth (2002). Self-management approaches for people with chronic conditions: a review in Patient Education and Counseling 48: 177-187, Shannon, Ireland, Elsevier.

Barnett, Kevin (2011 ?). Beyond the Numerical Tally: Quality and Stewardship in Community Benefit, Oakland, Public Health Institute.

Block, Peter (2008). Community, the structure of belonging, San Francisco, Berrett-Koehler.

Brown, Marisel and Kevin Barnett, (2012). Return on Investment and Community Health Improvement: An Examination of the Role of Hospitals, Oakland, Public Health Institute.

Burton, Mark and Melanie J. Chapman (2004). Problems of Evidence Based Practice in Community Based Services, *Journal of Learning Disabilities*, 8, 58-70.

Collins, Jim (2005). Good to Great and the Social Sectors, New York, Jim Collins.

Connell, David J. (2001). Reformulating Community as a Complex Social System, Qualifying Exam Paper, Rural Studies Ph.D. Prince George, University of Northern British Columbia.

Cutts, T. Edward Rafalski, Cori Grant and Razvan Marinescu (2014). Utilization of Hotspotting to Identify Community Needs and Coordinate Care for High-Cost Patients in Memphis, TN. *Journal of Geographic Information Systems*, 6, 23-29.

Diamond, Jared (2012). The World Until Yesterday, New York, Viking Penguin.

Fuller, Robert W. (2006). All rise: somebodies, nobodies, and the politics of dignity, San Francisco, Berrett-Koehler.

Garrett, L. (2000). Betrayal of trust: the collapse of global public health, New York, Hyperion.

Gunderson, G.R. and James R. Cochrane (2012). Religion and the Health of the Public: Shifting the Paradigm, New York, Palgrave MacMillan.

Gunderson, G.R. with Larry Pray, (2009). Leading Causes of Life, Nashville, Abingdon Press.

Health Systems Learning Group Monograph (2013). Stakeholder Health, available at http://stakeholderhealth.org/wp-content/uploads/2013/09/HSLG-V11.pdf.

Hubbard, Joanna (2013) Communities as Living Systems (how nature can inspire fresh perspectives on complex problems) posted at https://joannahubbard.wordpress.com/2013/12/09.

Kania, John and Mark Kramer (2013). Embracing Emergence: How Collective Impact Addresses Complexity, *Stanford Social Innovation Review*, Jan. 21.

Kula, Irwin with Linda Loewenthal (2006). Yearnings: embracing the sacred messiness of life, New York, Hyperion.

Lindberg, Curt and Marguerite Schneider (2012). Leadership in a Complex Adaptive System: Insights from Positive Deviance, Citation: Academy of Management Best Paper Proceedings.

Lipmanowicz, Henri and Keith McCandless, (2013). The Surprising Power of Liberating Structures, Seattle, Liberating Structures Press.

Luthar, Suniya S. Editor (2003). Resilience and Vulnerability, Cambridge, Cambridge University Press.

Nussbaum, Martha C. (2011). Creating Capabilities: The Human Development Approach, Cambridge, Harvard University Press.

Reeler, Doug. (2007). A Three-fold Theory of Social Change, Cape Town, Community Development Resource Association.

Stakeholder Health (2014-2015). Website, various interviews Bobby Baker, Paul Laurienti, and articles, at http://stakeholderhealth.org/.

Stone, Michael K. and Zenobia Barlow (2013). Seven Lessons for Leaders, Berkeley, The Center for Ecoliteracy.

Warren, Mark E. Editor (1999). Democracy and trust, Cambridge, Cambridge University Press.

Wheatley, Margaret (2007). Finding Our Way, San Francisco, Barrett-Kohler.

------ (2006). Leadership and the New Science, San Francisco, Barrett-Kohler.

------ (1999). Bringing Schools Back to Life: Schools as Living Systems in Creating Successful School Systems, Christopher-Gordon Publishers, September 1999.