

## Performing

Playing the Macro Violin • The Field Structure of Performing •  
Principles of Performing • Systemic Integration • Innovation  
Ecosystems • Field Shift of the Evolving Ecosystem • An  
Evolutionary View of the Modern Health Care System • Field Notes

**W**e have just spent some time on prototypes, an experimental exploration of something new. A prototype contains some of the essential characteristics of the final product or ecosystem, but is only the first of many iterations. As it evolves, it retains the best features of its earlier forms.

After prototyping, the question is: so what? How can we use what we learned in our small-scale experiments and advance or apply it to the transformation of the whole system? For example, in the Namibia case, all the prototype work took place in just one province. But how can these insights be used to transform or evolve the larger system across all of the country's provinces?

At this stage of performing, we focus on how presencing is embodied in everyday practices. It may be helpful to think of the theater. If you've ever been in a live production, you know how the actors get input from one another as well as guidance from the director, and the performance benefits from

that refining process. Things are added; things are removed. Theater is a living structure—contained, honed, and refined. Only after many rehearsals is the curtain ready to go up. And still it evolves, but now with the added component of the audience’s energy and presence.

### Playing the Macro Violin

Performing means to operate from a larger field that emerges from our deep connection with the audience and the place around us. The violinist Miha Pogacnik described this type of peak performance experience as “playing the macro violin.”

“When I gave my first concert in Chartres,” he remembers, “I felt that the cathedral almost kicked me out. ‘Get out with you!’ she said. For I was young and I tried to perform as I always did: by just playing my violin. But then I realized that in Chartres you actually cannot play your small violin, but you have to play the macro violin. The small violin is the instrument that is in your hands. The macro violin is the whole cathedral that surrounds you. The cathedral of Chartres is built entirely according to musical principles. Playing the macro violin requires you to listen and to play from another place, from the periphery. You have to move your listening and playing from within to beyond yourself.”<sup>9</sup>

The question we are left with, in more mundane settings such as the health care systems, is how to discover and to connect with this type of “macro violin.”

#### Discovering the Locally Embedded Macro Violin

Dr. Schmidt said, “In all our feedback, there was one theme and insight that increasingly moved onto center stage. It’s the insight that the only sustainable way to take our system to its next level of development is to focus on regional self-governance among all participating actors. This sort of feedback has made me ever more courageous to take concrete steps in this direction. As a consequence, we now have formed a group with key leaders from all sectors in the

region we are part of. Our aim with this group is to produce a common vision for where we want to go to as a region and to decide on the next step.”

“It’s interesting that now we deploy fifteen physicians at night instead of thirty-two, yet things are working much better now,” one physician reported. “And we’re not alone anymore.”

This networked system is still evolving. It has, however, become increasingly clear that the larger system still spirals from crisis to crisis, and many feel they are “trying to fix a dying system.” Some feel that rather than try to keep the larger, “dying” health care system alive, “maybe we should just pull the plug and let it die.” What remains very clear, however, is that, in stark contrast to other regions of the country, the results of the various network initiatives are fewer complaints and lawsuits, as patients’ complaints have virtually dropped to zero. And the physicians have no more crisis meetings to attend. Furthermore, there is now a better partnership between patients and doctors. One physician said, “in my case, I have rediscovered the joy of work.”

Physicians and patients are now connecting differently. They have the formal structures and shared experience to work differently together. The coordination of care and, more broadly, the communication among physicians across the region have improved. But probably the most subtle change is in how the self connects to the whole system and what impact the individual can have on that system. Though still overloaded, physicians feel less isolated, more engaged, and more effective.

When I asked Dr. Schmidt how he would account for all these changes, he responded, “On the one hand, it is the experience of shaping something; that’s a source of empowerment. On the other hand, it is to see the context in which you and your colleagues work. That changes your view of the larger system. You learn to see the meaning of your work in the context of the whole region. Seeing that larger whole and how your work relates to it is empowering. Through your better knowledge about how the system works, how the region works, and by getting to know an awful lot of people, you end up having a different access to making things work—things tend to flow more effortlessly.”

## The Field Structure of Performing

When moving from the field of prototyping to performing, the main focus shifts from shaping microcosms to shaping and evolving the larger ecosystem of institutions and people. Just as the delivery of a newborn marks the real beginning of parenting, prototyping marks the real beginning of co-creating. What follows is the need to shape a context that allows the newly arrived being to take its next developmental steps.

Once the living prototype is delivered and assessed, the question is how to take it to the next level of its journey—how to embed it in an institutional infrastructure that allows it to evolve by “operating from the larger ecosystem” as opposed to operating from each institution’s ego-system.<sup>ã</sup> In the case of small groups or individuals this institutional infrastructure may be a set of supporting places, practices, peers, processes, and rhythms that allow the new to be developed and sustained.

As the U movement progresses from presencing to crystallizing, prototyping, and performing, the new quality of the collective field that first began to emerge at the bottom of the U—being connected to the sources—is embodied more fully. Figure 4.0 shows this unfolding through the emergence of a new pattern from the center that increasingly connects with, evolves, and co-shapes all other aspects of the larger ecosystem.

## Principles of Performing

Figure 4.2 depicts one way of conceptualizing such an institutional ecology. The three circles represent three separate fields: business, government, and civil society. Notice how they overlap. In the center are the interfaces.

The key idea is simple. Organizations are not one; they are multiple. And in order to “breathe,” they must be embedded in a web of relationships. In this case, that web deals with the supply chain or manufacturing function, with the delivery function or the customer interface, and with the innovation function of the performance system. Each operates out of a different kind of economics: scale, scope, and presencing. While the specifics in organizations

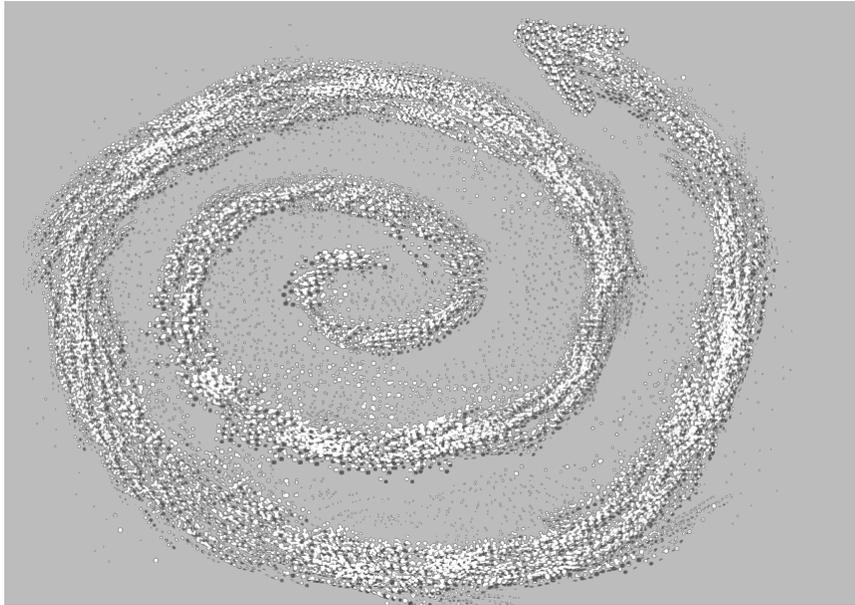


FIGURE 14.1: THE FIELD STRUCTURE OF PERFORMING

of other sectors are different, the general principles are the same. In the case of global NGOs, for example, there is one system that works on the ground in order to help and empower the beneficiaries in the field. Then there is the whole infrastructure piece that must be in place to adequately deliver the services to the field. That includes not only funding but also developing logistical infrastructures and so forth. The whole supply chain must be in place in order to deliver services effectively and at reasonable cost. And finally, there is an innovation system to deal with a rapidly changing world.

Looking at this figure, you will see three main dimensions that map the major issues and challenges in the world of management and organizations today. The first marks the integration along the horizontal dimension—it integrates the seamless stream of value creation as perceived by customers or patients. This horizontal dimension is usually referred to as the demand-supply chain.

The second marks integration along the vertical dimension: the parallel sphere of learning, innovation, and change.

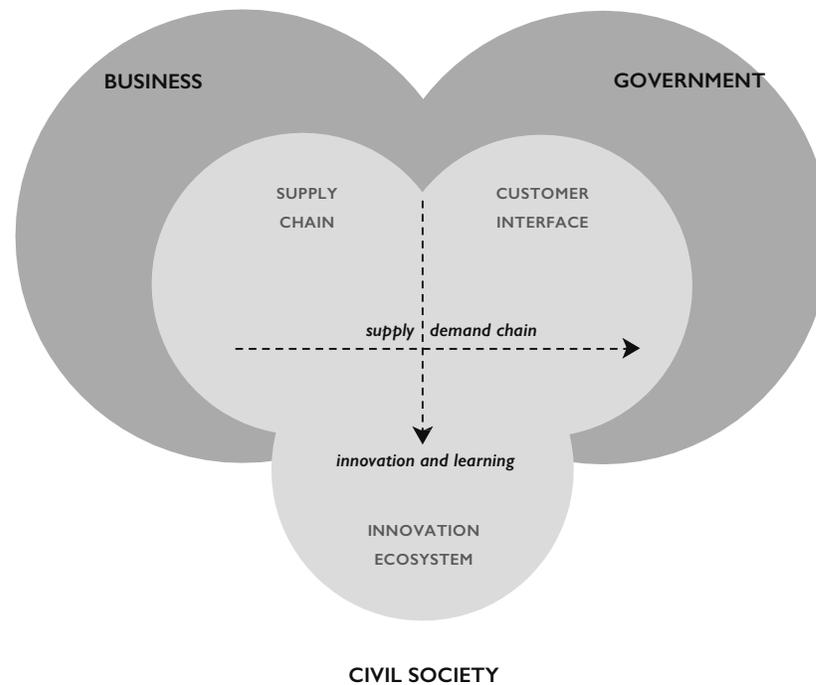


FIGURE 14.2: TRIAD OF INSTITUTIONAL ECOLOGY

Finally, the third dimension deals with the relationship of the performance system just described (the inner bubbles) with the larger social-ecological context (the three larger or outer bubbles).

Applying this framework of an integral institutional ecology helps shed light on the story of the health care network shared above. It suggests that the underlying dynamics in which that story evolved were driven by three major forces of institutional change: systemic integration, innovation, and a shift between the system and the self.

### Systemic Integration

The first force of institutional change shows up in the imperative of systemic integration in the core process of value creation—the clinical and medical

pathways—throughout the system. This development is depicted as integration along the horizontal dimension in figure 4.2.

In the forum’s diagnosis-related groups and their disease management programs, this integration shows up in total quality circles and other methods and tools used. The name of the game is to change a functionally driven performance system into a cross-functionally managed performance system.

While this type of change is pervasive in transformations of larger systems across sectors and industries, it is also worth noting that the promise of this type of reorganization usually remains unrealized. For example, when diagnosis-related groups were introduced into the German health care system, a flat-rate case compensation scheme was intended to decrease overall costs by giving hospitals incentives to discharge their patients earlier and thereby increase the “productivity” of the system. Sure enough, the average number of days patients remained in the hospital went down. So far, so good. Except that some people claim that as a consequence, the total costs of the system have been going up.

“How could that happen?” I asked Dr. Florian Gründler from the health care network.

“Let me give you an example from last week. Last Friday the hospital discharged and sent me a patient that I had sent it a couple of days earlier. But instead of being in better condition, his condition seemed worse. When the ambulance driver delivered him to my office, I looked at him and realized that he was having a heart attack. So after providing emergency care I sent him straight back to the hospital, where of course he gets registered as a new patient because he didn’t go there with a heart attack when I sent him in last week. So, you see, that’s how the system works: as the average hospital days per case go down, the total number of days, along with additional health issues and costs, goes up.”

Dr. Gründler’s story reminded me of numerous other stories of change efforts that failed because of an insufficient comprehension of the issue of social complexity. Successfully redesigning a medical system requires more than just understanding the technical and medical complexity of the

issue. The designers must fully understand and deal with the issues of social complexity, different cultures, interests, and views. Simply imposing another change program on the overworked and underpaid hospital operators won't work.

## Innovation Ecosystems

The imperative of the ever-increasing pressure to innovate—that is, pressure to create more value with the same or fewer resources—is the second driving force of change. It evolves along the vertical dimension: how to complement and enhance the operational performance system with a parallel structure of constant innovation and learning across boundaries. Examples of this kind of innovation infrastructure include the newly created emergency care control center. This center created a space where “you are right at the pulse of the region” and where the physicians also observed that it “facilitates some important learning processes across physicians, emergency care staff, fire-fighters, and others.”

The driver of this kind of change is not the abstract optimization of clinical pathways but a hands-on exposure of key practitioners to real cases, patients, and issues, all while dealing with them in real time.

However, there is still an important limitation to this kind of approach to innovation. It remains more or less bounded by the constraints of the current system. That is, the health care system is designed to deal with the symptoms of sickness. It isn't designed to strengthen the sources of health. This brings us to the third force.

## Field Shift of the Evolving Ecosystem

The third and still incipient force is the subtle shift in the relationship between the system and the self. As Dr. Schmidt noted, “[When you] see the context in which you and your colleagues work, that changes your view of the larger system. You learn to see the meaning of your work in the context of the whole region. Seeing that larger whole and how your work relates to it is empowering. ... You end up having a different access to making things work—things tend to flow more effortlessly.”

Using the four levels of patient-physician relationships, these shifts can now be seen as ways to tune in to a level 4 relationship. When these moments of presence happen, and when they are connected with the right attention and intention, they can become a positive force in the field and have a tangible impact on the other players in the system. As one of the senior health care executives in Germany observed, “The quality of commitment and intention that this group radiated over time changed the consciousness of the decision makers in the [larger] system.”

## An Evolutionary View of the Modern Health Care System

Consider the dynamics of the three core dimensions depicted in figure 4.2. The resulting picture is an evolutionary view of the health system that differentiates four different stages of development (see table 4.6).

The first column, “Institutional Care,” depicts the traditional health care system in Germany, which Chancellor Otto von Bismarck created in the late nineteenth century as a preemptive strike against the rising Socialist Party in Germany. This system, governed by vertical lines of hierarchy, is the backdrop for the current three-core dimension of change. Almost everybody agrees that change is necessary, among other reasons because demographics (an aging population) and political issues (reunification with East Germany) have made it too expensive.

Column 2, “Managed Care,” shows where the mainstream of the system is currently gravitating, not only in the United States, by adding the market mechanism to the existing hierarchy. The idea of managed care is to integrate the whole medical pathway alongside the horizontal dimension in figure 4.2.

Column 3, “Integrative Care,” adds to the model of managed care by linking the operational level of health care delivery with an innovation ecosystem, as exemplified by the creation of the new emergency care control center. Patient-centered integrative care is organized around concrete patient pathways and life-spaces that allow the level 3 type of patient-physician relationship to evolve (example: home-based care).

Column 4, “Integral Health,” depicts a possible future health care system that incorporates all four levels of patient-physician relationships and focuses

on strengthening the sources of health (salutogenesis) instead of battling the symptoms of pathology (pathogenesis). Just as the earlier models introduced additional governance mechanisms, this one introduces a new governance mechanism for coordinating the interrelated health care activities better and in real time: seeing from the whole. Infrastructures that facilitate this kind of shared seeing, sensing, and acting—of which the Patient-Physician Dialogue Forum is an early example—are key to developing this type of system.

	Institutional Care	Managed Care	Integrative Care	Integral Health
<b>Organizing paradigm</b>	System centered	Outcome centered	Patient centered	Human centered
<b>Patient-physician relationship</b>	Level 1	Levels 1–2	Levels 1–3	Levels 1–4
<b>Key axis</b>	Functional (institutional structure)	Medical pathways (core process)	Patient pathway (patient-system interface)	Biographical journey
<b>Innovation mechanism</b>	Intra-institutional, functional effectiveness	Outcome driven, cross-institutional, cross-functional	Patient centered, cross-institutional	Human centered, metainstitutional
	Pathogenesis	Pathogenesis DRG, DMP, TQC	Pathogenesis New emergency care control center	Salutogenesis
<b>Dominant type of complexity</b>	Detailed complexity	Dynamic complexity <sup>a</sup>	Social complexity <sup>b</sup>	Emerging complexity <sup>c</sup>
<b>Coordination mechanism</b>	Hierarchy command	Market price	Dialogue: mutual adaptation	Presence: seeing from the whole
<b>Infrastructure</b>	Social legislation (Bismark)	Rules, norms to make the market mechanism work	Infrastructures for learning and innovation	Infrastructures for seeing in the context of the whole

a. This refers to the integration of different types of functional, technical, and medical knowledge.

b. The integration of different cultures, worldviews, and strategic interests across institutions.

c. Emerging situations where the problem, diagnosis, and solution evolve over the course of the project.

TABLE 14.1: FOUR EVOLUTIONARY STAGES OF MODERN HEALTH SYSTEMS

Where would the regional health care network be positioned on this map? The network evolves somewhere between columns 3 and 4, while its larger systems context happens to move from institutional to managed care (columns 1 and 2). Just as the four levels of patient-physician relationships aren't good or bad as such—they are only appropriate or not appropriate to a certain health issue or situation—the four health systems depicted in table 4.4 aren't necessarily good or bad, either. They differ in their primary focus and level of patient-physician relationship. But this is what we must remember: problems arise when health issues that reside on levels 3 and 4 are being addressed with mechanisms that function on levels 1 and 2, and vice versa.

### Field Notes

Organizations are not one but three. They evolve along three dimensions, integrating the stream of current value creation (horizontal dimension), the parallel systems of continuous innovation and learning (vertical dimension), and the living connection to the evolving social context (third or surrounding dimension).

The key to developing level 3 and 4 institutions is the creation of effective learning infrastructures that help to facilitate the inversion of the health system.

Having seen some learning communities that work and even more that didn't, I have crystallized my observations and lessons learned in eight points. They are as follows:

1. Core group composition. The more the composition of the core group reflects the composition of the whole community and context, the better. For example, a learning community of researchers, consultants, and practitioners that is organized by a core group made up only of consultants would defeat the purpose.
2. Primacy of praxis. All real learning is grounded in real-world praxis.<sup>6</sup> There are three kinds of praxis: professional praxis—striving for

performance excellence; personal praxis—striving for self-leadership; and relational praxis—striving to improve the quality of thinking, conversing, and acting together.<sup>6</sup>

3. Practice fields and tools. No symphony orchestra or professional basketball team can achieve world-class excellence without practicing. Likewise, leaders and managers, in order to accomplish their corporate and interactional goals, need (a) tools and (b) practice fields in order to learn to use these tools more effectively.
4. Parallel learning structures. A parallel learning structure is the cornerstone of any learning architecture. A parallel learning structure is any setting that allows actors to reflect on their experiences, to share what they learn, to engage in new experiences, and to get help from peers.<sup>7</sup>
5. Purpose and shared principles. The quality of purpose depends on (a) its content and (b) its connection to people. A learning community that serves only the future business of its center is a bad example. A learning community that builds on the highest aspirations of all its participants is the counterexample.
6. Passion, or personal embodiment of purpose. Usually nothing significant happens unless there is someone who holds it all together, who makes it work. Self-organization does not self-organize. Self-organization needs people to actively create the holding spaces that allow self-organization to evolve.
7. Perception-driven participation. How can one create an environment in which people ask “What can I give?” rather than “What can I get?” Two critical mechanisms are (a) to start with an initial gift such as joint intellectual capital that sets the tone and (b) to establish shared practices of perception that allow contributions to the common knowledge base to be perceived, acknowledged, and appreciated.
8. Products. Products that are created using the intellectual and relational capital of the community—such as training courses for new methods and tools—serve as vehicles for both competence and community building.