How to Lead *Infectiously* in the Era of Big Problems

EPIDEMIC LEADERSHIP

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For the joyous crowds, the great herds, the endless flocks,
the teeming schools (of fish and children), and all whose
goodness incubates in obscurity ahead of coming abundance

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Introduction

When I started writing this book, epidemics didn't hold the attention of many people beyond epidemiologists and risk-policy wonks. Then, COVID-19 hit. By a freak of timing, I found myself writing as the pandemic ended hundreds of thousands of lives, closed our schools and workplaces, crashed the global economy, monopolized the daily news cycle, and drove us out of the open and into hiding, from our parks and streets and deeper into our screens and phones. Like all of us, I watched as the spread of a brainless virus exploited our societal divisions and inequalities, exposed the inadequacy of leadership and supply lines, and tilted a presidential election. A microscopic clump of genetic material enveloped in proteins made the reality of epidemics a palpable threat and an urgent teacher. It challenged our notions of command and control over our environment and opened the possibilities around what leading must become in a changed and changing world.

I write from my perspective as a doctor and particularly as an emergency physician. My clinical career began as a medical student at Stanford University and took root in the garden of pathology we call the emergency department during my residency at Hennepin County Medical Center in Minneapolis. I learned the highly specialized skills that allowed me to diagnose, treat, and resuscitate patients whose unpredictable palette of disease, distress, and destruction flowed into my workplace every day, night, and weekend. Over the course of my clinical career, I learned to find a sense of ease amid the chaos of lives abruptly unhinged from the illusion of "normal." I learned that high-trust team intelligence outpaced disconnected expertise. I learned that all the algorithms and protocols in the world don't equip us to match the way disease and illness multiply in our populations, a reality our

health care personnel recognized only too well from the strain on them during this most recent pandemic.

I also write from the perspective of an executive who has worked with hundreds of leaders and teams over the course of my career. I had the opportunity to help an emergency department and two health care organizations work their way through duress and subpar performance to results both objectively demonstrated and subjectively immeasurable. As the CEO of my state's largest trauma center, I watched several thousand people turn an entire organization around when it was listing badly during the national financial meltdown of 2008 (and when cynics predicted our inevitable collapse). Perhaps befitting an emergency physician and others who find themselves facing the braver work of leadership, I have always worked and learned in places where what used to work doesn't anymore, where people are trying hard and wearing out, and where hope is essential and hard to find.

We live in such times and places today. We have too much to do and not enough time to do it. Our technology ambiguously speeds things along and rushes us so fast we can't think straight. Our models of organization, leadership, and governance are breaking down, or at least groaning and cracking, under the weight of problems that are large, complex, and interconnected. Our world, whether we measure it in divisiveness, environmental degradation, or the vitality of our workplaces and communities, grows unhealthier and more stressed. The future arrives and beckons our response, yet we resist. Leaders have to grapple with all these things in a way that enables people to deliver better results, to learn relentlessly, and to re-energize and reconnect. Somehow those things have to happen not once, not in a few places, but repetitively, everywhere.

Along came coronavirus, specifically SARS-CoV-2, an obscure idea of a germ morphed into a worldwide infectious, political, social disruption with catastrophic and fracturing consequences. No more hiding. It's in our face, *here and real*. It has threatened our bodies, rattled our minds, split our towns and neighborhoods, and shocked our systems. More

quietly, it has asked us if we're ready, really ready, to accept a present reality that invites a powerful shift to a better future.

Epidemics represent and expose the scientific principles underlying networks, complex systems, biology, and, in the case of humans, neurobiology. Such disciplines are rife with research, complex mathematical and statistical formulations, and underlying concepts of physics and biology that can be bewildering. This book is not meant to be an in-depth scientific exegesis. Instead, it is intended as an invitation to think about leading with a new framework, a framework that unfolds into simple, accessible concepts and techniques that leaders can put to work wherever they are to create both individual participation and collective wisdom in a world where scaling both stability and adaptability has become non-negotiable.

The unsettling reality is that epidemics are here to stay; they're going to keep coming, and not just because of wet markets in China and close-clustered human populations and degraded habitats where long-locked pathogens can get loose, leap to us, and multiply across the globe. We have invited and designed a world of networks and swarms, and now we will have to adapt. Our computing power lives in clouds and networks; our social momentum rides on platforms and movements of easily accessible information and even more accessible—and influential—disinformation. Our small local worlds are linked, and the uptake and spread of ideas and actions—healthy and unhealthy—defines leading and following today.

These realities of the modern world—call it "high-velocity, high-volatility," VUCA, Industry 4.0, or just the twenty-first century—raise compelling questions for leaders.

- How do we deal with phenomena that come from nowhere and end up everywhere?
- How do we respond and act with agility without rushing ourselves into regressive patterns? How do we match the speed of what is coming at us while slowing down enough to create wide patterns of insight and intention?

- What do we keep, discard, and learn anew from a leadership perspective? What works and what doesn't anymore? How do we know?
- What do we need to understand to shape a positive future in our lives, teams, companies, and world?

The powerful possibilities are perhaps most compelling. We think, sensibly enough, about stopping epidemics, limiting their damage, returning to normal. At first glance—and second and third—the coronavirus is simply badness, destruction, hindrance. It exposes our operational bottlenecks, our leadership division, our social inequities. Look deeper, and it carries a leadership blueprint for effective action in a connected world.

If I have learned one thing in my lifetime of work as a doctor and a leader, it is that the world is abundant with good ideas and good people. I am only a single searcher of the billions of people who seek better ideas and ways, and I find them every day and everywhere—in the ER in the middle of the night, in slums in Africa, in schools and basketball teams, in start-ups and bureaucracies. Too often those ideas and people stay hidden and "uninfectious." We need them to rise now, to go epidemic and flood into every nook and cranny where their humble origins can metastasize into florid impact.

I have learned a great deal from the patients I have cared for and from the people who taught me and mentored me (which would include those conventionally labeled "followers"). I learned a great deal also from decades of long days out in bad weather and good in my Montana homeland, where the ubiquitous surging of living things defined my experience and shaped my subsequent thoughts. The science of my profession and the land of my upbringing have helped me understand the beauty and wisdom in biology. Amid a world that has ignored the lessons of biology for too long, my hope now is to share a bit of what biology knows to participate in an epidemic of good.

This book is about our changing concept of leadership in a century when things move faster and overwhelm sooner, where anything can become very big very quickly, and each of us can feel very small. This book is about how leaders can shape and scale both stability and adaptation far beyond their individual contact points; as such, it is also a book about the design and ethic of social power. The epidemics we face, whether Ebola or COVID-19, whether QAnon or racism or opioids, are not going away. Indeed, conditions are set that will invite them to flourish and erupt.

This book has two sections. The first section builds from the universal experience of well-intentioned individuals who find themselves overwhelmed, starting with my sobering encounter with that reality as an emergency physician. Chapter 2 explores the potential advantages of how epidemics arise and grow for those who are encountering the "math problem" of personal effort in the face of diffuse and powerful obstacles. Chapter 3 delves into the implications of complex environments on what leadership does and how it will need to operate in our era of immense challenges. Chapter 4 explores the secret sauce of epidemics for leaders, the idea of self-organization that offers a flywheel to scaling the deliverables of leadership: performance, learning, and vitality.

The second section focuses on the practice of epidemic leadership and how leaders can design and sustain positive epidemics as systemic leverage in human systems. Chapter 5 emphasizes the identification of a positive pathogen as the basis of a constructive epidemic. Chapters 6 through 9 explore the elements of self-organization with respect to epidemics—conditions, interactions, and multipliers—with a special focus on networks and their unique capability to accelerate or obstruct leadership efforts. Chapter 10 explores the paradox of technology in supporting and complicating epidemic leadership. Finally, the type of thinking and the foundational sorts of social pathogens we need moving in today's world comprise Chapter 11, the final chapter.

The reason I write this book intertwines with the impact the pandemic meted out: the realities of our world are unsettling. I write

this book because, as a doctor, anything that threatens the vitality of individuals, populations, and communities rouses my concern, and there are far more causes for concern than I could ever address as one lone healer. There is no single bedside I can rush to, no drug I can prescribe, no diagnostic algorithm I can wield. An ethic of healthy twenty-first-century community has to swarm everywhere—through our schools, our economies, our neighborhoods, our corporations, our conflicts, and our institutions. Many people would say such permeation is not possible. But somewhere, in or near Wuhan, China, in late 2019, arose a virus that was nameless, without money or power, with no business plan or Twitter following, with no passport and no cognition—and now it's everywhere, because we passed it among ourselves.

The good news about our current reality is that we have the knowledge and access to exploit these same conditions to create innumerable positive epidemics. It is not just time to lead in the middle of an epidemic, to prevent the next one, or to arrest bad ones. It is time to lead *like* an epidemic, launch multiple epidemics, and have an epidemic of leaders who know how to "epidemic."

Understanding Epidemics

1 My No Good, Very Bad Night in the Emergency Department

You're gonna need a bigger boat.
—Amity Island Police Chief Martin Brody in Jaws

Friday Night in the Emergency Department

August 15, 2003, Billings, Montana

We begin in illness and injury. On this hot Friday evening, patients swamp the emergency department in the regional trauma center where I work. In the late summer heat, the night is just starting and has already flooded us with a raft of patients, and it promises to keep building. The waiting room overflows with more people. I have worked hundreds of nights like these in the previous decade plus, and I know the pattern. The quiet heat and the coming sunset belie the more ominous certainty of my shift ahead. People would get sick, some dramatically so. People would die. No one had gone about their day thinking these things would happen, but we know. In the emergency department, we check our equipment and ready ourselves with certainty.

As I cross the threshold of the automatic double doors into the department to begin my shift, I know it's busy even without scanning the electronic register we call "the board," a remnant of the days when

we used to list each patient and their chief complaints in bright dry erase marker on a big whiteboard before privacy concerns made it obsolete. I can hear the beeping of monitors, the shift in cadence of nurses' feet, and a low kind of ER buzz. The source is hard to pinpoint, like the low but incessant sound of unseen insect wings. To a casual observer, the department seems quiet, orderly, bright with fluorescent light. We like it that way—who wants to work in, let alone be sick in, a chaos of noise and motion?

The full cornucopia of unexpected disaster and discomfort bubbles out of the streets and homes and open spaces of life in America and flows into every room in our emergency department: automobile trauma, diabetes, cardiovascular disease, emphysema, diverticulitis, stroke, assault, cervical cancer, migraines, lacerations, domestic abuse, and opioids. The terms are medical and numbingly antiseptic, but the reality is stark: as the people of my town enjoy the warm summer evening, they are also crashing, dying, bleeding, fighting, and writhing in droves. While they go about their daily lives, they are part of a large, oddly silent tsunami of ill health that washes over the entire population.

No one is catastrophically ill at the moment, so I ease into my shift, getting labs and X-rays started on a few patients while I mentally accept that we will be working behind for a few hours. No one on the team likes working from behind. We prefer to stay ahead of the wave, seeing people as they come in. It is safer that way, and psychically easier for us. When the wave breaks over us, when we get behind, delays pile up and surprises happen, and surprises mean a higher chance of bad things for patients. Some nights, despite our best efforts, especially hot ones on summer weekends, the wave breaks, and we are playing catch-up. Tonight is one of those nights. The department has been behind since the afternoon, and it will be several more hours before we can get on top of the wave again.

The patients are varied, which is normal for us. The ER is the funnel for anything that can go wrong anywhere, at any time, for anybody. I see an obese patient whose knees hurt, a woman with vaginal bleeding,

a middle-aged man with chest pain, a mom with back pain who can't lie down comfortably, an 80-year-old man with bad lungs. Nothing out of the ordinary, except I see all those people in the first 15 minutes, because twice that many wait unseen after that. I use my "30 seconds to meaningful rapport" to inspect and connect with each person I see. My trained eye scans breathing dynamics, skin color, tone of voice. I see eyes and facial expressions, plumb for fear or hidden motivations, search for the best way to settle every person who meets me for the first time in this place that is their bad detour and my daily work. My hands find theirs, and I rest them on shoulders and knees.

I step out of an older man's room into the low hum and look right, then left. I am impressed and grateful for what I see in the team of nurses, techs, registration clerks, and my emergency physician colleague seeing patients alongside me. Several years before, we weren't so much a seamless round-the-clock clinical team as a collection of technically proficient individuals. We couldn't elevate our game in the face of unrelenting pace. We didn't work that well together, and we weren't able to mesh the technical craft of our job with the human presence of connecting to each and every person who was ill, whatever their circumstances.

Eight years later, almost everything is different. More people come to us for care, and the metrics that define "good department" are positive: patient satisfaction and staff engagement have rebounded to high numbers from low ones, safety and quality metrics are strong, and the department sustains itself financially. Nurses are on a waiting list to get a position in the ED from other places in the hospital. Patients come by foot and ambulance, airplane and helicopter. Thank you notes dot the bulletin board in our break room, some with pictures of healed patients on vacations or hikes in the nearby Beartooth Mountains. Nurses, techs, and physicians work hard to help each other across the shift: quiet high-fives, thank-yous, and smiles pepper our interactions.

This night, we are at the top of our game. The patients are getting attentive and skilled care, and the team works fluidly without stress

under the pressure of pace and pathology, moving fast without hurrying. We flex and bend to the needs of each patient and the staccato flow of the pace. As an emergency physician, I am at the peak of my craft. Well-trained and supported by capable nurses and skilled physicians alike, taught by thousands of patients, I am in the sweet-spot overlap of state-of-the-art training and sufficient experience, eight years out of a leading residency in my specialty of emergency medicine. I am comfortable on such weekend nights, at ease with the people I work with, the maladies and mishaps I would see, my own strengths and gaps as a clinician.

Despite the team's skill and my experience, a creeping dread wells within me as I scan up and down the hallway. It is my birthday, and while I am used to working holidays of all kinds and at all hours, this particular moment collides jarringly with all my years of effort, learning, triumphs, mistakes, hopes, and deaths in an unsettling pang in my gut and chest. In every room in our emergency department that night, while the ill and injured are getting what they need and we are chewing steadily at the backlog of patients piling into the waiting room, a bigger problem waits—no, *grows*—outside and beyond, unhurried, unstoppable, and inevitable. Nowhere does this unsettling gloom stick more than in my nose. The smell of blood, alcohol, feces, urine, antiseptic wipes, plastic tubing, vomit, and air freshener mix in my nasal cavity and settle like fine dust into my brain. Years before, when I was thinking of medicine and not yet doing it, I might have gagged. Now I just take a deep breath. It is not the smell of living.

"What you thinking, Scary Larry?" Dana, the charge nurse, appears at my elbow with a slight tug. "Big things or right-now things?"

She and I have worked together long enough to have earned our mutual nicknames for each other: Super Nurse and Scary Larry. I have worked with her while she handled two critically ill patients as the primary nurse while she held the charge nurse helm at the same time in the middle of the night. She can meet the wave. She knows my tendency to arc from micro-focus on the things at hand to macro meanderings