Chapter 1

A Primer on Social Capital

Let's start by defining what we mean by *capital*. A simple description is "anything that confers value or benefit to its owners" (Hargrave 2024). This definition makes one thing clear – capital is good to have, and having more is better than having less. Capital gives its owners an advantage – an edge in comparison not only with their competitors but also with their current selves. In other words, capital enables organizations to improve.

Differences in how organizations perform can often be explained by their access to various types of capital. If they have more *financial capital* (money), they can build new facilities. If they have more *human capital* (capable employees), they can start new programs and adequately staff existing ones to meet the needs of their customers. If they have more social capital, they can do everything more creatively and efficiently. If financial capital and human capital determine what an organization has the potential to do, social capital enables the organization to fulfill that potential.

Five books have been particularly influential in shaping my appreciation of social capital and providing clarity on the steps that can be taken to build it in healthcare. All five

are written for general audiences, but their insights are highly relevant to the work of healthcare:

1. *Bowling Alone*, by Robert D. Putnam (2020)
2. *Brokerage and Closure: An Introduction to Social Capital*, by Ronald S. Burt (2005)
3. *Connected*, by Nicholas A. Christakis and James H. Fowler (2009)
4. *Teaming*, by Amy C. Edmondson (2012)
5. *Team of Teams*, by General Stanley McChrystal et al. (2015)

In aggregate, these books describe:

- The essential elements of social capital – reciprocity and trust
- Two types of connections that form the scaffolding of social capital – bonding and bridging
- The function of social networks formed by bonding and bridging connections
- The importance of teamwork – from teams formed on the fly to teams of teams

Before going into these interrelated topics, we begin with some general insights about the nature of social capital and why it has emerged as an important topic in recent years.

Social Capital's Arrival

The concept of social capital was introduced to many in the year 2000 with the publication of the first edition of

Bowling Alone by Robert Putnam. The book's title reflects Putnam's observation that "[g]iven population growth, more Americans are bowling than ever before, but *league* bowling has plummeted" (Putnam 2020, p. 112).

In dozens of examples, Putnam shows that Americans are less connected in ways that once gave meaning to the term *social fabric*. Bridge clubs had broken up and attendance at Parent-Teacher Associations was down. At Tewksbury Memorial High School near Boston, "forty brand-new royal blue uniforms newly purchased for the marching band remained in storage, since only four students signed up to play" (Putnam 2020, p. 16). Two decades before, there had been 80 members in the band, but membership had been dropping ever since. The downward trend of social involvement has only increased since the turn of the 21st century. For example, church membership, which stood at 70% in 1970 (Jones 2021), dropped below 50% in Gallup surveys for the first time in 2020.

Putnam argued that these changes in civic and social life in America were important and were eroding what he called "social capital." He was not the first social scientist to use this term (Bourdieu 1986, pp. 241–258), but it was novel enough at the time that he put the term in quotation marks the first time he used it. Putnam went on to say that the "core idea of social capital theory is that social networks have value[;] . . . social contacts affect the productivity of individuals and groups" (2020, p. 19).

Putnam defined *social capital* as "social networks and the norms of reciprocity and trustworthiness that arise from

them" (ibid.), which, in a community or an organization, translate into ways in which people relate to each other and work together. These shared norms, values, and understandings facilitate cooperation in healthcare – within teams, between different groups in an organization, and between the organization and other stakeholder organizations. Social capital can also influence interactions between staff and patients and their families.

Bowling Alone attracted wide attention, including among many in healthcare, because it arrived as people working in the field were beginning to realize that their work had become . . . lonely. Because of medical progress, there were more people working in healthcare organizations than ever before, but the paradoxical effect was that people felt isolated.

The use of electronic medical records was becoming mandatory at this time. Activities that were once performed in groups, like going down to radiology to look at x-rays together, were increasingly replaced by individual interactions at computer terminals. Even when clinicians *did* round on patients together, they were looking at computer screens more than at patients or each other.

The changes were not just at the bedside. In an article I published in the *New England Journal of Medicine,* "Quiet in the Library," I made a number of observations about my medical school library:

> The library at my medical school has never been a better place to work. The journals are shelved in perfect order. The copying machines have no lines.

> Quiet, comfortable places in which to read are plentiful. The reason: hardly anyone goes there anymore.
>
> Only a few years ago, this library was noisy, chaotic, and often frustrating – but it was full. For the researchers, medical students, and physicians who once haunted the stacks, the need for access to information has only intensified. But an explosion of knowledge, combined with the emergence of the Internet as the ideal searching tool, is transforming medicine, with implications reaching far beyond the library walls (Lee 2005, p. 1068).

My article continued: "Memorization is a solitary activity; learning how to think when confronted with uncertainty is not." That kind of work – *thinking*, as opposed to *reacting* – is often essential for truly excellent patient care. Reacting dominates one's time when sitting at a computer terminal. Thinking goes better when people are working and learning together.

I know the following sounds idealistic, but it happens to be true: Well-functioning groups are always smarter than the smartest individual within them. We all have blind spots. We all make mistakes. If people within a group are really interacting, they catch each other's mistakes and they point out each other's blind spots.

But that requires real connections among them.

The Currencies of Social Capital: Reciprocity and Trust

Robert Putnam's book focused on the connections individuals have with their communities, while Ronald Burt's

book, *Brokerage and Closure*, is more directly relevant to organizations seeking to improve their performance. But both books describe elements of connections that managers in any type of organization will recognize as important in their professional worlds – reciprocity and trust. Just as dollars and euros are the currencies of financial capital, reciprocity and trust are the currencies of social capital.

Reciprocity

Putnam expresses general reciprocity as "I'll do this for you without expecting anything specific back from you, in the confident expectation that someone else will do something for me down the road" (2020, p. 21).

In retrospect, I realize that he might well have been paraphrasing the message I received a few days after I arrived at Brigham and Women's Hospital to start my medical internship. I told my senior resident that another intern had asked me to cover his patients for two hours while he dashed out to finalize his apartment rental; I wanted to be sure it was OK. My resident said, "Sure." And then he looked up from the record he was reviewing and added, "You never say 'no' to a fellow intern here."

I was taken aback. It was a casual remark, but I knew that he was asserting something important about our group of 24 interns – and I liked it. I knew that I would never ask anything of my fellow interns that I didn't really need. But, if I had to ask, it was great to know that they would almost surely say "yes."

With time and experience, I came to understand that my resident was helping create a type of social capital gold – a group norm in which colleagues say "yes" without having to know the details. When you have strong bonds within the group, you don't have to size up the situation before you agree to a request. Teams work better and people are happier when that type of social capital exists.

Not every person in our internship group embraced the norm of saying yes without having to know the details, but it was true for most of us right from the start, and more adopted it as the year went on. That improvement over time highlights an important difference between financial and social capital. When you spend financial capital, you have less of it. But social capital has reinforcing effects and virtuous cycles; the more you create and put to the test, the more you get. Trust grows when trust passes tests. Someone says "yes" to you when you need help, and you say "yes" when you are asked to do the same.

Reciprocity is qualitatively different from doing something for altruistic reasons or doing something because it is in your personal self-interest and you are expecting to be paid back by the other party. You do what you are supposed to do because the members of the group share long-term mutual interests, and a group norm like never saying no to each other leads to acts that collectively benefit everyone in the group.

Reciprocity isn't restricted to small groups like the 24 people who were interns with me. For example, in some communities, there is a strong social norm that "we take

care of our own," and when someone is discharged from the hospital, their neighbors take turns bringing food and helping out in other ways. The result is that often the use of skilled nursing facilities and rehabilitation hospitals is much lower in these communities.

Reciprocity doesn't just happen out of the kindness of people's hearts. Reciprocity usually becomes a norm when there is a sense that there are consequences if one does not participate. Those consequences tend to be social, not financial. If you don't embrace the norm, you risk being ostracized.

One example from healthcare is the expectation among clinicians at the Mayo Clinic that you always answer a page from another clinician immediately. It can be a doctor calling a doctor to share worrisome news, or a nurse calling a physician to say a patient had developed a fever and was delirious. The issue doesn't matter; if you are a clinician being paged by another clinician, you answer right away. You don't finish driving to where you are going; you pull off the road. You don't finish a conversation, even with a patient; you excuse yourself and answer the page.

As a result, clinicians talk to each other on the phone rather than just through the electronic medical record or emails. Radiologists don't recommend additional tests at the end of their readings; they simply page the clinician who ordered the test. They feel like team members even when they don't see each other often or at all.

This isn't the way it is at most organizations in healthcare. Much more common are cultures in which physicians answer pages if and when they choose to. And because no one knows when a page will be answered, clinicians often don't bother. They send their information or their requests by emails that sometimes get read at midnight or the next day.

It's obviously better for patient care if clinicians talk to each other right away, but I was skeptical when I first heard about the Mayo immediate-answer norm. Nevertheless, I found it to be true during my first visit to the Mayo Clinic in 2015. It occurred to me that I wanted everyone else to drop what they were doing and answer me right away when I paged them, but I didn't particularly want to do that myself (the opposite of reciprocity).

When I asked doctors at the Mayo Clinic why they reliably did what they are supposed to do and answered their pages right away, they looked at me like I was asking a dumb question. I pushed ahead, and said, "Well, what would happen if you *didn't* answer your page immediately?" I felt like the Devil, tempting them with the possibility of them doing something bad.

One said, "The earth would open, and you would be swallowed up and disappear." Another said, "You would be put outside in the winter cold, and you would die." A third said something slightly less colorful but still compelling: "You just don't want people to say that you are the kind of person who doesn't answer his page."

Clinicians at Mayo know that if they answer their colleagues' pages right away, *their* pages will get answered right away too. To bring the concept of reciprocity to life, Putnam cites two quotes: one from Yogi Berra – "If you don't go to somebody's funeral, they won't come to yours" – and another associated with the Gold Beach, Oregon, Volunteer Fire Department – "Come to our [fundraising] breakfast; we'll come to your fire (Putnam 2020, p. 20)."

The firefighters were not really suggesting that they would come to your fire only if you came to their fundraising breakfast. Instead, they were reminding others that they could be trusted to come fight fires wherever and whenever they occurred. It was reasonable for them to therefore trust that the town's citizens would turn out for their fundraising breakfast. It was a gentle reminder that reciprocity should characterize their relationships.

Healthcare needs that same reciprocity dynamic between caregivers and patients and among caregivers themselves. Taking care of patients is every bit as unpredictable as firefighting, and patients need to be able to trust that healthcare personnel will respond when the need arises. An effective response to patients' needs usually requires more than the efforts of one individual. Teams must respond with caregivers who can rely on each other to do whatever it takes to meet the needs of patients and each other.

Trust

Both Putnam and Burt plunge deeply into the topic of trust. Putnam points out that groups characterized by

trustworthiness work more efficiently for the same reasons that money makes transactions more efficient than barter. Imagine having to consider whether a dozen eggs is a reasonable trade for a hammer. Or imagine working with colleagues who say "Let me think this over" every time you ask them to do something. Most managers are all too familiar with relationships in which everything is negotiable; no one on either side of those relationships wants to work that way.

It is in areas of uncertainty that trust matters most. The work of healthcare is uncertain, because patients and their medical needs are variable. What needs to be done on any given day for any given patient is uncertain. In this setting, it is valuable to have cultural dynamics where people say "yes" without knowing the details, because the details are unknowable. Burt wrote, "You trust someone when you commit to a relationship before you know how the other person will behave. The more unspecified, take-for-granted, the terms of a relationship, the more trust is involved" (2005, p. 162).

Burt was describing what Putnam calls *thick trust*. No one can expect trust to emerge just at the moments when it is needed most; it is best built over time. Putnam wrote, "Frequent interaction among a diverse set of people tends to produce a norm of generalized reciprocity" (2020, p. 21). The denser the ties among people, the stronger the opportunities to build trust – and the ties among people working directly together in hands-on healthcare are about as dense as they come. In close-knit groups where bonding connections are strong, the manager

can quickly detect and intervene when individuals are not responding to their colleagues or deviating from the group's norms.

Thick trust bound my internship group together. We were an ethnically and culturally diverse bunch and one of the first in which women comprised more than a third of the interns. We formed such strong bonds that I – and several of my fellow residents – married another group member. We have remained friends throughout the years even though our career trajectories have scattered us across the world.

Our mentors also contributed to our groups' cohesion. They knew who we were – not just our skill sets but what motivated us as people – so they knew how to get us to do our best in any situation, from covering another shift to responding to a code. Later, they occasionally nudged us along our career paths. In recent years, we've regrouped a time or two to honor our mentors' contributions to medicine and celebrate their retirements.

In contrast with thick trust – what you experience among close colleagues over time – *thin trust* is the sense that you can count on people whom you might see rarely or never at all. Putnam pointed out that "thin trust is even more useful than thick trust, because it extends the radius of trust" (2020, p. 136).

For example, thin trust among many types of stakeholders helped Israel keep its case mortality rate extraordinarily low during the first part of the COVID-19 pandemic.

Healthcare providers lost no time in collaborating with insurance companies and government agencies to reduce risks of transmission and implement vaccination programs with unusual speed. It took only three weeks to vaccinate 90% of the population age 60 and older. As noted by Eyal Zimlichman, chief medical officer at Sheba Medical Center: "We're used to times of emergency" (Zimlichman and Lee, 2021).

The Instruments of Social Capital

Just as stocks, bonds, and annuities are instruments of financial capital, connections, social networks, and teams are the instruments of social capital. They create value and facilitate the flow of resources and information.

Connections

Burt uses the phrase *structural holes* to describe the spaces between groups of people. Connections transmit information across these holes. Both Burt and Putnam describe two key types of connections – bonding connections and bridging connections.

Bonding connections are characterized by thick trust. They occur within groups – for example, when a team on a patient care unit meets for a safety huddle or gathers socially outside of work. Such interactions have an *inward* focus and are important for a sense of solidarity and identity.

Bridging connections occur *across* groups – for example, when caregivers from different departments or different

hospitals get together. When connections like this work well, they help people to look *outward* and learn from each other.

Both types of connections play critical roles in the creation of social capital and deserve focused attention from managers and leaders. You need bridging connections to learn, and you need bonding connections to put that learning to work. Putnam references sociologist Xavier de Souza Briggs's distinction between the two – bonding social capital is essential for "getting by" while bridging social capital is critical for "getting ahead" (2020, p. 23).

Putnam described how these two types of connections influence how people look at themselves and relate to others. He wrote: "Bridging social capital can generate broader identities and reciprocity, whereas bonding social capital bolsters our narrower selves. . . . Bonding social capital constitutes a kind of sociological superglue, whereas bridging social capital provides a sociological WD-40" (2020, p. 23).

Superglue and WD-40 are two tools that account for about 80% of my successful efforts fixing things around my home – and I suspect that the building of bonding and bridging connections may account for about 80% of my successful efforts in management. What makes these connections so critical is the importance of the bidirectional flow of information, both within and across groups, and what happens when that information reaches the other side of the connection.

Evidence for the power of combining bonding and bridging connections (and thick and thin trust) can be found in the creative research of Brian Uzzi, a sociologist at Northwestern University's Kellogg School of Management. Uzzi studied predictors of success – both financially and critically – in Broadway musicals and found that the probability of success rose with the number of prior collaborations among key players like actors, producers, directors, composers, and choreographers – but only up to a point. With extremely high numbers of prior collaborations, the probability of success declined. The analyses suggested that the ideal combination was a history of prior collaboration among several, but not all, of the key artists.

If everyone had worked together before, the result could be just a reproduction of their prior work. But with the injection of new ideas from outside the core group, the result could be superb. An example cited in the paper was *West Side Story,* which combined the skills of Broadway veterans Leonard Bernstein (the composer), Jerome Robbins (the choreographer), and Arthur Laurents (the playwright) with those of newcomer lyricist Stephen Sondheim. The result, records show, was tension, disagreement, and irritation among the creators – but also something new and magical (Uzzi and Spiro 2005). While Uzzi's research wasn't conducted in the context of healthcare, it has a message for leaders in healthcare organizations: They need to support both kinds of connections, bridging and bonding.

The response to the Boston Marathon bombing illustrated the value of both connections. Within the Brigham – and the

city's other level-one trauma centers (Massachusetts General Hospital, Beth Israel Deaconess Hospital, Tufts Medical Center, and Boston Medical Center) – trauma response teams had formed bonding connections during months of emergency drills. They had also formed bridging connections with one another and with the city's Emergency Medical Services. These connections enabled triage teams at the bombing site and ambulances carrying the injured to coordinate the transport to each of the centers so that none was overtaxed. As a result, there were no deaths among the scores of badly injured people treated at any of the hospitals.

Social Networks

How do you go about strengthening and extending the connections that enable social capital? Key insights on that work can be found in *Connected: How Your Friends' Friends' Friends Affect Everything You Feel, Think, and Do* by Nicholas A. Christakis and James H. Fowler, which describes basic steps in building social networks and governing what values are transmitted across them. Their advice is heavily grounded in their research; it's also fun and even moving to read.

Christakis and Fowler describe two fundamental aspects of social networks. The first is "connection" – who is linked to whom. The second is contagion, which pertains to the values that flow across those connections. As Christakis and Fowler point out, social networks can transmit negative values, like racism, or they can transmit positive values, like charitable giving. It's not enough to build social capital by building and strengthening connections; we

subsequently must use the social capital and transmit the right values across them (2009, p. 16).

The brilliant paper in which Christakis and Fowler brought these ideas to life was published in 2007 in the *New England Journal of Medicine*. In their 2009 book *Connected,* they present the work cited in that paper:

> [R]igorous epidemiological methods [were used] to show that if a friend of a friend of yours gains weight, you are more likely to gain weight—even if you don't know that friend of a friend. In fact, there was danger of weight gain even if the person gaining weight was a friend of a friend of a friend. The reason for the spread of obesity in this pattern is that norms are developing around us all the time, even if we are oblivious to them. If others are eating dessert, we are more likely to eat dessert. If others eat a healthier meal, we are more likely to do the same (p. 17).

Christakis and Fowler go on to explore the ways in which the *shape* of social networks matters. The first critical question is how many people we are connected to. But a second question is how interconnected the people with whom we have relationships are. For example, if you have five close friends, that is lovely. But if your five friends also know each other well, and *real* relationships exist among them, then the norms that exist spread more easily among them and are much more powerful.

The term that social network experts use for the interconnectedness among your connections is *transitivity*.

Simply put, if your friends are tightly connected to each other, then you are all stuck together. You can't break off relationships with someone if you get in a spat, because you are going to be running into each other at book club or pot-luck supper night or some other social event. The connections among you are stronger because of the structure of your social network.

On a larger scale, social networks are more than the clusters around any one individual. Because people are influenced by those around them, large groups can move in one direction or another like a flock of birds or a school of fish. Christakis and Fowler provided convincing evidence that social networks have a life of their own: They are more like a single organism than a collection of organisms – an insight with powerful implications for leaders and managers.

Teams

Within groups inside an organization, Burt described how the social capital of individuals aggregates to the social capital of their teams. He wrote: "Teams composed of people whose networks extend beyond the team to span structural holes in the company are significantly more likely to be recognized as successful" (2005, p. 45). In other words, a team where members talk only to each other is not as likely to be as effective as a team where members have meaningful contact with outsiders. Even worse is a team where members do not interact much or well with each other. The role of managers is to build reciprocity and

trust – and thus connections – in their part of the organization, both among individuals and across groups.

Great teams are important assets for healthcare organizations. But the challenges of healthcare are constant, variable, and unpredictable. When problems arise, there often isn't the chance to build up thick trust, which may take years of working together, within teams. Harvard Business School professor Amy Edmondson suggests that forming teams should be a natural part of working together. She writes: "Teaming, coined deliberately to capture the *activity* of working together, presents a new, more flexible way for organizations to carry out interdependent tasks. Unlike the traditional concept of a team, *teaming* is an active process, not a static entity" (2012, p. 28).

She continues:

> It involves coordinating and collaborating without the benefit of stable team structures, because many operations, such as hospitals, power plants, and military installations, require a level of staffing flexibility that makes stable team composition rare. In a growing number of organizations, the constantly shifting nature of work means that many teams disband almost as soon as they've formed (p. 28).

In her book *Teaming*, Edmondson emphasizes the importance of learning. After all, new teams are usually pulled together because the traditional organizational structure

is not ideal for new challenges. Edmondson believes that collective learning requires individuals to:

- Ask questions.
- Share information.
- Seek help.
- Experiment with unproven actions.
- Talk about mistakes.
- Seek feedback.

Edmondson recognized the barriers to these behaviors, and she has shown how the presence or absence of "psychological safety" helps explain why some teams are effective and others are not. Military teams, for example, have "after-action reviews" in which everyone understands that it is everyone's duty to speak up about mistakes that may have occurred. After all, repeating the mistake might cost lives. The same is true in healthcare, of course.

Edmondson's framework for successful teamwork requires "four behaviors: speaking up, collaboration, experimentation, and reflection. . . . These behaviors are enacted in iterative cycles. Each new cycle is informed by the results of the previous cycle. Cycles continue until desired outcomes are achieved" (2012, p. 105). In sum, teaming requires data to understand the challenge and assess progress; a culture within the group where there is a commitment to learn and improve; and the psychological safety needed for team members to throw out ideas, admit they were wrong, and prepare to try someone else's idea.

Like Edmondson, General Stanley McChrystal and colleagues realized that truly excellent teams – those in which the team members would do anything and everything for each other – were more flexible and thus more effective than troops organized in traditional ways. The military had a long history of creating superb teams like the celebrated Navy SEAL teams. But McChrystal recognized that the culture that brought strength to these teams was also a barrier to their cooperation.

The issue was the shared sense among members of teams that it was us against the world – including other members of the U.S. military! This sense was the superglue of bonding connections on steroids. As McChrystal put it:

> Imagine the closest roommate relationships you've ever had and multiply that by one hundred. The bonds within squads are fundamentally different from those between squads or other units. In the words of one of our SEALs, "The squad is the point at which everyone else sucks. That other squadron sucks, the other SEAL teams suck, and our Army counterparts definitely suck." Of course, every other squad thought the same thing (2015, p. 127).

These teams had fantastic bonding connections, but at the price of limited bridging connections. They had plenty of thick trust but little thin trust. McChrystal understood that he needed more than a large number of excellent teams to control Al Qaeda throughout the world; he needed those teams to work together, like a team of teams. He needed

his teams throughout the world to learn from each other. He needed thin trust as well as thick trust. And he needed information to flow quickly throughout the network and be trusted and used immediately.

To describe the military application of social capital, McChrystal and his colleagues coined the phrase "team of teams." They did not want to lose the magic of the tight teams where every individual knew every other individual, where they all knew they shared a common purpose, where they had learned to trust each other over time and in so many varied circumstances.

These military teams have the same sense of reciprocity as my resident defined for me when he said, "We never say no to another intern here." McChrystal understood that it was possible to achieve that confidence in a group of 10 or 25 soldiers but impossible across a task force of 7,000. A different kind of functionality was needed to make those teams work together like a team of teams.

One important step that McChrystal took was to have conference calls every day at 8 a.m. in which representatives of every team throughout the world would share information related to Al Qaeda's activities and the effectiveness of their responses. For the next 22 hours, those teams would function with complete or near-complete autonomy, but all the while, their leaders knew that they would be convening again the next day as a team of teams.

This approach has been adopted and adapted in many healthcare organizations over the last decade. For example,

Intermountain Healthcare developed a tiered system of huddles with clear criteria for escalating issues, so that the critical issues reach executive leadership every day before 10:30 a.m. The six tiers and the times at which they meet throughout the system are:

1. 8:45 – Managers
2. 9:00 – Directors
3. 9:15 – Hospitals
4. 9:30 – Trauma/Community/Rural
5. 9:45 – Community Care/Specialty Care
6. 10:00 – Executive Leadership Team

The huddles are brief meetings in which participants stand around whiteboards. Leaders then write action plans, and follow-up is described in subsequent huddles (Harrison 2018). The subtext of the process to every manager was "You are the leader of a team . . . and that team is part of a team of teams."

Another version of huddling culture has been implemented at Meritus Health, where "instead of weekly 3-hour sit-down senior management meetings, the organization's dozen senior leaders adopted a system of daily 15-minute huddles in the hallway." They do daily improvement rounds in which leaders go to different parts of the organization to check in on how improvement initiatives are progressing. A visit to Meritus inspired the observation that leaders there need good shoes, because they don't spend much time in their offices alone looking at computers. The leaders

of that system believe that more frequent action-oriented interactions have increased their speed in decision making and their sense of accountability (Joshi, 2022).

One of the most ambitious applications of the team-of-teams approach can be found in the "Command Center" of Jewish General Hospital, which is more than a hospital – it is a regional health network that has the Montreal Hospital as its hub. During the COVID pandemic, Jewish General Hospital was overwhelmed with patients, as were so many other institutions throughout the world. Among its responses was developing a Hospital-at-Home program, a program planned and implemented over a three-day weekend.

But another response (directly influenced by Team of Teams) has been to create a Command Center with data feeds that monitor the flow – or lack of flow – of patients throughout the network. The technology and its displays (including a large room in the basement of Jewish General with flat-screen monitors covering the walls) are impressive. But more impressive is the "human-ware" – the 8–10 huddles of leaders that occur throughout the day. Leaders from key departments – ranging from the emergency department to the ICUs to the Hospital-at-Home program, to patient transport, to housekeeping – come together to see where patients may be "stuck" and ready to move on, and they solve the problems together.

What can we learn from the five books mentioned at the top of this chapter? That social capital is based in reciprocity and trust, built by bonding and bridging connections

among people, compounded through teamwork, and amplified across networks.

Building social capital requires forming both bonding and bridging connections and then using those connections to help the organization perform better. I make the case in the next chapter that this work is needed in healthcare now more than at any time in the past.