The Challenges of Leading Healthcare Organizations

John Conbere & Alla Heorhiadi

Abstract

Healthcare organizations in the United States are struggling with external and internal factors that limit their performance. One of the internal factors preventing healthcare organizations from being optimally effective is their unique nature of leadership. The authors, based on their experience of consulting in healthcare and teaching physician leaders, made an attempt to analyze the unique features of physician and nurse leadership in healthcare. Some elements of socio-economic theory are suggested as a remedy to overcome the side effects of this uniqueness.

Key words: SEAM, socio-economic approach to management, healthcare organizations, physician leadership, steering organizations.

Healthcare in the United States is expensive, and not as successful as other high-income nations. In a report from the Commonwealth Fund, Aquires and Anderson (2015) drew on data comparing healthcare in the US with twelve other high-income countries (Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States). The result was that the US spends significantly more than the other countries on healthcare while receiving the worst outcomes. Table 1 shows the comparison of USA and these countries.

Table 1.
Comparison of healthcare costs and outcomes

	The USA	Other high-income countries
Health care spending average per person in 2013	$9,086	Between $6,625 and $3,364
Number of practicing physicians per 1,000 population	2.6	between 4.3 and 2.3
Price for bypass surgery	$75,345	between $15,742 and $42,130
Life expectancy for people born in 2003	78.8 years	between 80.9 and 83.4
Infant mortality per 1,000 live births in 2013	6.1infant deaths	between 2.4 and 5.7 infant deaths

It is not at all surprising that the US cannot match healthcare numbers of the leading European countries, given the challenges faced by the US healthcare organizations. According to one source, health care organizations have difficulties with complying with government requirements and mandates, implementing value-based reimbursement, technologies investments and implementations, and addressing rising pharmaceutical costs (Appold, 2016). According to Alemian (2016) the top three challenges of healthcare organizations are (a) the transition from volume-based healthcare to value-based healthcare, (b) rising costs, and (c) talent shortages.

Most of the challenges described above are caused by external factors, yet there are numerous internal challenges within the provider industry as well. In 2017, EY conducted research about factors impacting healthcare organizations' performance and growth. Their report pointed out numerous problems that prevent healthcare organizations from delivering better care at lower costs, such as inefficiency, inconsistent quality of care, clinical workforce challenges, and lack of trust, transparency, and coordination (EY, 2017).

We agree with all of the above and we would add one more internal challenge – poor leadership in many healthcare organizations. We make our claim based on more than a decade of consulting in healthcare systems and teaching physician leaders. However, we want to state upfront a very important disclaimer– we DO NOT [our emphasis] attach poor leadership to any specific individual. We have met many very talented, intelligent, and passionate leaders. Some of them were exemplary strategists and extraordinary individuals. However, the inefficient organizational system and the dominant mental model of modern management have prevented these individuals from being fully successful in living up to their talents. Thus, in this paper, our goal is to analyze the barriers to effective leadership, and in particular physician leadership, of healthcare organizations and to suggest that socio-economic management might be one way to improve the practice of leading and managing in healthcare organizations.

Barriers to effective healthcare leadership

The structure of leadership in healthcare. In most organizations, there is one top authority and thus the chain of command is clear. In healthcare, there are two chains of command, or two domains of authority, which complicates the management process. Physicians have the authority over medical decisions. Administration has authority over non-medical decisions.

Having two chains of command is not itself a problem. The problem lies in different aspects and is two-fold. First, there is often not enough steering and collaboration between physician leaders and administrators. In worst case scenarios, there can be turf wars between physicians and administration and deep mistrust of each other which fosters "us vs them" culture.

Second, the two domains of authorities require a management matrix, in which some employees report to 2 or sometimes 3 managers. Lack of clarity about boundaries or scope of issues can lead to confusion about reporting. In our practice, we often heard staff complaining about the matrix reporting. Sometimes, staff do not know to whom to report which issues. In situations when the supervisors are in conflict, staff feel like they are caught between two fires, which causes stress and poor morale. For staff, reporting the same information to each supervisor, the process can be duplicative, leading to wasting time and effort. Sometimes the management matrix creates room for manipulation.

For example, in a clinic that is part of a hospital system, if a clinic director is a nurse, physicians or other specialists working in this clinic do not see the nurse as their manager. One of the reasons is that if a physician reported directly to the Nurse Clinic Director, this would create concerns among the medical group -- the liability and risk in the practice lie under the license of the physician. If a physician with proper leadership training were the Director, this would be a more acceptable model for physicians. However, the gap in physician reimbursements for leadership versus practicing is substantial and thus leading a unit does not get enough of physician attention needed. As result, a clinic may become the workplace with broken communication, poor work climate, low morale, and lost productivity.

Rising through the ranks. In healthcare, similarly to other trained professions, becoming a leader often happens through promotion from the ranks. Many physicians and nurses rise to managerial positions without any management training. Promotion to supervisory or management positions often happens based on being proficient in technical skills. Even when physicians and nurses have an MBA, they are still not prepared for the hands-on practice of supervision of other people. Few managers in healthcare are trained to manage organizations using systems thinking, or to be able to plan and then implement a strategic plan.

> Physicians preparation for leadership and management tends to be minimal. A typical career path for a physician who has become an administrator of a department or leader of a health care organization is that he or she was recognized as an excellent clinician, teacher, or researcher. While laudable, these skills are not the competencies needed to lead departments or health care organizations at this time. The newly promoted physician may lack financial, change management, communication, motivational, team building, risk management, and leadership skills. (Satiani, B., Sena, J., Ruberg, R., & Ellison, 2012)

Limitations of management training. Programs to educate physicians to be leaders and managers are growing in number. Since 2000, the number of MBA programs for MDs has doubled, from 30 to more than 60 (Gorenstein, 2017). Healthcare systems also have been creating their own training programs. There is some concern that these programs may not be effective enough to create really good physician-leaders. In a review of 45 articles about

physician leadership programs, Fritch *et al.* (2014), found some gaps in physicians' training which included "a lack of programs that integrate non-physician and physician professionals, a limited use of more advanced training tools such as interactive learning and feedback in order to develop greater self-awareness, and an overly narrow focus on individual-level rather than system-level outcomes" (p. 673).

There appears to be far fewer programs to teach nurse-leaders concepts and skills to be good leaders and managers. While nursing training tends to be more holistic and inclusive of taking people's feelings into account (more than is the case with physician training), nurses in their usual training are not taught the management and leadership skills which are needed to lead an organization.

Specifics of physician professional training. Professionally, many physicians are trained to believe that there is always a right answer. This training is rooted in positivistic research methodologies and tends to consider and value only experimental research. Social science methodologies that study human experience are often dismissed as not being valid research.

For a quick reference, different epistemologies lie behind positivistic and interpretive research. Positivistic research is based on the belief that a researcher can be neutral and does not have an impact on what is being studied. A study subject or object can be dissected into parts, which enhances the process of receiving valid information about the research topic. Interpretive research, which is common in social sciences, is based on the belief that neutrality is impossible because the researcher will inevitably have some impact on subjects of the study. Interpretive research also implies a holistic approach, which means that a researcher must always study a topic in context. It is important to note here that more interpretive research can be found in nursing, where phenomenology is often used to study patient experience.

While having the right answer in the surgery room, or during the patient visit, is good and needed, spilling "the one right answer" approach into social interactions can be counterproductive. Social reality is much more complex, and thus different opinions, while appearing contradictory, have valid points. Yet, physicians due to their training to value "facts," may dismiss opinions of others, especially those opinions that contradict the physician's belief about what is true. In our consulting, during feedback sessions that summarize statements from all employees, we often hear from physicians, "I do not agree with this statement," implying that therefore the statement is not true. Seeing one's own opinion as an objective fact and someone else's opinion as a false perception can quickly stifle the dialogue, needed to move an organization forwards. Needless to say, that a leader who has the only right answers probably is not a very effective leader.

Insufficient training in interpersonal and intrapersonal skills. Having an MBA degree does not make one a good leader. Good leadership calls for solid inter-personal and intra-

personal skills. Intrapersonal skills include ability to self-reflect, identify feelings, and be aware of self and others in different situations; intrapersonal skills are the foundation for good interpersonal skills. Interpersonal skills include active listening skills, conflict resolution skills, ability to negotiate and persuade, willingness to collaborate, in other words any skill needed to interact with others well. Yet, in their medical training most physicians are trained to listen until they can make a diagnosis; the moment they think they figured out the diagnosis, they stop listening (Conbere & Heorhiadi, 2008).

Intrapersonal and intrapersonal skills are considered *soft skills,* and they do not fit either the traditional mental model of being a good physician, nor the model of a transactional leader. A transactional leader tends to be directive, has solutions to problems, and motivates employees by rewards and punishments. While transactional leadership is a common style in health care, there is growing recognition that the most effective leadership style for health care of the future will be transformational. Given the challenges the healthcare organization face, leaders' tasks will not be to provide solutions but rather find solutions to adaptive challenges in the "collective intelligence of employees at all levels" (Heifetz & Laurie, 2001, p. 6). Adaptive leaders have to be open to involving others in the decision-making process, and thus they have to be open to listening to and valuing the ideas of others.

Leading in adaptive way is antithetical to traditional medical training which does not foster inter-personal skills and self-awareness of physicians. As result of their training, many physician leaders have selective listening, poor ability to be self-reflective, poor collaboration skills, and think about data in a manner that may exclude other viewpoints (Conbere, Heorhiadi, Brown, & Campion, 2010; Conbere & Heorhiadi, 2008).

Physician independence hurts leadership. Medical training prepares physicians to be independent decision-makers. They need to decide about a diagnosis quickly and accurately, this is especially important when a patient life is at stake. At the same time, perceiving self as being independent hinders physicians to be team players. Physicians see their value only in providing their professional expertise, they may see little value in participating in change initiatives, since these do not bring income directly to the physician.

Being a sole decision-maker contributes physicians' resistance to the idea that they need supervision. We were advised by a physician leader to use a euphemism to replace the word *supervisor* when communicating with physicians. This ingrained independence hinders physicians' ability to be a team player and makes steering more difficult.

The essence of good management practice includes participation of employees, which means they are being listened to, and have a voice in decision-making. Participative management is key to reducing employees' resistance to change. To be effective in their management role, physician leaders, need to overcome their own bias about independence and learn to manage in a participatory manner.

Specifics of nurse professional training. While nursing professional training is more holistic, it also has some counter-leadership features. Personal characteristic and professional training that make an excellent nurse, such as kindness, ability to accommodate other people's needs, etc., may hinder the ability to be a good manager/leader.

Nurses are trained to help patients and help quickly. Therefore, when a nurse suddenly gets promoted to a leadership/supervisory position, the tendency to quickly fix a problem remains. Without being trained in systems thinking, it is hard to see a problem as a symptom of a deeper cause that has strategic nature. And even harder it is to recognize that quick fix may lead to bigger problems down the road. In our consulting, we continuously have to restrain nurses to fix a problem before the deeper causes that underlie the problem are identified. We remind nurses that what they see as a problem is only a symptom of the "organizational disease". To understand the nature of the problem and eliminate it, a deeper analysis is needed.

Professional training and personal traits may also impact the way nurses manage people. Many nurse supervisors soften feedback where an employee needs to hear a stronger message. They may have difficulties with holding staff accountable. Some nurses do not stand up to those physicians who cross the boundaries of professional behavior or are unaware of their destructive behaviors.

Newly promoted nurses may not know how to balance their time between their operational activities and managing staff. For some nurse leaders, managing staff means picking up work that their staff were not able to do. As a result, they end up putting out fires, and taking on more work than they are able to do. They get used to emergencies being part of life and may not recognize that some emergencies are the result of poorly planned time, lack of organizational thinking, and lack of leadership skills. The concept of steering employees toward strategic goals seems strange, if not alien, to some nurse directors. Some nurses, especially younger ones who still try to prove themselves in their roles, may not see that their commendable tendency to be problem solvers and people helpers only enables organizational dysfunctions and perpetuates the inefficiency of the organization.

A single primary focus on patient care. In health care organizations, concern about patients and patient care overrides everything else. This concern can manifest itself in the amount of time physicians set aside for management tasks, usually too little, and always secondary to patient care. Some physicians may ignore or be late for meetings, giving patient care the priority over management. The needs of the physicians-as-managers are secondary to the needs of patients, and as a result, the health of the organization is threatened. The difficulty comes from having two roles, and making management the secondary concern. Many physician leaders do not find the right balance between patient care and management tasks. The result is the individual patients receive good care, and the needs of the organization are not met. Only

physician leaders can do their leadership work, and failure to allot enough time to be a good leader-manager sabotages the effectiveness of the organization as a whole.

Summary. To be successful, health care organizations need the leadership of physicians and nurses. Due to the nature of medical training, lack of and inadequacy of existing management training for physicians and nurses, leadership training for both groups needs additional attention. This attention has to be placed to the way physician and nurse leaders are trained, yet also to how organizational system supports and utilizes physician's skills. Only with effective physician and nurse leadership and a healthy organizational structure will healthcare organizations become more efficient and provide higher quality of care at lower cost.

Socio-economic management is management of the future

The outdated dominant model of management. The modern management theory is rooted in concepts developed during the late 1800s and early 1900s. The thought leaders of the time tried to increase effectiveness of the workplace. Ideas like separating work design and execution, implementing high work specialization, and designing regulations to shape and control human behavior were innovative for that time and aimed at making workers highly efficient. Those ideas formed the management practice and became the heart of modern management theory. Despite being more than a century old, this theory still shapes the dominant mental model of management in the Western world. Many managers and employees adopt this theory without realizing that it is based on flawed beliefs about the human nature, work, and workplace. According to this mental model, human beings are rational, feelings and emotions are not part of work, and people should be obedient and comply with organizational rules that can override individual needs. After employees are hired by an organization, they become commodity, human capital, like any other resource the organization has (Conbere & Heorhiadi, 2014, 2018).

The premises of socio-economic management. The alternative to traditional mental model of management is socio-economic management, which is a radical transformation of philosophy about modern organizations. The concept *socio-economic* means that the *socio* aspect of work cannot be decoupled from the *economic.* To succeed, organizations must care for the people whom they employ. When employees feel engaged, they are most productive. According to socio-economic theory, human potential is the primary driver of sustainable growth. Unless people can develop their knowledge and skills, and use them in a meaningful way, organizations will not achieve its highest potential and effectiveness.

Socio-economic approach to management (SEAM) was founded by Henri Savall in 1973 in Lyon, France. SEAM is based on research into its effectiveness, so it is an evidence based approach to organizational change and management. One of the core principles of SEAM is that

every organization has structure (which includes rules and traditions as well as physical buildings) and behaviors (how employees act). When structure and behaviors are functioning well, the organization tends to thrive. However, when they do not work well, that is when they are dysfunctional, the dysfunctions lead to costs which are hidden, as they are not measured by traditional accounting (Savall & Zardet, 2008, 2016; Savall, Zardet, & Bonnet, 2008).

There are processes like Lean and Six Sigma which are designed to reduce waste in the workplace. These have much potential, but only if the human, or socio, side of the workplace is addressed. If the socio side of work is not addressed, quality improvement processes tend to be abandoned after time (Kennedy, 2016). For leaders and managers, tending to the socio side, means understanding the basics of how to treat and manage people (not processes!) in the workplace.

The systemic cause of problems. Traditional management has an embedded belief that when there is a problem, there is a person at fault behind it, and thus that person should be blamed and corrected. According to socio-economic theory, the cause of any organizational problem is the system that is not working effectively. So any problem can be seen as generated by the system –hiring a person without the right skills, not providing the right training, not supplying the resources needed for success. When employees feel freed from potential blame, morale improves quickly.

SEAM promotes the idea that people are intelligent, and when there is a problem in the workplace, often the people involved will be able to solve the problem. Solutions imposed on employees top down usually are less effective, as these solutions are rarely based on information that the people doing the work, have. Top down solutions are also disrespectful of employees who have necessary first-hand knowledge about problems and their solutions.

For example, in a hospital's business office, many work processes were cumbersome, communication was weak, and morale was low. During the SEAM intervention, these ineffective work processes were identified, and hidden cost were calculated, reflecting the cost of inefficiency. When employees were given the charge to improve these processes, they were delighted to get rid of what they saw to be stupid processes. For years the employees disliked the wasteful practices, but organizationally nothing changed until employees were empowered through SEAM. The leadership lesson was allowing employees to use their knowledge to improve the system, rather than relying only on the managers to fix the problem. After a year of intervention, in the business office, hidden costs had been reduced by more than 20%, morale improved, and cooperation with other departments of the hospital increased.

~~S~~teering as effective leadership. According to socio-economic theory, leading or managing any organization is like steering a ship. Steering includes (a) aligning people and resources towards achieving organizational vision and strategic goals, (b) synchronizing the work of different parts of the organization (silos) so their efforts are in accord with the

organizational mission and strategy, and (c) developing the human potential of employees who make the organizational ship go to its strategic destination.

Socio-economic theory suggests that steering the organization is the primary task of managers. Good leaders know how to steer their ship. Steering thus is more than just only leading or only managing, it has elements of both. The need for steering is supported by management expert Henry Mintzberg (2013), who was adamant that the dichotomy between leadership and management is illusory: Good managers lead, and good leaders manage.

Lack of steering. Lack of steering is the primary cause of problems in organizations. Lack of steering may take different forms and to give an idea how they look like, below are some examples of lack of steering. Example 1 is an organization that does not have a clear direction or visions. Usually this happens when top leaders do not agree on the organizational mission or strategic plan. In our practice, we worked with leadership groups in which each top leader had a different interpretation of the mission, or a different understanding of how to fulfill the mission. The lack of agreement on mission and strategic plan led to competition to reach different goals and caused de-synchronization and misalignment of different divisions and their goals.

Example 2 of lack of steering is organizations in which employees do activities or undertake initiatives that are not part of the organization's strategic plan. The proverbial strategic plan that sits on a shelf becomes a real dysfunction and tangible hidden cost. Example 3 of lack of steering was demonstrated by an organization, in which top leaders used their strategic meetings to review all expenditures in the multi-million-dollar budget. They spent so much time and energy on the budget review, instead of thinking strategically, that they were not able to steer.

Not putting enough time into steering and then expecting the organization to meet its strategic goals successfully is common in healthcare organizations. This is especially obvious in the mid-level managers who do much of their everyday technical work, after which they do not enough time left for steering the employees who report to them.

Fostering physician leaders who can steer healthcare organizations into the future

Physicians, as a group, are intelligent and dedicated professionals. When they take on a leadership role, they need some help in adjusting to their new role. SEAM is one way to provide help. We do not claim that SEAM alone can do all the work. For instance, becoming self-aware and learning to listen differently can be achieved through more specialized training. However socio-economic theory and the elements of the SEAM intervention have the potential to guide physician leaders and to reinforce their leadership skills. The biggest value that SEAM provides is introducing to a different mental model of management and/or leadership. Leaders who have been involved in SEAM enrich their vocabulary by a new word - steering. Understanding and applying the concepts of steering makes them better leaders (Jensen, 2018).

Recognizing the socio. The socio-economic theory has the potential to help every leader recognize that the socio aspects of the workplace are equally important as the financial. The theory becomes manifest in the SEAM intervention, during which leaders hear diverse and sometimes contradictory viewpoints. This might be a challenge for those physician leaders who insist that they know the right answers. The SEAM process is designed to give everyone the opportunity to hear all viewpoints, with the belief each voice has validity.

Having the right data. Many organizational leaders do not realize that their strategic decisions are made without accurate or full information. According to socio-economic theory, around 40% of organizational economic performance is not taken into consideration by traditional accounting. This lack of information affects an organization's effectiveness by turning a lot of activities into dys-functions which leads to hidden costs. Socio-economic research shows that average hidden costs in organizations can be between $20,000 to 70,000 per employee per year, depending on industry. During SEAM interventions, leaders receive a wealth of data that cannot be achieved through traditional financial sheets.

Dealing with root causes rather than fighting symptoms. Who can better than healthcare professionals know that a patient's symptom is not the disease. What has to be cured is the cause of the disease. SEAM teaches leaders to look for root causes of problem that have a structural origin, rather than trying to fix the symptoms.

Using SEAM management tools. The SEAM management tools are helpful to all managers, including physician leaders. The competency grid, when done for the leadership team, is a reminder of the skills all leaders need to be successful. Outlining the knowledge and skills required to be a good manager and leader is a starting point for physicians, giving an agenda for learning tasks in the future.

The greatest task of any leader is creating a viable strategic plan, and then getting all members of the organization to align their work to the plan. Much too often a plan is made, but implemented poorly (Conbere & Heorhiadi, 2017). The SEAM tools support the creation of a strategic plan that focusses both on development and reduction of hidden costs to pay for the development. Through a Priority Action Plan that each manager makes and shares with their supervisor, the focus of the managers' effort and time are agreed upon. As this practice cascades throughout the organization, alignment is greatly improved.

Conclusion

Becoming an effective leader, with the right knowledge and skills, is a difficult task. In healthcare, the task is even more difficult. Medical training does not prepare physicians or nurses to be leaders. The primacy of caring for the patient undermines the time and effort physicians

and nurses put into steering. Some physicians have the opportunity to attend leadership training, but too often, this training does not address the development of self-awareness, necessary to be successful leader. SEAM by itself is not the solution, but the SEAM process and philosophy can help leaders become more effective, and can support leadership training for physicians and nurses.

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John Conbere, MDiv, EdD, President of SEAM, Inc, Co-director of SEAM Institute.

Alla Heorhiadi, PhD, EdD, Vice President of SEAM, Inc., Co-Director of the SEAM Institute.