The Medical Staff in Transition: A New Creed for Physician Leaders

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The healthcare industry is committed to payment reform as a way of controlling costs, improving quality and service, and better aligning incentives within the provider community; hence the transition from payment-for-volume to payment-for-value.

The focus is shifting from isolated events to managing episodes of care and managing health and/or disease across time and across traditionally separate domains (i.e., eliminating care performed in silos). The ultimate vision is an attempt to create team-based, patient-centric, evidence-based, and coordinated health management.

This new delivery system is to be held together by an integrated/interoperable electronic medical record (EMR) and ultimately reinforced by the new payment models. The public reporting of process and outcome data, as well as patient satisfaction scores, is intended to prevent the withholding of essential services. In this system, profit is linked to health maintenance, disease and case management, and direct patient involvement in his or her own care through shared decision making. The Institute for Healthcare Improvement's Triple Aim is the foundation of this approach. The aims are to improve care (including quality and patient experience), improve community health status, and lower cost. The objectives are to ensure that the right person does the right thing in the right way at the right time and in the right place, as a way of promoting wellness and optimum disease management in an efficient environment.

A number of factors are driving consolidation within the provider community. Falling operating margins, the staggering cost of information technology, and

restricted access to capital are some of the factors driving the consolidation of healthcare organizations. Physicians are progressively seeking the income security of employment relationships. The high costs of new medical technology, an inability to recruit younger colleagues to independent practice, and a reduction in payment for physician-owned ancillary services are additional factors driving physicians toward integration.

The standardization of healthcare delivery in service of reducing waste and improving aggregated quality of care is transforming what was a cottage industry into an industrialized model of care. The commoditization of healthcare services, a growing emphasis on science and technology, the ease of access to medical information provided by the Internet, and the growing desire on the part of especially younger patients to be active decision makers in matters that impact their own health are all fueling a total transformation of the healthcare industry. A necessary consequence is the need to transform relationships within the provider community, particularly those relationships between physicians and hospitals/health systems.

This special section describes the transformation of the medical staff in its transition to value-based care, along with challenges and opportunities for physician leaders, senior executives, and boards to address these changes and engage physicians optimally throughout all levels of the organization.

The Changing Face of the Medical Staff: From Individual to Team

As the provider community integrates, there is a growing need for physician involvement in leadership and in the management of healthcare services. Historically, as physicians worked autonomously, individual competency and vigilance were seen as the determinants of healthcare quality. Healthcare delivery was an individual sport akin to golf. Today healthcare delivery is far too complicated to be managed by any single individual. Team-based care is becoming the norm—a sport more like volleyball wherein there is role clarity and role interdependency as illustrated in the slogan, "dig, set, spike." To shift the metaphor, in the world of payment-for-volume, the physician culture primarily valued autonomy, so physicians were like solo musicians awarded on the basis of how often and how loudly they played. The world of payment-for-value requires an orchestra in which individuals are rewarded based on the quality of the music they create together.

Distinguishing Leadership from Management

When considering physician leadership challenges, it is important to distinguish leadership from management. Leadership focuses on people and intangibles, is future oriented, works on paradigms, and is about the what, why, and "want to" aspects of organizations. Management, on the other hand, focuses on processes and tangibles, orients to the present, works within paradigms, and is about the "how to" aspect of organizations. Leaders "manage relationships." Managers manage processes. As discussed in more detail here, physician leadership in value-based care requires many physicians to break new ground, as they have not historically

had to manage relationships. This cultural shift is significant and one that needs to be addressed systematically.

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Foundational Challenges to Physician Leadership

Learning to Speak a New Language
As physicians move into positions of leadership and management within the larger healthcare organization they are confronted by many challenges—some of which are absolutely foundational. The first is to appreciate that today's healthcare organizations are still run primarily by businesspeople (i.e., non-clinicians). Businesspeople and clinicians speak totally different languages, frame issues from totally different perspectives, and use different metrics to define success. Often, when viewing the very same data through these disparate perspectives, businesspeople and clinicians come to opposite conclusions. To each the conclusion is imminently clear. When the other disagrees, the impression can be that he or she either cannot understand or chooses not to; he or she is either incompetent or self-serving and in either case cannot be trusted. Too often, when one doesn't speak the language of another the response is to speak more loudly and, in effect, shout in an attempt to be understood. Clinicians and businesspeople need to explain their perspectives with clarity and be willing to openly listen to the perspectives of the other. In a sense, there is a need to be bilingual.

Disparate Ethics? Individual Patient vs. Patient Population
Similarly, clinicians and healthcare administrators are guided by a different set of ethical principles. Clinicians have an ethical responsibility to serve as the individual patient's advocate. That is, short of doing harm, the clinician should do anything that might conceivably benefit his or her patient, ideally irrespective of the patient's ability to pay. Administrative leaders of healthcare organizations must think more holistically: they serve as the advocate for all patients served. Their responsibility is to create the greatest good for the greatest number. As a consequence, administrators tend to think systemically over a longer time horizon, while clinicians tend to think more linearly with a more constrained sense of time. Each of these perspectives is attended by an equally valid but separate set of ethics. No one can simultaneously serve both.

Another foundational distinction is that physicians work to the principle of distributive justice: for the clinician, the end justifies the means. As long as the outcome is positive, the path taken is immaterial. This is especially true when the physician is the autonomous "captain of the ship." Healthcare organization leaders, however, work to the principal of procedural justice. In the organizational culture, everyone who might conceivably be impacted by a decision must be included in the conversation. Failure to do so is met by a passive-aggressive response. This can lead to significant delays in decision making, which frustrates action-oriented physicians. The command style of leadership—which comes naturally to physicians whose primary way of relating to the healthcare organization is by issuing orders—creates dissonance in the organization.

The EMR
The current state of the EMR presents another foundational challenge. Physicians think in narrative—something that exists in an analog environment. Telling stories does not fit into a digitized world of numbers. Nuance is lost in a digitalized format—the patient is not a check box. Additionally, the EMR was first intended to simulate the traditional paper record and then evolved to respond to the need to provide required information to the regulatory and payment communities. By and large it is not (yet) a clinical decision support tool. Useful clinical decision support programs tend to exist as "best in breed" offerings. Linking best-in-breed programs requires creating multiple interfaces that are the nightmares of IT professionals. Packaged programs developed by informatics vendors integrate modules by design and are less prone to breakdown. As a result, clinicians have been forced to serve the computer system as opposed to the computer system serving the needs of the caregiver. Thus, most caregivers (including physicians) do not feel that the EMR has facilitated or enhanced their ability to provide quality care. Certainly it has driven the caregiver away from more direct patient care activities. A frequently heard comment is, "We take care of the computer, not the patient."

The Challenges of Payment Reform

Payment reform presents significant challenges to the physician community and its leadership. Bundled payments (i.e., bundled prepayment for episodes of care potentially covering a breadth of services from those narrowly isolated to a specific procedure or illness all the way to global capitation) turn upside down the existing power structure within the provider community. Profit results from eliminating waste and providing equivalent or superior care in less costly environments. In most communities, the healthcare organization is the largest generator of revenue and thereby the primary source of capital. In the world of bundled payments, it becomes the most expensive cost center. Similarly, in the world of payment-for-volume, proceduralists generate the greatest revenue. When physicians are paid on the basis of how much they do, there is a tendency to do more. At times, good business reflects bad science; certain highly remunerated services in a payment-for-volume world don't always reflect evidence-based justification. With bundled payments these cash cows become "golden calves." Hospitals

When the physician group is comprised of aggregated physicians, as in an IPA, the contracting expectations, management functions, rewards, and accountabilities are all performed by the economic entity, not the individual medical staff organizations to which the individual physicians belong.

The transition from payment-for-volume to payment-for-value will occur over a significant time interval. This has been described as jumping to a second-curve business model. The challenge is in knowing when to make the jump. Jump too soon and the organization sacrifices significant revenue; jump too late and it fails to prepare for the coming reality. This schizophrenic environment significantly complicates the transformational process—the very process in which the role of physician leaders is ever more essential and still in flux.

and health systems that are preparing for payment-for-value know that they will no longer be able to rely blindly on such "cash cows" in the future.

In a bundled payment model, wellness, health maintenance, and disease management become critical to organizational success. These ambulatory-based interventions become the primary generators of revenue. This will significantly disrupt the existing status hierarchy within the provider community, and significant tension will result when physician income is reconfigured.

In addition, many of the functions currently performed by physicians will be increasingly performed by non-physicians (e.g., nurse practitioners and physician extenders). The role of the primary care physician is moving away from the "bedside" and towards the management of information and the appropriate allocation of ancillary services. Older primary care physicians who value a personal doctor–patient relationship resist such a future, while younger physicians are quite comfortable accepting this role.

Success in a payment-for-value environment ideally requires an insurance vehicle and actuarial expertise. These are not core competencies of the traditional provider community. Thus, it will become necessary for many healthcare organizations to partner or merge with, or incorporate organizations with actuarial/insurance expertise. There is a need to underwrite a large population in order not to be victimized by the risk of small numbers. This is another factor driving the current wave of consolidation in the industry. A failure to meet these parameters relegates the healthcare organization to being a subcontractor for someone else.

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Lessons can be learned by assessing organizations that are cited as models prepared to accept risk in response to payment reform (for example, Kaiser Permanente, Group Health Cooperative based in Seattle, Geisinger, Scott and White, Mayo, Cleveland Clinic, and large IPAs such as Hill Physicians in California). Certain commonalities are apparent in these integrated delivery systems:

- They are all physician led and often built upon an already existing multi-specialty group practice.
- Physicians are usually employed in a salary-based arrangement.
- They own their own health plan.

Leadership Challenges Related to Reorganizing the Provider Community

As physicians progressively move into an employment and/or integrated relationship with the healthcare organization, and as important healthcare services progressively move away from the hospital, the traditional organized medical staff structure becomes progressively more irrelevant. The sole purpose of the organized medical staff is to assess and to improve the quality of care. These activities are intended to support credentialing and privileging, and to promote continuous quality improvement. As hospital–physician relationships become increasingly based on economics, the relationship cannot be managed through the organized medical staff because it is not an economic entity. Moreover, care that must be integrated across time and across domains requires a perspective that transcends the traditional hospitalized patient.

The traditional medical staff organizational structure—though outdated—is likely to stay in place for the time being. Accrediting bodies still require the existence of such a structure, even as its required functions become usurped by other structures. Inpatient care is becoming progressively more complicated and hospitalists and intensivists are often involved in managing patients affected by multiple disease processes. The services of hospitalists and intensivists are usually contracted and frequently outsourced.

Thus, the traditional medical staff structure must overlap relationships between unrelated entities, seeking to facilitate handoffs in the inpatient setting when responsibilities cross domains.

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Coordinating Care across Providers

With value-based payment and new care delivery systems to accommodate new payment structures, providers now must coordinate care across professions, specialties, time, and across the traditional inpatient and ambulatory divide (i.e., across the continuum of care). The provider community is now responsible for the quality, cost, service satisfaction, and appropriateness of care provided in all care settings. To achieve these ends there is a desire to reduce variation and consistently apply evidence-based interventions. Coordinating care across professions and specialties conflicts with the traditional departmentalization of the organized medical staff structure. Non-physicians are traditionally excluded from medical staff participation, and departmentalization impairs the synchronization of care. For these reasons, an economically integrated provider community will manage the relationship between quality and cost going forward—not the traditional medical staff.

Tensions between Employed and Independent Physicians

During this time of transition in the structure of the medical staff, a great tension can exist between employed physicians and those members of the medical staff who remain independent. As the percentage of physicians in employment grows, independent physicians progressively fear being isolated and excluded from access to patients. Because it is not an economic entity the organized medical staff structure tends to focus on the needs of the independent physicians who see it as the only means to present a collective voice in defense of their autonomy. Adding to the imbalance, the behavioral expectations and objectives of the employed physician group are at times in conflict with those of the medical staff.

Generational Differences

Perhaps somewhat analogous is the tension that exists across generations of physicians. Older physicians tend to be more traditional, autonomous, digitally impaired, and intrinsically motivated to work long hours. Younger physicians, on the other hand, tend to orient toward shift work, are comfortable delegating responsibilities to others in a framework of team-based care, and are quite comfortable in an electronic environment. Integrating care that transcends generational differences is a significant challenge to those in positions of physician leadership. These differences are especially difficult to resolve in the traditional medical staff organization. Most younger physicians don't attend medical staff meetings, which traditionally are scheduled before or after the "workday." Younger physicians, who seek work-life balance, are disinclined to participate in forums that infringe on their personal time.

When success is dependent on synchronizing care, and when individual participants accept that they can get more of what they care most about by working together with others than by continuing to work independently, collective interest will trump self-interest. Balanced accountability in an at-risk economic model requires a degree of integration and cultural shift not possible in the traditional medical staff organization. The traditional medical staff has become an impotent vehicle for managing relationships within the evolving provider community.

ACO Physician Structures

There are many ways to structure and assemble an accountable care organization (ACO), including considerations as to how the clinical integration will be structured. ACOs are on the high end of the physician integration spectrum, and most providers enter into them understanding that their performance will be held to certain constraints and requirements. Political and demographic realities seemingly demand an approach that accepts "any willing provider," in order to create an ACO that is large enough to take on and sustain a degree of risk. The supporting theory seems to be to welcome in anyone who chooses to join, define performance expectations, subsequently hold them accountable for their performance, and then exclude those who fail to meet expectations.

However, this approach of indiscriminate hiring is overly simplistic. The danger is that mediocrity could result as the collective migrates towards the mean. The truly outstanding performer does not want to associate with mediocrity. Firing

someone is incredibly more difficult than hiring the right person. And perhaps most importantly, the culture that results from indiscriminate hiring creates an inertia that is very difficult to overcome.

In this light, creating a successful ACO physician structure isn't as straightforward as it seems. Businesspersons tend to see physicians as fungible and this attitude serves the demographic and political realities that support an "any willing provider" attitude. However, there are two essential elements that inform hiring decisions: can the individual perform and does he or she share organizational values? Current wisdom dictates to hire for values and train for skills.

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How to Proceed? Learning to Become Adaptable

When stressed by the need to adapt to transformational forces there is a natural tendency to revert to familiar ways of responding. As healthcare leaders are becoming aware, this will not work going forward—the pace of change is progressing exponentially. Business models come and go at an ever-accelerating pace consequent to disruptive technologies, changing reimbursement models, changing regulations, etc. The key competency is an investment in adaptability. In order for physician leaders to thrive in this new environment, there is a need to separate substance from form, a need to distinguish the essence of who you are and what you do from the way in which it is currently being manifested. What is your shared purpose, what are your shared core values, and how can they be expressed differently in response to an ever more rapidly changing environment?

The reorganization of healthcare delivery in response to payment reform has shifted power to the clinicians. Currently, many sources of capital are seeking to align with large aggregates of physicians, whether they are IPAs or existing multi-specialty groups. Large insurers, for-profit hospital systems, venture capitalists, and even a large dialysis company are seeking to economically align with physicians. Some large employers, who are usually self-insured, are building their own provider networks. Healthcare organizations need to appreciate the shifting locus of power within the provider community.

One thing is perfectly clear: the structures and relationships that served the provider community in the past will not serve it well in the rapidly evolving present/future. Governance structures are changing in response to consolidation in the industry. Historically independent hospitals are progressively being aggregated into larger systems wherein decisions made at a system level frequently encroach upon local prerogatives. As physicians become more incorporated into positions of healthcare organization management and leadership, traditional ways of relating give way to new structures.

The amalgamation of the traditional hospital workshop and independent physician artisans (medical staff) is creating a new and unique organizational structure. The new entity requires transforming traditional attitudes in deference to creating a patient-centric, team-based, information-driven commitment to balanced accountability. The interdependency between managing infrastructure and optimizing clinical care must acquire new competencies that serve the need to integrate and orchestrate health maintenance and disease management across traditional silos and across time.

Implications for Board Members and Healthcare Administrators

Director/administrator–physician relationships have evolved over time. When healthcare was purely a cottage industry, physicians were viewed as customers to be served since they provided the patients that filled beds and operating rooms, and ordered procedures and tests that served hospital-owned ancillary services.

The advent of DRGs forced the need to challenge autonomous physician decision making that often interfered with profitability. Then, when physician income was threatened, many physicians sought to move the locus of diagnostic and therapeutic procedures into physician-owned facilities. As a result, directors and administrators began to view physicians as competitors and individuals who had to be controlled in service of the hospital's business model. In many ways the same dynamic applies to the pursuit of meaningful-use dollars in attempts to make expensive electronic records more affordable.

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With the advent of requirements for publicly reporting data and with the progressive linking of reimbursement to efficient and effective care, physician engagement became essential and hospital leaders began to see the physician as a more integral component of the healthcare organization. For boards and administrators, current reality demands not seeing physicians as employees, but rather as strategic and tactical partners in the enterprise, and as essential authors of processes designed to maximize wellness, health, and disease management.

From a structural perspective, the incorporation of physicians into the traditional healthcare organization structure most often results in the creation of a separate branch within the organizational chart. Typically there is a system board that oversees the traditional organizational structure; now it also includes a separate branch that represents the affiliated physicians. The physician group usually has its own leadership and management positions and its own governance structures, and reports, through its leadership, to the

oversight board. The doctors, in effect, exist in parallel with the more traditional side of the healthcare organization. Managing the infrastructure and clinical work are opposite sides of the same coin. However, this parallel existence must transform into a cohesive collaboration. Over time, "we" versus "they" must become "us." The need going forward is to actualize a necessary interdependency in service of the population that entrusts providers to serve their needs. Providers and administrators now must come together in mutual respect, mutual trust, and mutual appreciation.

Changing Structures and Requirements for New Skills

In many larger healthcare organizations physicians are taking on management roles. These physicians are placed in positions of responsibility for influencing the cost *and* quality of specific service lines and/or procedures. Often this occurs in the form of a management services contract. At other times, specific physicians are identified and given the oversight responsibility in exchange for a directorship stipend.

These physicians often co-exist in a dyad relationship to a service-line manager who is responsible for providing the necessary supporting infrastructure. To perform these functions, physicians in management positions must be knowledgeable on issues related to healthcare economics, performance improvement, and the measurement and feedback of data. They must also posses an understanding of organizational culture, how it differs from physician culture, and how it impacts communication and performance. In addition, they must understand the principles of process redesign in order to maximize throughput in a patient-centric way, thereby achieving effective, efficient, appropriate care with high levels of patient satisfaction.

Author Jeffrey Pfeffer has identified seven practices that distinguish high-performing organizations:[1] 1) selective hiring, 2) self-managed teams and decentralization of decision making, 3) comparatively high compensation contingent on organizational performance, 4) employment security, 5) extensive training, 6) reduced status distinctions and barriers, and 7) extensive sharing of financial and performance information. These characteristics stand in sharp contrast to the hierarchical, top-down industrial model that characterizes most healthcare organizations.

Boards and senior leaders should consider the current state of their organization's medical staff and physician leadership structures, and assess if the corresponding physician leadership development plan is vigorous enough to help move the organization successfully through the transition to value-based payment. Integrated, values-aligned physicians and physician leaders must be at the core of every organization's approach to eliminating waste, reducing variation, and improving outcomes. This is a powerful way to enable those at the sharp edge of patient care to redesign that care in a patient-centric way that simultaneously reduces cost and improves quality.

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How Should Physician Leaders Respond?

In a world in which the pace of change is progressing exponentially, leadership must serve organizational adaptability. According to the complexity scientist Ralph Stacey, adaptability is influenced by four critical variables.[2] First is the amount of new information that is shared within the organization. Too little information perpetuates the status quo, while too much information can panic the organization. Second, adaptability is served by promoting a diversity of perspectives. Maximizing diversity enlarges the potential from which solutions can emerge. Third, diversity is of no value unless those diverse perspectives are connected in conversation. Finally, adaptability is influenced by how power is dispersed in an organization. Too much power at the top can narrow the range of options while diffusing power equally throughout the organization precludes an organized and coordinated response.

It is the responsibility of organizational leadership to prioritize and focus organizational strategies. If an organization has too many goals (some suggest more than three), it will accomplish none. When there are too many initiatives imposed on an already overburdened workforce—especially when those initiatives are not prioritized—the result is fragmentation of effort and a failure to create meaningful change.

Physicians in positions of leadership and management need the ability to establish and manage highly functional integrated teams comprised of many different professions in order to manage health, wellness, and disease in a patient-centric way, across time, specialties, and locations all linked together by a shared common information system. These physicians will require people skills and need to understand how to effectively communicate, motivate, and focus members of a team in order to maximize performance.

Physician leaders have an obligation to direct motivation. Both the quality and the quantity of work performed are influenced by an individual's motivation.

1 *The Human Equation: Building Profits by Putting People First,* Harvard Business School Press, 1998.

2 *Complexity and Creativity in Organizations,* Berrett-Koehler, 1996.

Author Daniel Pink identified three primary motivators of work done by professionals: autonomy, mastery, and purpose.[3] Autonomy means having a personal say in how you perform your work. While being held accountable for the outcome of your work you feel free to help design how the work is done in pursuit of the intended objectives. Mastery refers to an individual's desire to continue to grow and develop at work and to the actualization of an individual's potential. If you are not progressively challenged there is a tendency to become bored and disinterested. Finally, a dominant influencer of motivation is the belief that your work has meaning and purpose—that what you do makes a difference.

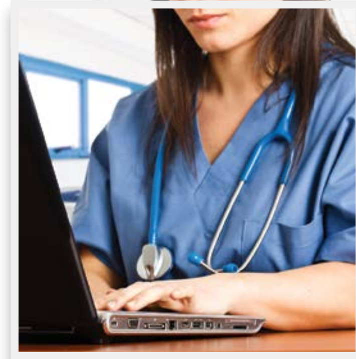
> Physician leaders need to develop a skill set that focuses on managing relationships. It is akin to shifting the role from being a musician in an orchestra to becoming the conductor, responsible for bringing together historically disparate components into an integrated whole.

Pink also comments on the difference between extrinsic and intrinsic motivation. Extrinsic motivators (most often monetary), especially when individual and conditional, erode both the quality and the quantity of the work they are intended to promote. Additionally they destroy teamwork and can compromise ethical behaviors. It is the intrinsic motivators (autonomy, mastery, and purpose) that primarily extract discretionary effort.

Vision, Dialogue, and Measurement

From a leadership perspective, this all boils down to three primary areas of importance: vision, dialogue, and measurement. Vision is the essential responsibility of leadership. Absent a transcendent purpose, the default is to economic self-interest. Groups cohere around shared purpose and they are bound together by a mutual commitment to the behavioral manifestations of a shared set of core values. Essential to the relationship is an alignment of self-interest, with group interest and an appreciation that one can achieve more of what is important to him or her by working together with others rather than by continuing to work alone. That is why, in a world changing so rapidly that the future is unknowable, it is essential to focus on intrinsic motivators—to be guided by the intangible aspects that give meaning and purpose to work. In this environment, profit isn't directly pursued, but rather ensues from a primary commitment to shared purpose.

To successfully manage relationships, it is imperative to increase mutual understanding, trust, and appreciation among individuals or groups of individuals. This is achieved through dialog and not debate. Similarly, dialog nurtures the creative potential that exists in the collective wisdom of assembled individuals. Margaret Wheatley wrote that when people of shared purpose are given access to necessary information and allowed to engage in soulful dialogue, magic happens.[4] Essential to dialogue is a willingness to suspend judgment and attentively listen to others. In dialogue, people stop making statements and begin asking questions; there is a collective appreciation for how the group's current way of responding is co-creating their current reality; and participants begin to speak primarily from the heart and not the head.



Measurement is the third leadership element. It is important to identify the metrics that define success—one cannot manage what is not measured. In addition, measurement is a self-fulfilling prophecy; what is measured tends to change in the direction intended. Real-time, measured feedback is essential for maximizing performance. However, a word of caution is necessary here. The sub-optimalization principle in general systems theory is that if each sub-system or component of the system, regarded separately, is made to operate with maximum efficiency, the system as a whole will not operate with the utmost efficiency.[5] That is why it is important to measure integrated throughput in addition to assessing the performance of component processes.

Conclusion

In parallel with the healthcare system's transition to value-based payment, physicians in positions of leadership must develop a skill set that focuses on managing relationships, and also learn new ways to invest in their own success. How can physician leaders maximize their performance in service of the greater good of others? Like most challenges in life, there is a ladder to climb on the way towards maximizing potential. A danger is the emphasis during formal medical training on the pursuit of perfection. When physicians are expected to be perfect it is difficult to publicly express vulnerability. Unless one is willing to admit that his or her current state of knowing is either incomplete or incorrect, one cannot learn. At the earliest stages, formal courses and literature review create insights and build skills and competencies. At first these tend to be formulaic, prescriptive, and rote, which is typical of the journey from neophyte to expert. With experience, knowledge matures to wisdom, something especially important in the world of the intangibles.

This physician leadership journey is analogous to the physician's journey from medical student through residency, fellowship, and years of practice. Ideally these skills become polished in thoughtful reflections that attend cumulated experience. At any stage of development it is important for physician leaders to identify and engage coaches, mentors, and guides who can help nurture their desire to be all they can be in service of others.

The Governance Institute thanks Joseph S. Bujak, M.D., FACP, healthcare speaker, facilitator, and consultant, for contributing this special section article. He can be reached at jbujak@attglobal.net.

3 Daniel H. Pink, *Drive: The Surprising Truth about What Motivates Us,* Penguin Group, 2009.

4 *Leadership and the New Science: Discovering Order in a Chaotic World* (3rd Edition), Barrett-Koehler, 2006.

5 Lars Skyttner, *General Systems Theory: Problems, Perspectives, Practice,* World Scientific Publishing Co. (U.K.), 2005.