



Healthcare Trustees
of New York State

Hospital-Medical Staff Culture Clash: Is It Inevitable or Preventable?

The Challenge of Governance

Published by Healthcare Trustees of New York State

May 2005

Written By

Martin D. Merry, M.D.

*Adjunct Clinical Associate Professor
of Health Management and Policy
University of New Hampshire*

Doctors Sue Hospital Trustees

Physician ordered not to discuss removal from board.

*~ Front page headline
in a local newspaper*

Introduction

Tensions between hospital medical staff and hospital administrators have been growing since the rise of the latter as a recognized and respected profession with the vast post-World War II expansion of hospitals and hospital services in the United States. Both groups are united in their desire to offer patients and communities optimal health services; however, all too often promising intentions are thwarted by conflict. Typically, this conflict stems from different mindsets and unconscious assumptions that the groups bring to the table. To address this problem, hospital administrators are encouraged to:

- recognize culturally-based differences in the perceptions of key stakeholders;
- assure positive contexts for creative conflict management; and
- envision a new, collaborative culture that embraces the best of what each stakeholder brings to the emergent system.

The front page of the local newspaper is not a place hospital board members, chief executive officers, or medical staff presidents would like to read about themselves.

On the surface, this story sounds familiar: another power struggle over who is really running the hospital – the person on top of the hospital management hierarchy or the

person(s) on the top of the patient care hierarchy.

This particular version of hospital medical staff conflict grew directly from hospital cost constraints of the mid to late 1990s. This was a period of unprecedented ascendancy of managed care's power to dictate or negotiate lower payments to hospitals, which responded by cutting expenses. At a certain point, continued cost cutting threatened to affect patient care. Hospital admitting physicians began to take notice. Confident in the power they had traditionally wielded, physicians individually or as medical staff made their demands known to hospital administrators.

However, something unexpected sometimes resulted from these meetings. In the specific case generating the above headline, the medical staff took their case directly to the hospital board, in the person of the medical staff's elected president who was an ex officio member of the board. Month after month, this physician aggressively made his case, implying a growing lack of confidence in hospital management.

In the past, such a scenario often resulted in the updating and distribution of the chief executive officer's (CEO) resume, not infrequently followed by a medical staff "vote of no confidence," followed by a "fresh start elsewhere"

for the unfortunate CEO. After all, what community lay board—faced with 100+ angry physicians whose patient admissions were the financial lifeblood of the hospital versus with one highly replaceable CEO—could withstand this kind of pressure?

However, this story played out differently. In a true, “man bites dog” twist, the medical staff president, not the hospital CEO, received his walking papers from the board. Fed up with this particular individual, and in a direct challenge to the medical staff bylaws, the board told the medical staff, in effect, “We don’t care who you elected as your president and representative to the board, we will not tolerate this individual any longer. You can send whoever else you wish.”

Backed by the state Medical Society and American Medical Association, the medical staff filed suit, generating the above headline. The state hospital association and the American Hospital Association supported the hospital. The case went before the State Supreme Court, where it was thrown out on a technicality. The de facto “winner” was the hospital governing board.

Just what made this conflict so explosive, that propelled this story to the front pages of local news media, to national wire service coverage, and ultimately to the state’s highest court? This conflict was more than a simple power struggle over who would prevail in key financial decision making at the hospital. This was at root a culture clash between two groups—physicians and lay administrators/board members—who brought very different mindsets to the boardroom. In a very real way, the two groups were using very different “cultural languages,” with neither able to translate the other’s words.

I. Culture: Is It Finally Time to Understand and Manage It?

Just what is “culture,” and how did this “collision of cultures” get so out of the control of otherwise thoughtful, intelligent, caring, and well-intended individuals?

It was not only control issues over financial decisions but also a deep personal and professional cultural divide that separated this physician leader from his lay administrative counterparts. This story was, in fact, just one of a large number of cultural fault lines that made their appearances in the decade of the 1990s. As the editor of the Integrated Healthcare Report stated as early as 1994, “I can tell you that I hear about the

problem of mixing very different cultures all the time. For example, academic vs. community, solo vs. group practice, hospital vs. physician, and payer vs. provider. Organizations that are attempting to integrate physicians need effective approaches to creating a unified culture.”¹

As these parties come together, they are finding that they are ill prepared to deal with often significant orientation and communication gaps that flow from their very different training and experience. They find, in short, that they are operating from very different professional cultures.

II. Defining Organizational and Professional Culture

Organization expert Edgar Schein defines culture as a pattern of shared basic assumptions:

- learned by group members;
- taught to or assimilated by new members;
- used to solve problems of survival; and
- affect the way members perceive, think about, feel, and act in all aspects of their daily work life.

He also notes that “once shared assumptions exist, they function to provide meaning to daily events, make life predictable, and thus reduce anxiety.”²

Mr. Schein’s definition suggests that an organizational or professional culture is something that individuals absorb over time as a guidance mechanism. This relationship of culture development over time has an important implication: Culture is, by its very nature, oriented toward the past. As another has distilled, “Culture is the sum total of ways of living built up by a group of human beings and trans-

mitted from one generation to another.”³ Further, in noting that culture serves, among other purposes, to counter anxiety, Mr. Schein implies that in times of stress culture may come forth to exert especially significant influence.

So, if one is under stress, will a professional culture that is built up over time and received by the current generation encourage a leap forward into the future? Alternatively, might it tend to draw one into a more familiar territory; a time, perhaps, when the world seemed more in order—like the past? And if physicians are drawn to a time of **greater autonomy**, and if administrators fall back on their training and experience in managerial notions of “**command and control**,” what is likely to happen when these parties disagree over an issue of major importance? In this context, the case study above may not be so bizarre as it first might appear. While extreme in its ultimate manifestations, the conflict is quite understandable in terms of the huge personal and professional cultural gap that separates the parties.

III. Is Culture Something That Can Be Understood, Perhaps Managed?

Picture an average lunch hour in the doctors' dining room, a sanctuary where only physicians can gather. On a given day, the hospital CEO shuns her business suit, dons a white lab coat with monogrammed name and title, hangs a stethoscope casually around her neck, perhaps even clips a pocket ophthalmoscope to the breast pocket. She picks up her cafeteria tray and strolls nonchalantly into the physicians' dining room.

Levels of Culture

ARTIFACTS—Visible, hearable, feelable manifestations of underlying assumptions, such as behavior patterns, rituals, physical environment, dress codes, stories, myths, and products.

SHARED VALUES—Espoused reasons for why things should be as they are, such as charters, goal statements, norms, codes of ethics, and company value statements.

SHARED BASIC ASSUMPTIONS—Invisible but surfaceable reasons why group members perceive, think, and feel the way they do about external survival and internal integration issues, such as assumptions about mission, means, relationships, reality, time, space, etc.

~ Adapted from Edgar Schein

Will a few eyebrows rise? Will this be a topic of discussion in the surgeons' locker room? Will the "medical staff underground" begin to buzz? In Mr. Schein's concept, the CEO has entered the realm of "levels of culture." In particular, she has violated a taboo related to cultural *artifacts*, which Mr. Schein defines as "visible, hearable, feelable manifestations of the underlying assumptions, e.g., behavior patterns, rituals, physical environment, dress codes, stories, myths, products, etc." She has *visibly* usurped a whole series of artifacts that declare, "I am a physician," and then openly entered a space that all previously had *assumed* was the domain of "physicians only."

Why might the CEO's action elicit so visceral a response from the physicians? What is the big deal anyway? From the perspective of culture, the answer to these questions lies not on the "artifactual" surface, but below—in Schein's realm of values and assumptions. Values are probably not a problem among physicians and operations managers. In fact, in discussions and during the course of retreats

focusing upon institutional mission, physicians and administrators typically share many values regarding what health care is all about—*healing, community service, etc.*

Assumptions operate, according to Mr. Schein, beneath the level of day-to-day consciousness. They influence people from a space that they tend not to recognize. No one believes that the medical staff president and the board consciously planned and carefully, methodically carried out the events that put them on the front page. Indeed, it would be surprising if all parties did not at some point ponder how they had become caught up in such a strange tale—especially after finding themselves on their local newspaper's front page.

Assumptions are a potentially treacherous locus of contention because they are generally unseen, and thus not considered by either physicians or administrators as they go about their daily work. Both groups tend to be blind to culture's influence on day-to-day actions and how their unconscious assumptions affect their attitudes, actions, and reactions to one another.

IV. Is Culture Just a Passing Fad—Or Is It Really Important?

Just how significant is this notion of organizational culture as a general issue of institutional management? We need not look far for some authoritative endorsement of culture's importance.

Management is about human beings. Its task is to make people capable of joint performance, to make their strengths effective and their weaknesses irrelevant. This is what organization is all about, and it is the reason that management is the determining, critical factor . . . Because management deals with the integration of people in a common venture, it is deeply embedded in culture . . . Thus one of the basic challenges managers . . . face is to identify those parts of tradition, history, and culture that can be used as management building blocks. . . Every enterprise requires commitment to common goals and shared values. Without such commitment there is no enterprise, there is only a mob. The enterprise must have simple, clear, and unifying objectives. The mission of the organization has to be clear enough and big enough to provide common vision. The goals that embody it have to be clear, public, and constantly reaffirmed. Management's first job is to think through, set, and exemplify those objectives, values, and goals.

~ Peter Drucker, *The New Realities*⁴

Technological change still drives education processes today, but with two differences. The first is that the change comes with a disruptive relentlessness that used to take decades to play itself out, and now takes only years or months. The second difference is that our concept of technology is opening up to include managerial issues. Culture is probably the most dramatic of these issues. Time was, not long ago, when people believed that a culture, even a business culture, was a given. Like the weather, it was something you couldn't do anything about. Now when managers speak of their business culture, as often as not it's to talk about changing it, using it, manipulating it in some way—to better serve the business. Culture has become a tool . . . managers today must live the questions, [of which] there are four . . . They have to be lived simultaneously, but I present them here in the order of priority:

- What is this business for?
- What kind of culture do we want?
- How do we do our work?
- What kind of people do we want to work with?

~ James Champy⁵

As historians and sociologists who have studied American medicine have observed, the relationship between hospital and physician has been fraught with conflict for most of this century Both sides of the hospital/physician relationship were able successfully to achieve remarkable growth without resolving the fundamental tensions between them. The current generation of health care executives, medical school deans, and physician leaders are caught in the transition from an atomized entrepreneurship to an organized, collegial physician culture. Fostering collegiality – a scarce commodity in the current clinical environment – is the essential task in creating an integrated health care enterprise. In the explosive climate of many medical communities today, the task of leadership is akin to driving a nitroglycerin truck along a bumpy road. Leaders without the political skills to sense the bumps before they hit them will never know what hit them.

*~ Jeff Goldsmith
Hospital/Physician Relations:
A Constraint to Health Reform⁶*

As these references suggest, **those who ignore this vital dimension of organizational life do so at their peril.**

V. Probing Culture For Its Learnings and Its Action Implications

If we are willing to grant for a moment that organizational and professional cultures are important and that assumptions constitute a core, potentially powerfully influential element of culture, it makes sense to inquire into what processes create the assumptions that physicians and managers bring to their discussions and negotiations.

Our first stop in this inquiry relates to the educational processes of physicians and managers. Sandra L. Gill has concisely outlined the very different orientations and behavioral characteristics that tend

to emerge from medical doctor and business/health administration education.⁷ Medical schools and business/health administration programs turn out graduates with quite different “programming.” Moreover, attitudes and behaviors wholly appropriate to the patient’s bedside or the operating room may be woefully inappropriate in the boardroom. This different “programming” can lead to a collision course between physicians and managers in times of stress over the future of a health care entity, as each brings an entirely different set of mindsets to the table.

Key Differences Between Physicians and Managers

PHYSICIANS

Doers
 Reactive
 Immediate response
 Deciders
 Autonomous
 Independent
 Patient advocate
 Professional identity
 Independent professional

MANAGERS

Designers
 Proactive, long time span before results
 Long-term response
 Delegators
 Collaborators
 Participative
 Organization advocate
 Organizational identity
 Interdependent professional

~ Sandra L. Gill

However, the cultural gap does not end with the very different professional cultures that flow from medical schools and business/health administration education. Hospitals have operated historically as *de facto* split organizations. Two distinct lines of authority have characterized this split: clinical services dominated by physicians and the medical staff organization and operations services managed by a traditional management hierarchy.

To complicate the picture even further, the medical staff organizational structure does not share the accountability hierarchy of the operations side of the hospital. In fact, the medical staff is a "mini-democracy." That is, the board does not select physician leaders, as the organization chart would imply. They are chosen by their peers in periodic elections. This places physicians in the position of having defined legal/institutional accountability for quality *up* the organization, to the board. But they are simultaneously accountable *down* the organization, to the rank-and-file physicians who elected them (and whose bylaws contain language on how the rank and file can remove them). So, in times of perceived conflict between physicians and the hospital, which accountability are medical staff leaders likely to feel with the greatest heat? Will it be that from the bankers, lawyers, and corporate chiefs (and hospital CEO) serving on the board or the colleagues with whom they reciprocally refer and care for patients on a daily basis?

In the past, this arrangement has somehow carried on, but at a large, and now unsustainable, cost. As many hospital and health system chief financial officers will attest, the money to support the inefficiencies of such an aberrant organizational structure is rapidly vanishing.

The combined effects of isolated professional enculturation and structural isolation of physicians and managers in their daily work have created a situation unsustainable at any cost. As they face the very real necessity of massive health care system redesign, each group needs the other. In sum, the time has arrived in which these two groups must work more collaboratively to design and implement new health systems.

If it is from the level of conflicting assumptions that cultural conflict arises, it will be necessary to bring these assumptions to the surface to make the invisible visible.

An example illustrates how differing cultural assumptions work their way into the day-to-day functioning of hospital culture. Reflecting perfectly the symbolic meaning that cultural artifacts convey, one medical staff among the author's experience commonly refers to administration as "mahogany row." While referring literally to the wood paneling adorning the administrative corridor, this term also carries rich symbolism. It reveals physicians' *cultural assumptions* regarding administration. Indeed, when told this

Creating the New Culture:

- Adopt and promulgate a new "system" vision.
- Identify beliefs in the old culture that must be changed as well as traditions to be honored.
- Implement an explicit cultural change plan that is linked to major strategic changes.
- Involve persons in designing the new system.
- Align individuals' economic incentives with the new vision.
- Lead change, don't manage it.

~ Philip Nathanson

story, physicians in any audience know intuitively just what these two simple words connote: a physician viewpoint of administration as misguided in their sense of priorities (community institution instead of “doctors’ workshop”), pretentious, bureaucratic, isolated from the “real work” of the hospital, and—perhaps *most* insidiously—*whose work is inherently less important than that of physicians*. Is it surprising that administrators subjected to behaviors emanating from this assumption might perceive physicians as demanding, arrogant, or otherwise difficult to deal with?

Is there evidence that corroborates these observations regarding physician and managerial cultures in conflict? Unfortunately, the whole subject of professional cultures in health care seems curiously understudied. Perhaps the dual pressures of managed care and massive health care restructuring are just now bringing this “sleeping giant” of health care organizational function to light. Anecdotes abound. For example, at a recent hospital board retreat attended by physicians, administrative staff, and board members, table groups were asked, among other questions, what administration needed

from physicians. The mostly highly rated need cited by the administrative staff turned out to be “respect for each other so that we all can progress, as expressed by physicians a) behavior and b) treating administrative and nursing staff with respect.” This speaks volumes about what these administrators were experiencing in their day-to-day encounters with physician members of the medical staff.

Such physician attitudes are based most likely not on any *inherent* sense of superiority, but on their (again, assumption-based and thus culturally-driven) belief that the primary work of health care is what *they* (physicians), not managers, do. The obsolete “doctors’ workshop” concept of a hospital is still the “mental model” to which many physicians (largely unconsciously) continue to adhere, and this no doubt is the source of many of their “we own this place” attitudes and behaviors. Given the absolute interdependency of clinical and management science in today’s health systems, such a notion is now dangerously obsolete and wholly counterproductive to the effective development and management of health systems.

VI. A Proactive Approach to Creating and Managing Organizational Culture

"Ready, Fire, Aim!"

What is the best setting in which to begin a dialogue on creating a new culture? Familiar settings with their plethora of cultural artifacts tend to perpetuate "programmed" cultural viewpoints. The off-site retreat may offer opportunity to break free of these cultural stereotypes. The physical surroundings are new, all dress casually, no pagers interrupt, and people can connect easily. This is a setting in which all might probe beneath the surface of cultural artifacts to discover common values, to better understand one another's basic assumptions—and perhaps to envision a new, common vision that encompasses the best of everyone's positive intent.

The formula for such an event might be:

- invite stakeholders;
- budget adequate time (two to three days is optimal);
- select an environment that honors and nurtures participants (e.g., includes families);
- establish a process that, at a minimum a) encourages participation, b) probes values and assumptions, and c) allows people to change with dignity;

"Ready, Fire, Aim!" continued on page 16

Given the dimensions of the divide between physicians and managers, how can health care leaders move beyond this potential cultural snake pit? If they are, in fact, locked into culturally-driven conflict, physicians and administrators desperately need new forums for communication and understanding. Culture-based conflict has a truly perverse ability to be self-perpetuating. Protagonists become locked into stereotypical behaviors that have the effect of fueling their disagreement, maintaining their misunderstanding and distance. Each party sees clearly the perverseness of "the other side," even as each remains largely blind to how their own behaviors sustain the frustrating "dance."

Leaders facing such an organizationally paralyzing dilemma should create an explicit cultural development concept, one that is integral to strategic planning efforts involving both organizations and physicians. The following is a basic formulaic approach to proactively address the creation of unified clinical/managerial organizational cultures.

1. Develop an explicit organizational culture development plan.

Philip Nathanson got the basics right in a recent article.⁸ This is not surprising, since he writes not from

theory, but from his own experience in creating one of the more successful health systems in the United States.

2. Hold an off-site retreat. Do it at a first-class location, the best affordable.

For success, a retreat (some prefer to call them "advances") must dig all the way down to the level of cultural assumptions. To accomplish this "cultural excavation," it is essential to escape past cultural "tar pits," to move creatively "outside the box" of prior thinking and actions. Participants must escape the day-to-day environment that, under the strong influence of embedded cultural artifacts, constantly reinforces the old culture.

Invite families—make sure that social events and recreation accompany the hard work of the retreat. Culture is deeply human in its essence, and it is vital to plan culture change around the inherent humanity of people. This humanity is even more basic than their professional and institutional conditioning. Tapping into this humanity is a vital part of addressing such deep issues as the cultural assumptions that will guide future planning and implementation efforts to form the basis of a new, collaborative organizational culture.

3. Make sure the agenda will do it.

The old-style agenda that had various parties “reporting their activities” to one another to “maintain communication” simply does not cut it anymore.

An off-site retreat offers a unique opportunity to break up cultural stereotypes, leave home back home, and move into a substantive agenda designed to foster change. Elements of such a change-oriented agenda include:

- a concentrated environmental assessment specifically relevant to the goals of the retreat;
- focused attention to processes that can surface values and assumptions of participants, e.g., story-telling about why individuals chose health care as either a vocation (physicians and managers) or major commitment (trustees);
- exercises built around organization vision and mission—and particularly how the environmental assessment and values/assumptions influence this vision; and
- action planning, with specific follow-up plans and assignment of responsibility.

“Seek first to understand, then to be understood,” a gem from Stephen Covey’s best-selling classic, *7 Habits of Highly Effective People*, might function as an ideal theme for such retreats.⁹ The parties often arrive at such retreats with a strong sense of “what’s

wrong with” the “other side.” It is essential in such a climate to begin a process of letting go defended positions, to begin the pursuit of a more unified, clinical-managerial culture. And since such retreats bring in trustees representing a myriad of businesses, professional orientations, and community viewpoints, it is vital for all parties to listen to one another, to begin a process through which they might understand the deeply embedded assumptions that underlie the diverse personal, professional, and organizational cultures present.

4. Understand that only a “new leadership” will make it happen.

An old, power politics-based, “command-and-control” leadership is unlikely to enjoy sustained success in the incredibly complicated and dynamic environment that characterizes health care organizations. A leadership definition relevant to the creation of unified organizational culture might be “the ability to influence people to move in a direction and/or toward a goal they might not otherwise choose.”¹⁰ Today’s successful leaders will not simply “command-and-control” people into line. The demands of a market-driven health care system, one with increasingly knowledgeable and assertive patients/consumers and employees, will demand the same breed of change masters in health care that other world class industries have bred over the past decade. Two authors of recent *Harvard Business Review* articles have nicely captured the essence of this “new leadership.”^{11,12}

“Ready, Fire, Aim!” continued from page 15

- outline a future reality around shared values and assumptions; and
- develop actions, measures, and follow-up plans.

A commitment to action/follow-up is key to focusing and building upon the energy that such a retreat can generate. Given the current level of uncertainty in health care, no one should conceive a retreat process as offering a precisely-aimed “rifle shot” to future success. The metaphor is not “ready, aim, fire.” Establish a “good enough” action plan to focus people’s energy, launch actions, and establish a process that can constantly correct the future course. In other words, the effective path is “ready, fire, aim.”

Leadership

"The ability to influence people to move in a direction they otherwise might not take."

~ Martin D. Merry, M.D.

"As Peter Drucker has pointed out, the chief object of leadership is the creation of a human community held together by the work bond for a common purpose. Organizations and their leaders inevitably deal with the nature of man, which is why values, commitments, convictions, even passions are basic elements in any organization. Since leaders deal with people, not things, leadership without values, commitment, and conviction can only be inhumane and harmful."

~ Warren Bennis

It is beyond the scope of this commentary to delve further into the leadership and management science these leaders must tap. The global economy is spurring prom-

ising advances in management and leadership science. Knowledge of and skills in this "new leadership" are an essential resource to leaders, and the literature is growing.*

"A hospital or health system has its own soul and spirit, and these are derived from its personality, culture, and values."

~ Robert E. and Richard K. Toomey

"There must be some reason that this [systems integration] will make professionals feel better about their work. Something has to get better in the care of patients; something has to be more professionally interesting and exciting. It's not enough just to make it a business proposition."

~ James Reinertsen, M.D., CEO of HealthSystem Minnesota

". . . (T)o successfully respond to the myriad changes that shake the world . . . transformation into a new style of management is required. The first step is the transformation of the individual."

~ W. Edwards Deming

*Articles on the "New Leadership" in addition to those already referenced are included as the resources that follow the references for this commentary.

VIII. Conclusion

Few seriously argue anymore that health care in the United States is evolutionary; it is in a revolutionary phase. Ever since the passage of Medicare legislation in 1965, it seems that creative health care financial wizards have figured out how to “game” every cost-containment idea the payers have invented. The net result has been an unconscionable escalation of health care costs over the past 30 years. Because of work publicized by the Institute of Medicine of the National Academy of Sciences and other respected authorities, we know also that far too many seeking health care are actually harmed via inadequate systems and the human error caused by deficient systems design. Most would agree, despite its capability for miraculous cure, U.S. health care today is a mess. Will we be able to overcome cultural clashes, will we be able to seek a higher purpose in the collaborative redesign of health care in America? Will we be able to develop both the vision and implementation strategies that might create truly innovative health care systems?

Some provider communities will be spectacularly successful in addressing this challenge of creating patient/community-oriented, superb value (high quality, reasonable cost) health care systems. Systems that fulfill these visions will be those that will master the challenge of creating unified cultures between practitioners of the clinical and managerial sciences. In so doing they will point the way toward health systems delivering value that is virtually unimaginable by those still locked into cultures of a past era.

Resources Relevant to the “New Leadership”

- Bennis, Warren & Burt Nanus. *Leaders: The Strategies for Taking Charge*. New York: Harper and Row, 1985.
- Block, P. *The Empowered Manager: Positive Political Skills at Work*. San Francisco: Jossey-Bass, 1989.
- Covey, SR. *Principle-Centered Leadership*. Fireside, 1992.
- Dreher, Diane. *The Tao of Personal Leadership*. Harper, 1997.
- Drucker, Peter F. *Managing in a Time of Great Change*. Truman Talley Books/Dutton, 1995.
- Jaques, E. and Clement, CD. *Executive Leadership*. Arlington, VA: Cason Hall & Co., 1991.
- Labovitz, G. and V. Rosansky. *The Power of Alignment*. New York: John Wiley & Sons, 1997.
- Morgan, Gareth. *Images of Organization*, 2nd Edition. Sage, 1997.
- Senge, PM. *The Fifth Discipline*. New York: Doubleday/ Currency, 1990.
- Stacey, RD. *Complexity and Creativity in Organizations*. San Francisco, Barrett-Kohler, 1996.
- Weisbord, M. *Productive Workplaces*

Endnotes

- ¹ Private communication, John Cochrane to author, October, 1994.
- ² Schein, EH. *Organizational Culture and Leadership*. Second Edition. San Francisco: Jossey-Bass, 1992.
- ³ Sigmond, Robert M. *Collaboration in a Competitive Environment: The Pursuit of Community Health. Frontiers of Health Services Management*. V 11, N 4.
- ⁴ Drucker, Peter F. *The New Realities*. New York: Harper & Row, Publishers, 1989.
- ⁵ Champy, James. *Reengineering Management*. Harper Collins, 1995.
- ⁶ Goldsmith, Jeff, *Hospital/Physician Relations: A Constraint to Health Reform*. *Health Affairs*: 12:3.
- ⁷ Gill, Sandra L. *Can Doctors and Administrators Work Together? Physician Executive*, September-October, 1987.
- ⁸ Nathanson, Philip, *Health System Leader*, Vol. 2, No. 8.
- ⁹ Covey, SR. *The 7 Habits of Highly Effective People*. New York: Simon & Schuster, 1990
- ¹⁰ Bennis, W. *On Becoming a Leader*. Reading, MA: Addison-Wesley Publishing Company, 1989.
- ¹¹ Heifitz, R. and D. Laurie, *The Work of Leadership*, *Harvard Business Review*, V 75, N 1.
- ¹² Kotter, John P. *What Leaders Really Do*. *Harvard Business Review*, Vol. 68, No. 3.

HEALTHCARE TRUSTEES OF NEW YORK STATE

One Empire Drive / Rensselaer, NY 12144 / (518) 431-7999 / www.htnys.org