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MASTER OF ARTS IN LEADERSHIP
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

This is to certify that the Master's Thesis of

Carol L. Watson Saunders

has been approved by the Review Committee for the Thesis requirement for the Master of Arts in Leadership degree

Date of Oral Defense: 01/23/2001

Committee: Rosemary Link
Advisor

[signature]
Reader

Anna M. Hillenbrand
Reader

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Abstract

Servant Leadership is a theory of leadership in which the Servant Leader is motivated primarily by an intuitive desire to serve his/her followers. The leadership aspect is secondary. In this study, the concept of Servant Leadership was applied to the physician-patient relationship in a healthcare setting. The purpose of the research was to determine the satisfaction level of patients with their physicians. Questionnaires were mailed to one hundred randomly selected patients at a large mid-western outpatient clinic. Following are several of the questions included in the questionnaire. On the average, how long do you have to wait to see your physician? What is your level of trust with your physician? How well does your physician respond to your concerns? Does your physician tell you what you need to know? Do you feel that your physician would "go the extra mile" for you? Do you view physicians as leaders in the Clinic? The responses generally indicated high satisfaction with and a high level of trust in the physicians, and an indication that Servant Leadership is being practiced, although the respondents did not use that terminology. However, several respondents indicated that improvement is needed. Continuation of this research is important because physicians need to know what patients expect from them, and how they are performing in their patients' eyes. Physicians are naturally seen as leaders. The decisions they make and how they behave affects their patients, the clinic as an organization, and the community in which the physicians practice. Patient satisfaction is an important tool for measuring quality of healthcare. Research that builds on or adds to previous research benefits patients and physicians alike.

The goal of the researcher is to gather and present information that could be used to develop a model of Servant Leadership, which could then be used in healthcare settings to enhance patient satisfaction and improve the quality of patient care.

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CHAPTER I: BACKGROUND

INTRODUCTION

Quality of care is an important issue in healthcare today. Measuring patient satisfaction is one of the ways to measure that quality. Patient satisfaction is defined as the level of comfort a patient feels while in his/her healthcare clinic. Improving the level of patient satisfaction is becoming more and more important to healthcare managers seeking ways to adapt their institutions to the rapidly changing healthcare environment. Increasing patient satisfaction means expanding the patient's comfort zone. Among the benefits of increased patient satisfaction are: improved patient retention, increased patient referrals, more productive staff, improved collections, greater efficiency, and reduction in the number of malpractice lawsuits.

Improving patient satisfaction takes leadership. The kind of leadership practiced in healthcare organizations is very instrumental in determining the quality of care. Another important factor is the presence of health maintenance organizations (HMOs) and their role in recruiting physicians, who in turn are responsible for patient care. Leadership is important because of the relationship between physician behavior and practices and patient satisfaction and because the physician is viewed as a leader by patients and staff alike. Today, however, physician leadership is limited by the control of HMOs.

Leadership is manifested in many ways. Titles such as Chief Executive Office (CEO), Manager, and President can be, but are not always the same as leader.

Leadership, however, is a skill that is essential to an organization's vitality and success. This is especially true in an environment of constant change, such as the current health care environment. Other medical personnel and the community at large, as well as patients, routinely see physicians as leaders. Because of their role as leaders, physicians have a unique opportunity right now to exercise Servant Leadership and to improve the level of patient satisfaction in the process.

In the clinic, physicians are viewed as leaders because it is they who set the tone and make decisions that affect the entire clinic, as well as the patients they treat. The physicians generally are in charge or in control of what happens in the clinic. The research shows how leadership is a natural role for physicians, and how they, as Servant Leaders, can positively impact the satisfaction levels of the patients under their care. The focus in this research is on the patient in a complex domain. The research survey speaks to the balance between the physician-patient relationship. The research consisted of surveying adult patients at a large mid-western out patient clinic. **The purpose of the research** was to measure the satisfaction level of patients as it relates to the medical care provided. By determining what contributes to patient satisfaction, it is believed that a model of Servant Leadership can be developed that could be utilized by physicians to improve patient care. The research question is: how satisfied are patients with their physicians, and will the exercise of Servant Leadership on the part of physicians positively impact patient satisfaction?

The researcher acknowledges the important role that health maintenance organizations (HMOs) play in the operation of clinics and in the overall delivery

of healthcare today. However, the researcher purposely did not address the issues surrounding HMOs and the way healthcare and patient satisfaction is impacted by HMOs. The topic of HMOs is such a huge issue that it would have obscured the main topic of this research, which is patient satisfaction. Perhaps HMOs and how they have changed healthcare would be a good topic for future research.

There are many theories of leadership. The theory chosen for study in this research was the theory of Servant Leadership. Robert K Greenleaf first coined the term Servant Leader in an essay he wrote in 1970. When it was first presented, this theory was in contrast to the traditional theory of a leader in that the usual trappings of power and authority do not encumber Greenleaf's Servant Leader. The nature of leadership is determined by the Servant Leader's own motivation and also by the perceptions of others in the group, i.e., followers.

The Servant Leader begins with a natural feeling of wanting to serve his/her followers. The conscious choice to lead is secondary to the desire to serve. Greenleaf uses the character of Leo from Herman Hesse's Journey to the East to illustrate his notion of the Servant Leader. In the story, Leo's role is that of servant to the group of people he travels with; he performs menial chores. He also inspires and sustains the group with his spirit and his songs. When Leo disappears, the group becomes disoriented and disorganized, and eventually falls apart. Much later, it becomes apparent that Leo actually was the leader of the group.

In Chapter II, recent literature pertinent to the topics of patient satisfaction, leadership and the American healthcare system are reviewed to form the

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theoretical framework for the research. In Chapter III, the researcher states the problem, defines the research question and the variables, lists assumptions and limitations of the research, and discusses the significance of the study.

The researcher then presents the methodology for the research, including the research design, the setting of the research sample, measures taken to protect human subjects, the data-gathering instrument, and the procedures for analysis of the data. In Chapter IV, the data collected from the research is presented and discussed. Chapter V includes concluding remarks and recommendations drawn from the results of the research; the concluding remarks also include implications for leadership.

CHAPTER II: REVIEW OF THE LITERATURE

Patient Satisfaction

A definition of good healthcare is essential to make an accurate assessment of patient satisfaction. Let us explore the concept of good medicine. According to Knowles (1965), some of the fundamentals of good medicine are as follows. The physician should do no harm to the patient. The physician and healthcare organization should emphasize preventive services, educating patients to behave in more healthful ways. Communication and interaction should occur easily between patients and practitioners of healthcare. The physician or healthcare provider should treat the patient as a whole person by examining all factors that may affect the patient's health, both physiological and psychological. All efforts should be taken to avoid duplication of services and to provide for the highest possible level of efficiency, applying the latest in medical knowledge to the treatment process.

The most important measure of quality healthcare is a favorable outcome, successful surgery or treatment of a disease. However, this is not possible in all situations. A second way of measuring quality of healthcare is to measure the process of care giving: the measure of what is done and how well it is done while care is being rendered. A third measurement is to assess the facility or organized system in which healthcare is provided. The Joint Commission for Accreditation

sets the standards for hospitals nation-wide. Physicians have to pass state board exams before they are considered qualified to practice medicine; some physicians receive additional subspecialty training and certification.

Another measure of quality healthcare is patient satisfaction, which involves the following elements: cost versus convenience, outcome of care, and the patient-provider relationship. "Satisfaction creates a better business relationship in our competitive world and more word-of-mouth marketing", (Williams & Guerra, 1991, p.286). "Quality is the underpinning of good medical care and patient satisfaction" (Brown, Nelson, Bronkesh, & Wood, 1993, p.5). Merkouris, Ifantopoulos, Lanara, and Lemonidou (1999) discuss the increased interest in patient satisfaction as a valid indicator of the quality of nursing care, as well as the need to develop valid and reliable instruments to measure patient satisfaction, thus improving the quality of care.

Authors Brown, Nelson, Bronkesh, and Wood (1993) ask the question: If the patient isn't your customer, who is? Service is a business strategy; the delivery of healthcare is a business. Your patients are your customers. Patient satisfaction is one of the criteria by which physicians are chosen and retained. Business, industry, government, managed care and the patients alike all rate medical practices. Patient satisfaction is not an option. Clinical quality + service quality = patient satisfaction. " Patient satisfaction pays, economically and clinically. It solidifies loyalty and compliance, attracts new patients, and can improve practice productivity and efficiency…quality service is not a fad but a long-term reality

that directly affects medical care, patient outcome, and the success of your practice" (Brown, Nelson, Bronkesh, & Wood, 1993, p.5).

Mitry and Smith (1979) state that patients form their perceptions of satisfaction with healthcare services according to economic and behavioral quality dimensions. Economic dimension is defined as the complex utilization of available medical techniques, resources, and labor. The behavioral dimension includes full consideration of the needs of the patient-physical, psychological, and sociological.

According to Newsome and Wright (1999), satisfying patients has become a key task for all healthcare providers. Healthcare administrators, who often are physicians, are responsible for closing the gap between what patients need and want, and what healthcare organizations provide. One way of closing this gap is to utilize evaluations that measure patient satisfaction, a shift in the demand for services, and oral and written comments and complaints. Administrators may not be able to control or influence all variables in patient satisfaction, but they should at the very least, be aware of the variables, and be willing to improve those that are within their control.

Primary to this research is a discussion of what a patient may expect from his/her physician-what patient satisfaction means. G. J. Annas (1975), an ethicist, speaks of the rights patients have to assert themselves in what for many is a situation in which they feel powerless. Annas discusses the rules that healthcare facilities must follow in caring for patients, including informed consent and the patient's right to refuse treatment, consultation or referral to other physicians or

healthcare facilities, and abandonment of the patient by his/her physician. Annas reviews the procedures surrounding medical records, confidentiality and privacy of information, human experimentation, the terminally ill patient, organ donation and autopsy, and the payment of healthcare bills. All of these factors may affect patient service and the patient's level of satisfaction with the care given.

Complete medical care means appreciating and addressing the interrelationship of the social, emotional and pathological forces that affect the care of a patient. To paraphrase the Biblical injunction, " the care of the sick is a sacred task " (Field ,1967 p.3). In the not too distant past, patients suffering from prolonged illnesses for which there was no apparent chance of recovery were isolated and considered only in need of custodial care. As medical technology advanced, cures and treatments for many previously incurable diseases were applied to patients. Thus, patients suffering from prolonged illnesses came to be viewed as more deserving of care and consideration.

Illness affects every aspect of the patient's and his/her family's lives, whether or not the patient is in or out of a healthcare facility. Giving the patient back a sense of power and a feeling of comfort are components of good service to patients. Expanding the patient's comfort zone is what improving patient satisfaction means. The benefits to physicians and healthcare facilities of increased patient satisfaction include: improved patient retention, increased patient referrals, more productive staff, improved collections on bills, greater efficiency, and reduced malpractice liability. However, improving patient

satisfaction takes exceptional leadership. Titles such as CEO, manager and president are not the same as leader.

Patient satisfaction is a process as much as it is attitude: it must be planned, monitored and measured. Responding favorably to unhappy patients is a way to improve patient satisfaction. Patient feedback helps to identify problems. Make the solution fit the problem permanently. Don't just find someone to blame; fix the problem.

A number of patient satisfaction surveys have been conducted in recent years. Only a few will be mentioned here. Moores & Thompson (1986) report on the results of questionnaires completed by 1357 former patients of seven acute care hospitals in England. The questions deal mainly with the patient's perception of the nursing care received while the patient was hospitalized. Pettit & White (1991) explored perceptions of quality health care among physicians, nurses, hospital administrators, and patients by means of a self-report questionnaire. The results they received indicated that all groups had a different perception of quality health care. Lebow's " Consumer Assessments of the Quality of Medical Care" (1974) mentions four types of health care studies: structural, process, result, and impact. Structural studies deal with the organization of the institution providing care, how smoothly it functions, and how employee and client (patient) time is used. Studies of the process of care involve an analysis of how well health care professionals behave while rendering care to patients. End result studies focus on what happens after the care is given, what the result of the care is, whether or not the treatment given is successful. The assumption here is that given similar cases,

better care should result in a shorter period of illness, lower mortality rates, and less pain for the patient. Impact studies concentrate on the larger picture, what effect the health care rendered has on the community at large. This approach includes feedback from persons who have not seen physicians, thus providing survey results that can be more easily generalized. A fifth method of evaluation mentioned is a survey of patient perceptions of care. Results of patient evaluation showed that the most important qualities desired by patients are: 1) good doctors, 2) well-trained staff, 3) information from doctors, 4) professional interest in the patient, 5) pleasant staff, and 6) privacy. "Satisfaction was found to be related to improvement in condition, personal interest of the staff in the patient, and explanation received about their conditions" (Lebow, 1974, p.330).

Lebow (1974) also reports on four studies of pediatric patients. The parents of the patients were asked to give their opinions as to how satisfied they (the parents) were with the care rendered to their children. " Results showed that social class, education, doctor seen, length of visit, and diagnosis did not have any relationship to satisfaction with the visit. Patients expected that physicians would be friendly and communicative and when the physicians did not meet their expectations, satisfaction was decreased " (Lebow 1974, p.332).

Within the last few years, more attention has been focused on gathering patient satisfaction information form patient surveys (Gaynor 1999). Surveys have been done at the University of Minnesota Hospitals & Clinics, but the focus has been mainly on hospital services. Patients were surveyed as to the general feeling of satisfaction they received from various hospital services, such as nursing,

housekeeping, admitting, etc. The surveys done for this research are directed toward overall patient satisfaction, with a special emphasis on satisfaction with the services provided by physicians at a large mid-western out patient clinic. The surveys were sent to 100 adult primary care clinic out patients. The intent was to measure the level of satisfaction the patient experiences, and to see how the level of satisfaction could be improved if physicians exercised Servant Leadership.

Change is the norm today. "Security for an organization in an uncertain, changing environment comes not from domination but from flexibility: the ability to innovate and to master change management" (Alliance for Healthcare Strategy and Marketing 1987, p.45).

Leadership

Leadership is a skill that is essential to any organization's vitality and success. This is especially true in an environment of change, such as healthcare. According to Peters (1982), leadership is the most important requirement for organizational success. Peters uses the term "Rushmorean Leaders" to refer to Presidents Lincoln, Roosevelt, and others, whom he considers good leaders. He says that these leaders " live, sleep, eat, breathe, and sweat quality" (Peters, 1982, p.29).

Physicians are routinely seen as leaders by their patients and also by other healthcare staff, as well as by the community in which they practice. Physicians as leaders must have a vision of quality; they must be able to transmit that vision throughout their whole healthcare organization. Physicians have a unique

opportunity to become Servant Leaders by paying attention to what their patients want and by trying to improve the level of their patients' satisfaction. Patient satisfaction is a process as much as it is attitude; it must be planned, monitored, and measured. Responding favorably to unhappy patients is a way to improve patient satisfaction. Feedback helps to identify problems. Patient satisfaction is increased if the solution fits the problem permanently, rather than just finding someone or something to blame.

Leadership, according to Rosenberg & Clarke (1988), is the "process of directing and influencing the activities of group members," (p.48). Leadership involves others, both above and below the leader's level of management. The leadership process operates within an unequal power distribution. Leaders can influence and provide directions to others around them. Leadership involves not necessarily certain traits, but how the traits of the leader are put to use in a given situation. Leadership is a dynamic, ever- changing process that varies according to different situations, leaders, and followers. The process is the key element. According to Rosenberg & Clarke (1988), people are not born into leadership; they develop into leaders. There are certain essential qualities of leadership, which can be learned and practiced by anyone. Three main factors affecting leadership today are: commitment, complexity, and credibility. Commitment involves the difference between the number of paid working hours and the number of productive hours worked among non-managerial staff. Leadership is complex due to the many problems leaders must face while at the same time dealing with rapid, sometimes unexpected changes. Leaders today are under

much tighter scrutiny than in previous generations; their credibility and credentials to be leaders are often questioned. Long past indiscretions and errors in judgment are brought to the public's attention in an effort to erode support for a leader who may be well liked and respected. "Leaders can be targets of severe hostility-not that it is never deserved; sometimes it is. Nevertheless, the anger of others is difficult to bear" (Koestenbaum, 1991, p1).

Bennis (1989) talks about the "unconscious conspiracy" (p14) in the U.S. to prevent leaders of an organization of any kind from taking charge and bringing about changes. He analyzes the problems leaders have to face in order to effect change in their organizations. Among the problems are: bosses as heroes and celebrities; too many chiefs; when wining is losing; and the pornography of leadership. The pornography of leadership occurs, according to Bennis, when a leader takes action without being connected to it, without taking responsibility for the action. Bennis also discusses the Doppelganger Effect, which he defines as the tendency of many leaders to surround themselves with people who look, act, and think as the leader does. This is a natural tendency, but it leads to distortion of the truth. Bennis also talks about the" Me Decade" and how it has produced a generation of Americans who are unwilling to make sacrifices today in order to gain something better tomorrow. All of these and other day-to-day problems and tasks combine to make up the "unconscious conspiracy" which robs leaders of the ability and the strength to effect change.

Gardner (1990) talks about a crisis in leadership in the United States. He conducted a five-year study of organizations, during which time he

interviewed the leaders of organizations. He discussed issues such as elements of motivation, shared values, social cohesion, and institutional renewal. Gardner states that there is a crisis because how today's leaders act will affect the future of society. Today's leaders must understand the needs of the people with whom they work. Leaders need to focus their energies and sustain commitment to the stated goals. Gardner points out that attention needs to be directed to the problems of the large-scale systems that dominate our society. These systems need initiative and responsibility on all levels so that many individuals will be ready and able to become leaders by taking action to make their parts of the system work more effectively.

Bennis and Nanus' (1985) belief is that "leadership is the pivotal force behind successful organizations and that to create vital and viable organizations, leadership is necessary to help organizations develop a new vision of what they can be, then mobilize the organization change toward the new vision" (p.3). They speak of leaders as change agents who enable others to see a new vision, and then empower others to make the vision a reality. They refer to this new kind of leadership as "transformative leadership"(p217). In a more recent book on leadership, Nanus (1992) talks about how the lack of strong visionary leadership today in human institutions, such as the federal bureaucracy, corporations, non-profit agencies, universities and hospitals will be the deciding factor in solving many of the problems in the world today. According to Nanus, a leader has to develop a vision for his/her organization and then share it. "A vision is a realistic, credible, attractive future for your

organization. It is your articulation of a destination toward which your organization should aim…" (Nanus, 1992, p8). Visionary leaders do not feel threatened by change and chaos. They embrace it, because they know that ultimately it will benefit everyone.

In his classic volume on leadership, James MacGregor Burns (1979) talks about different kinds of leadership: moral, political, and intellectual. He gives numerous living examples of leadership in the political arena; he talks about heroes, transactional leadership, and transformational leadership. Transformational leadership is the most beneficial, Burns says, to both the leader and the followers. According to Burns, acts of leadership occur in presidential mansions, in parliamentary assemblies, and also in day- to- day pursuit of common goals by a group of people as well known to us as our parents and teachers.

Koestenbaum (1991) presents his theory of greatness in leadership through the image of the leadership diamond. The four points of the leadership diamond are: vision, reality, ethics, and courage. According to Koestenbaum, there are two sides to leadership: the strategic or external side, and the personal or internal side. Being a great leader means learning what really matters, namely that business is not about making money, products, or offering services. Business, as commerce, is a vehicle to achieve personal and organizational greatness, to accomplish something worthy and noble. Leadership requires teamwork and a change in how you act, preceded by a change in how you think. Success is a

culture that supports short term and long -term goals and objectives. He talks about the four P's: profits, people, products, and pride.

Heil, Parker, and Tate (1995) talk about leadership and the customer revolution. They present the leader as a revolutionary, meaning that a leader has to think outside of the box; a leader has to be creative and non-traditional. The leader is also a system architect, building change into the organizational system. The leader is customer advocate, developing apostles (customers) who are willing to spread the word and share the vision. A leader empowers those around him/her, thus creating an environment of creativity and commitment. People are the link between what the system allows and what the customer ultimately receives. The characteristics of the leader as hero are as follows. The leader deals in transformational change: change that has a positive, lasting effect on both the leader and the followers. The leader adopts the highest possible values, overcomes obstacles, deals effectively with uncertainty, is persistent even in the face of extreme skepticism, and rarely works alone. The leader's own value system drives him/her, rather than being driven by external forces. The leader creates a different sense of order.

Kanter (1983) talks about strategies for innovation, participation and productivity, and change masters. Kanter's change masters are " those people and organizations adept at the art of anticipating the need for, and of leading productive change." (Introduction) She states that the key to the rebirth of American corporations is the development of participation management skills and an environment which makes possible the full use of

new ideas that arise from within the corporation itself. By encouraging innovation and enterprise, managers can empower people to act. People are the most important asset of a company or corporation. "People seem to matter in direct proportion to an awareness of corporate crisis" (Kanter, 1983, p.17). People design innovations; innovations are not designed by machinery or technology. Corporations must rely on people, not the system, for success. Corporations need to foster an environment in which people are stimulated to act and also are empowered to do so.

Much can be discovered about a company by looking at the company's approach to solving problems. Kanter talks about integrative versus segmentalist companies. An integrative problem solving approach is associated with innovation; it is a "willingness to move beyond received wisdom, to combine ideas from unconnected sources, to embrace change as an opportunity to test the limits...to see problems as wholes, related to larger wholes and thus challenging established practices" (Kanter, 1983, p.27).

In segmentalist companies, actions, events and problems are compartmentalized, kept isolated from each other. Problems are solved by breaking them up into pieces. The pieces are then assigned to specialists, who work in isolation. Segmentalist companies are anti-change. Changes are isolated in one segment and are not allowed to touch any of the other segments. Communication between various segments of the organization occurs very minimally or not at all. As a consequence, motivation to solve problems declines in segmented companies. Segmentalism makes a company a slave of

its past and a victim, not a master of change. Stimulating innovation is difficult for a large organization. Innovation requires trust in the future; in other words, hope is required.

Hope is what Greenleaf (1977) presents through the theory of Servant Leadership. Greenleaf believes that institutions need able managers and leaders who care for the whole organization and have a statesmanlike ability to see beyond the present, and to prepare for the future. The key themes in Greenleaf's writing are power, ethics, management, organization, and servanthood. For some, the term "servant" may have negative connotations; however, if one digs deeper, one will begin to understand the spiritual nature of what is intended by pairing "Servant" and "Leader". Servant Leadership has deep roots in some indigenous cultures. The theory of Servant Leadership is similar to the consensus building practiced in Japanese companies. Greenleaf first coined the term servant leader in his 1970 essay entitled " The Servant as Leader". This theory of leadership was not very popular when Greenleaf first introduced it, but now management and organizational thinkers such as Max DePree (1989), Peter Senge (1994), Peter Block (1996) and Stephen Covey (1990) espouse the importance of an ethical base for organizations, the power of trust and stewardship, and the personal depths that real leaders must honor as they serve and empower others.

In a recent work on the challenges of organizational change, Kanter, Stein, and Jick (1992) state that leaders are critical to creating a company vision, motivating employees to embrace the vision and crafting an organizational

structure that rewards those who strive to realize that vision. But leadership alone is not enough. Success comes through a broad base of support, made up of followers, helpers, and co-owners of the change. This type of interaction is known as coalition building. Many organizations of the 1990's do not have just one leader. The authors present a model showing various "changemaker roles" and situations that require "some flexible wrestling with how change is to be managed, and by whom" (Kanter, Stein, & Jick 1992, p.390).

Several major organizations have restructured their operations based on the Servant Leadership theory. The Robert K. Greenleaf Center for Servant Leadership, founded in 1985 in Indianapolis, Indiana, monitors ongoing research in over 23 states of the United States and two provinces in Canada. Servant Leadership is not a tidy "how to" checklist; it is a philosophy, not a prescription. Servant Leadership is a path, not a destination. When Greenleaf talks about the "servant as leader" he is applying the philosophy of service to the practice of leadership (Spears, 1998, p. xi). For Greenleaf, service is a moral dimension not only of leadership, but also of life itself. Leadership is a special case of service, instead of service being a special case of leadership. Greenleaf wants his readers and his followers to look at how the actions and attitudes of service can transform relations among human beings. He acknowledges that this transformation is not easy. Servant Leadership begins with a genuine desire to serve, followed by the conscious decision to lead. The Servant Leader must be imaginative; he/she must not be a"yes, boss" person, but must look for ways to make the organization

better, no matter what it takes. The Servant Leader looks for a sense of mission. Where does the sense of mission come from? How does it happen? What is the process by which members of the organization get a sense of its reason for being? The Servant Leader enlists other through natural persuasion, not manipulation or slick rhetoric. According to Greenleaf, there is no type of organized human activity where persuasion and mutual service to a common vision cannot occur. The Servant Leader has a vision, a goal, and shares that vision with his/her followers, so that it becomes their shared vision. Greenleaf uses the term "Primus inter pares", meaning a team of equals (Greenleaf ,1998, p 61).

Spears (1998) identifies 10 characteristics that are critical to the development of Servant Leadership. 1) Listen to identify the will of the group and listen to one's inner voice. 2) Empathize, accept people and recognize them for their own unique spirits. 3) Heal oneself and one's relationships with others; make whole. 4) Be aware of oneself and one's surroundings; this aids in dealing with issues involving ethics and values. 5) Be persuasive, build consensus within the group. Greenleaf does not mean to use coercion; instead he refers to the natural type of persuasion rooted in the Quaker belief. 6) Conceptualize, "dream great dreams" (Spears, 1998, p.6). This requires discipline and practice, looking beyond the day-to-day tasks. According to Greenleaf, this is a role for trustees or a board of directors. 7) Foresight is necessary, the ability to understand the lessons of the past, the realities of the present, and likely the consequences of a decision for the future. Foresight is rooted in the intuitive mind. 8) Stewardship, a commitment to serve the needs of others, is detailed by Peter Block (1993). 9) Servant Leaders

are committed to helping people grow. Servant Leaders believe that people have intrinsic value beyond their contributions as workers in an organization or company. This commitment includes concrete actions to help employees improve both professionally and personally. 10) The Servant Leader seeks to build some kind of community among employees of an institution. All that is necessary, says Greenleaf, is for the Servant Leader to show the way by his/her own example. The Servant Leader believes that the primary purpose of a business should be to have a positive impact on its employees and the community, rather than just to make a profit.

Bennis and Nanus (1985) talk about the critical dimensions of leadership: vision, communication, trust, and deployment of the self. Greenleaf agrees with them. The Servant Leader must have a vision of where the organization is going, and must be able to communicate that vision, making it a shared vision. The Servant Leader must also be dedicated to the task of finding and obtaining the best possible future for the organization.

American Healthcare System

Pearson and Raeke (2000) state that trust is one of the central features of the physician-patient relationship. However, rapid changes in the healthcare system are threatening patients' trust. Change is not new to the American health care system. In fact, change seems to be the one constant for all health care providers. Persistent economic pressure and growing patient dissatisfaction are prompting health organizations to re-invent themselves. The fundamental problem facing

today's healthcare system is one of organizations and structure, not people and values. The emergence of managed care and health maintenance organizations (HMOs) has changed the delivery of healthcare a great deal. Whereas once physicians made the decisions about how their patients would be treated for a medical condition or illness, now healthcare decisions often are made by the insurance companies practicing managed care. A General Accounting Office Study shows only one in 10 Americans is satisfied with the health care system. (Leander, Shortridge, and Watson, 1996) Patients have become accustomed to, but not happy with, endless waiting, inconvenience, and an impersonal approach-being treated like a number instead of a person. Doctors, as well as patients, are dissatisfied. Lab tests results often have to be ordered immediately in order to avoid a long wait.

"Few would argue that the quality of clinical expertise in this country is second to none. The modern American hospital has the best-educated workforce in the world. It enjoys the best and latest technology and automation. Surgical techniques and success rates in this country are unsurpassed. But the modern American hospital provides poor customer service. Education and technology are necessary but not sufficient dimensions of good customer service. The patient needs and deserves more. Today's hospital cannot improve service until it defines its missions and capabilities in terms of its customers' needs and expectations as the customers-patients, physicians, and even staff, define them." (Leander, Shortridge, & Watson, 1996 p.66)

Healthcare institutions, especially hospitals, are among the most complex institutions in our society. Like hospitals, healthcare clinics seldom have a pyramidal structure. Often there are many competing groups, such as physicians, unions, and highly skilled, technical, and unskilled employees. Like hospitals, clinics also have to operate under the influences of outside forces, such as local,

state and federal regulations, and a number of accreditation bodies. Among the skills of an effective administrator are technical skills, human skills, and conceptual skills. The administrator must have specific knowledge and must have the ability to analyze, using various tools and techniques. Because the product is healthcare and human services, the healthcare administrator must be able to work effectively within his/her own group to build team skills. In addition, the administrator must be able to see the healthcare facility as a whole unit, and also to see how different facility functions interact with each other. Environmental assessment is another important skill for the clinic administrator. The healthcare administrator of the future must be highly responsive to the communities in which his/her facility operates; factors other than cost will be important to the success or failure of the facility. The skills necessary for effective healthcare administration must change as communities and institutions change.

Health care administrators can exercise good leadership by paying attention to their customers' (patients) needs. Authors Speedling and Rosenberg (1986) state that the concept of customer satisfaction (with health care services) is becoming more and more important to healthcare facility managers seeking ways to adapt their institutions to the rapidly changing health care scene. "A satisfied clientele and a favorable public image are as important to the viability and vitality of a health care organization as they are to other enterprises striving to achieve in a competitive environment." (Speedling and Rosenberg, 1986 p.9) Clients (patients) are becoming more informed about health care, enabling them to make better-informed decisions and choices. The authors then go on to suggest several

ways healthcare facility managers can contribute to the well being of their clients. Among their suggestions are making a good first impression, giving adequate information to the patient before a test or procedure, and making the healthcare facility environment as cheery and life affirming as possible.

" *Patient* focused restructuring" (Brown, Nelson, Bronkesh, and Wood, 1993, p 49) is the first wave of revolution in health care. In 1989, Lakeland Regional Medical Center, Lakeland, Florida, opened its first patient-focused care unit. All of the organization's energies are being focused back on the patient. Brown, Nelson, Bronkesh, and Wood (1993) provide an in-depth discussion of re-structuring to implement change to patient-focused care, with examination of the pitfalls and obstacles to achievement of the goals. Among the terms used by the authors are empowerment, teams, culture, vision, and values. "Quality means service" (Brown, Nelson, Bronkesh, & Wood, 1993,p 65). Doctors must take a leadership role, along with clinic managers, to bring about a change back to patient-focused care.

SUMMARY

Leaders have a great and lasting impact on those they lead. Leadership in general today has become much more difficult due to the many problems and changes leaders must face. Bennis, Nanus, Gardner, Kanter, Burns and Greenleaf all feel very strongly that we in the United States have a crisis of leadership. The decisions our leaders make now will determine how well our society survives in

the 21st century.

The crisis of leadership is especially evident in the area of health care. In spite of advantages such as the latest surgical techniques and a well -educated workforce, there is growing dissatisfaction among patients. Some doctors, as well as some patients are unhappy with long waits for appointments and test results, as well as depersonalization in the healthcare system. Often, medical decisions once made by the patient's physician now are made by a managed care or health maintenance organization (HMO). Health care leaders must be willing and able to change and must be able to help their followers adapt to new situations as the needs and wants of their customers (patients) change.

In the past, patients' needs have not necessarily been the primary focus of health care facilities. The focus is changing, as patients become more vocal in expressing their wants and needs. Patient satisfaction surveys are one tool for measuring the quality of the care received. The significance of satisfaction surveys is that they give the patient a voice to indicate what is important, what will make the patient happy. Improving patient satisfaction is good for business.

By virtue of the physician's role as healer of the sick, he/she has a unique opportunity to positively impact health care by practicing Servant Leadership. Physicians are naturally viewed as leaders by their patients, by other medical personnel, and also by the community at large. Physicians as healthcare administrators can close the gap between what patients need and what healthcare organizations provide. By focusing attention on patient satisfaction rather than just a favorable medical outcome, which isn't always possible anyway, the

physician will be practicing as a Servant Leader, and will transform the future of the healthcare organization and the future of healthcare itself. The research surveys measured the level of patient satisfaction and will provide ideas as to whether or not patient satisfaction should be improved, and if so, how this could happen. Questions such as the following directly address the issue of leadership in the clinic, and identify who the patient thinks is a leader. Do you consider the physician a leader in the clinic? What is your level of trust with your physician? Do you feel your physician listens to you? Do you feel that your physician would "go the extra mile " for you?

CHAPTER III: THE RESEARCH PROBLEM AND METHODOLOGY

Statement of the Problem

There is a crisis in American healthcare in that some patients as well as some physicians are dissatisfied with the quality of healthcare. Rapid changes in the healthcare system are threatening patients' trust. Patients are becoming increasingly dissatisfied and more vocal. They are tired of the endless waiting, the inconvenience and depersonalization experienced in so many healthcare facilities, and the high cost of healthcare. Often it seems as though the focus in healthcare is on cost saving measures rather than on delivering quality health care.

The healthcare crisis also involves a crisis in leadership. The decisions healthcare leaders make now will determine how well healthcare facilities and the American healthcare system in general will fare in the years to come. American healthcare needs exceptional leaders, people who are committed first to serving the patients, leaders who can carry their organizations through the changes of the present into the uncertainty of the future. In short, American healthcare needs Servant Leaders.

The Research Question

What kind of leadership on the part of the physicians at a large mid-western outpatient clinic is necessary to improve patient satisfaction? Will the exercise of

Servant Leadership positively impact patient satisfaction? Will patient satisfaction surveys give an accurate indication of what patients want from their physicians? How can physicians practice Servant Leadership?

Definition of Variables

Patient Satisfaction is defined as the level of comfort the person as a patient feels in the Clinic. According to Lebow (1974), patients want their physicians to be friendly and communicative. When they're not, the satisfaction level decreases. Social class, education, the length of the visit, or the diagnosis is not as important as how the physician presents him/herself to the patient. The research instrument, a patient satisfaction survey, measured the patient's satisfaction level.

Servant Leadership is the specific theory of leadership in which the leader's intuitive and primary goal is to serve the needs of his/her followers. For the purpose of this research, the physician is the Servant Leader; the patients are the followers. The focus is on the patient in the complex world of healthcare. Servant Leadership could also be experienced in the relationship between the physician and his/her co-workers-nurses and other clinic personnel. However, this researcher chose to focus on the physician-patient relationship.

Assumptions

1. Patient satisfaction can be improved.
2. Physicians want to improve patient satisfaction

3. Patient satisfaction can be defined and/or measured as one indicator of quality of care provided.
4. Physicians are able to practice Servant Leadership in their interactions with patients.

Limitations

The sample is small-only 100 patients at one out patient clinic were surveyed. Only one mailing was sent out, due to time constraints. Additional mailings might have produced more definitive results, possibly including more negative responses. The researcher is aware of patient dissatisfaction from professional experience over a period of several years.

The population base for the survey is limited to adult patients of one primary care clinic. Samplings sent to other specialty clinics, such as pediatrics or oncology, might have produced differing perspectives, as might a follow up sampling sent six months after the initial sampling. Additionally, interviews with patients as they are exiting the clinic immediately after an appointment might produce more accurate descriptions of patients' perceptions and feelings.

The Significance of the Study

The primary goal of a physician is or should be to serve his/her patients in the best possible way. In order to accomplish this, physicians need to know what patients want and expect from them. Using the surveys as a measurement tool will raise awareness of both patients and physicians as to what makes patients

happy/satisfied. The model of Servant Leadership that could be developed from the results of the surveys could provide an invaluable tool for physicians. This study will also serve as a foundation on which future researchers can build. Studies mentioned in the literature review dealt mainly with issues of patient satisfaction regarding hospitals and nursing staff. This research focuses strictly on patient satisfaction with the physician.

METHODOLOGY

Design

It is evident form the literature review that there is a crisis in leadership in the United States. The decisions US leaders make today will affect the future of that society well into the next century. This is especially true in the area of healthcare. Inconvenience, long waits, and depersonalization, as well as the rising costs of health care, have left many dissatisfied patients and physicians. This research sought to determine what patient want from their physicians, and how well those physicians are doing. Are the physicians acting as Servant Leaders? There are numerous ways to measure the quality of healthcare. Measuring the level of patient satisfaction is the method the researcher chose. The tool for measurement is a patient satisfaction survey that was sent to 100 patients at a large mid-western out patient clinic.

The Setting

The population that was studied included adult patients seen within the last six months by primary care physicians at a large mid-western out patient clinic.

Sample

The population was a random sampling of adult patients at a large mid-western primary care out patient clinic. Adult patient was defined as a patient 18 years of age or older. Rather than focusing on any particular specialty practice, the researcher chose to do a random sampling of a primary care clinic with the hope that this would provide a good cross section view of the level of patient satisfaction.

Human Subjects Protection

Confidentiality was maintained by numbering the surveys as they were returned. The researcher noted the number on each survey returned, but the names of the subjects were not asked for, nor were they used in tabulating the responses. The participants were sent a cover letter with the survey form. The cover letter explained the research and asked the patient to participate only on a voluntary basis and only if they felt comfortable in doing so. They were informed that participation would have no direct

bearing on their treatment in the clinic, as their names would not be linked to their responses. No individual physicians' names were used. It is hoped, however, that the responses will help to accomplish a positive change in physician-patient interaction at the clinic. Institutional Review Board approval was obtained from both the University of Minnesota and Augsburg College prior to the research.

Data Gathering Instrumentation

The patient satisfaction survey consisted of 29 multiple choice questions, with space for comments after several of the questions. The surveys were sent through the mail to 100 randomly selected adult patients of the Clinic. The patients were asked to complete the survey forms and return them in the stamped self-addressed envelope provided. The completed surveys were sent to a post office box. Only one mailing was done.

Data Analysis Procedures

The responses to each question were tallied. Descriptive statistics, as well as graphs and tables were used to present and analyze the data.

CHAPTER IV: PRESENTATION OF THE DATA

This chapter will present the data according to the general demographics and selected questions that yielded the most detailed information.

One hundred patient satisfaction surveys were sent out to adult patients who have been seen during the last six months at the Primary Care Clinic at Fairview University Medical Center, Minneapolis, MN. Thirty- seven people responded by completing and returning the survey forms. The researcher assumes from the completion and return of the survey forms that the respondents gave their consent to participate and that they are comfortable that their anonymity is fully protected.

In general, the responses were quite positive. Most of the respondents rated their relationship with their physician as excellent. They had no problem finding the Clinic, and thought that the parking facilities were satisfactory. Almost all of the respondents reported a wait of 30 minutes or less to see their physician. They reported a high level of trust with their physician, and believe that their physician would "go the extra mile" for them. They feel very much an active participant with their physician in their care management, and they feel that their physician listens to them and responds very well to their concerns. They feel comfortable in their clinic. Approximately half of the respondents have been coming to the Clinic for two or more years.

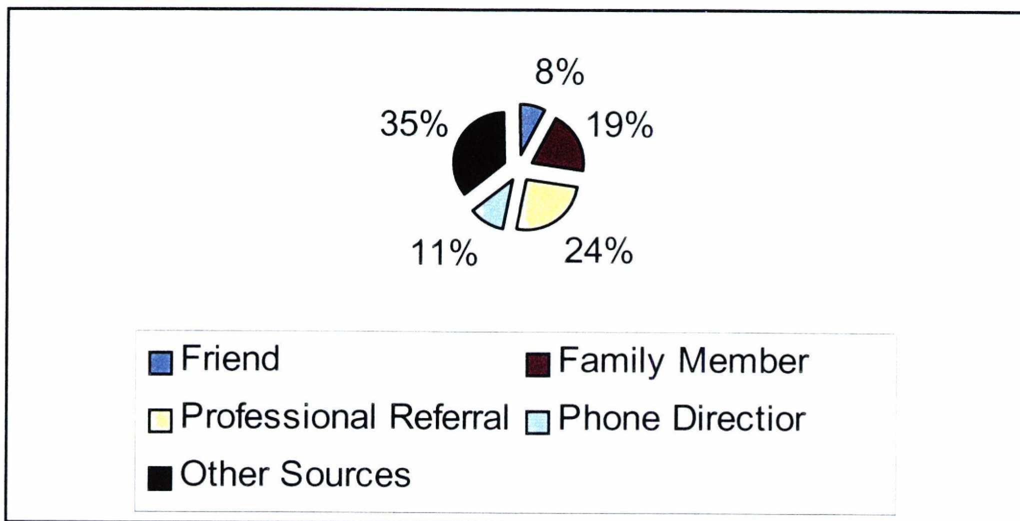
Of the thirty- seven who responded, 11 are males; 25 are females. One person didn't check sex. The oldest person to respond is78, the youngest is 25. The mean age is 54. Only two of the respondents don't have insurance coverage. One of the respondents

who checked yes to insurance commented that she has MN Care, which is a state program. Twenty- five out of the 37 are employed: 19 full-time, one part-time, and one is self-employed. The other four didn't check either part or full time.

People found out about the Clinic in a variety of ways, as illustrated in Figure 1.

Figure 1

Referral Sources



One respondent commented, "My sister had kidney cancer and Dr. X operated on her and suggested I have a yearly check up at the cancer detection center & I had since 1978. However cancer detection center doesn't exist anymore so I go to Primary Care Center once a year for check ups." Another person stated (I) "was scheduled for knee surgery with ortho MD of choice & I needed a primary physician who could refer to her". Yet another person found out about the Clinic from a U of M physician who spoke on heart surgery at a clinic at North Memorial Hospital.

Thirty-two respondents reported that they saw a number of specialty physicians. Four people left this question blank; one person marked it N/A (not applicable).

Figure 2

Specialty Physicians Seen

4= Endocrine

7= Ear, nose and throat

10= Dermatology

4= Gastroenterology

9= Cardiology

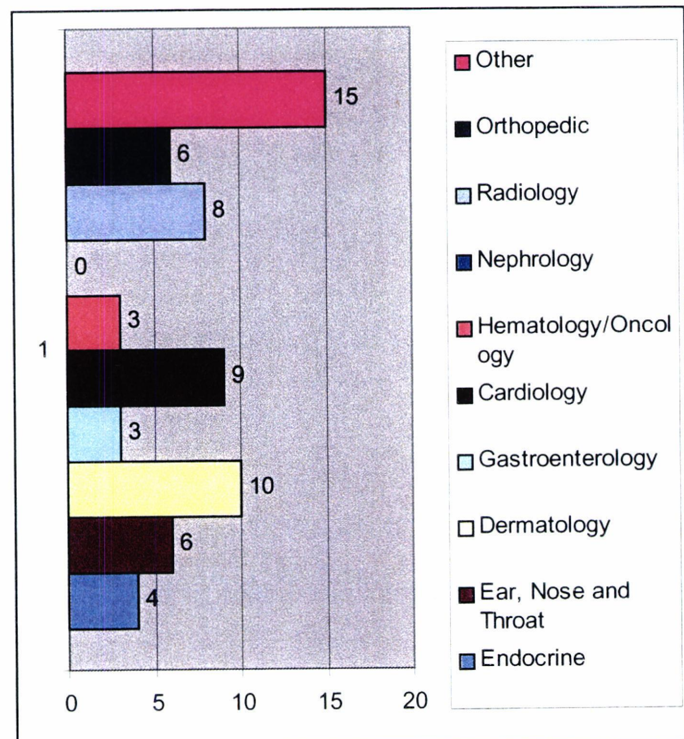
4= Hematology/Oncology

8 = Radiology

9 = Neurology

6= Orthopedic

16= Other (includes OB/GYN, Surgery, Ophthalmology, Boynton Women's Clinic Urgent Care, & Rheumatology, Laboratory, Lupus, Internal Medicine and Urology)

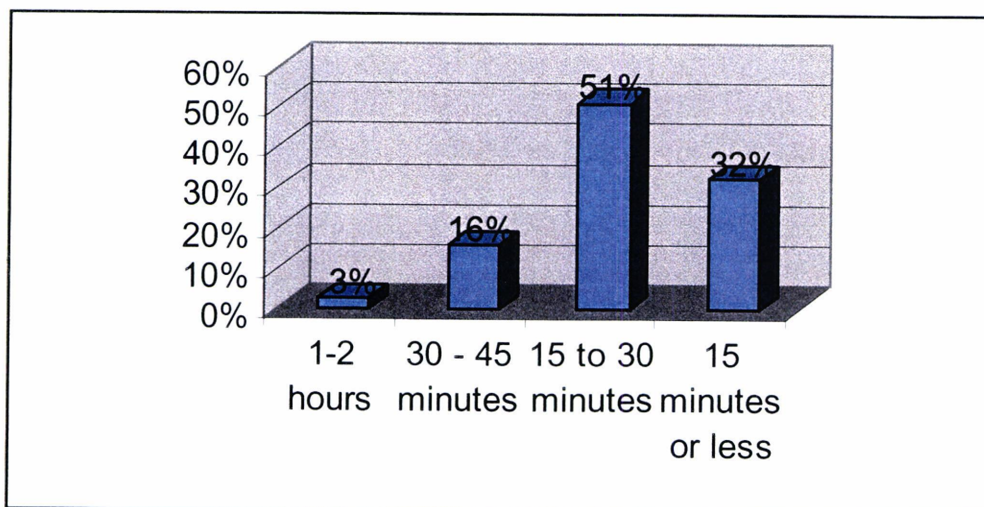


Nineteen people indicated that they saw more than one specialty physician; five people either marked this question N/A, or left it blank. Five of the respondents indicated that they were either University of Minnesota students or employees. A former University employee stated that she "worked at the U of M for 43 years and used the U of M Clinic

for health care". One person who is a student stated that she came to the Clinic via Urgent Care. Another person who was a University of Minnesota employee commented that she walked to the Clinic when she was still employed. Thirty-two respondents indicated that they had no problem finding the Clinic; three people said it was somewhat hard. One person replied "so-so", and didn't check any of the listed responses. Twenty-one people parked in the ramp, seven in the lot, two in the Garage, one at a handicapped meter, one next to the building, one on the West Bank, two in University parking, and one in high rise parking. Thirty-two respondents said that the parking was satisfactory; four said it was too expensive, and one person said it was too far from the Clinic. One person who said the parking is too expensive that the parking is " fine @ 9:30 AM".

Figure 3

Length of Wait to See the Physician

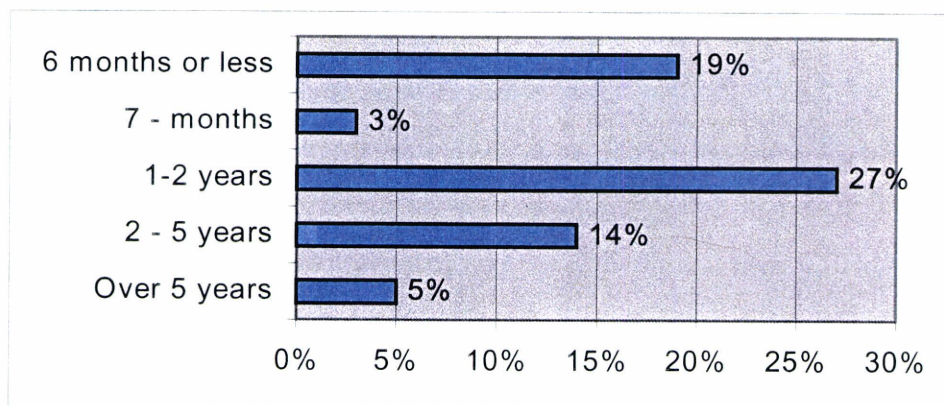


One respondent checked 15-30 minutes, and then commented "lately", "before" 30-45 minutes.

If test results were to be sent, 22 people indicated that the results were sent out promptly. Three people indicated the results were sent out late; two people indicated they needed to send a second request. One person said results were not sent at all; nine people left this question blank or checked N/A (not applicable). One person who left this question blank wrote in a comment: " I usually call the nurseline for test results. My doctor does respond fairly quickly as follow up".

Figure 4

Length of Time Patient Has Been Coming to the Clinic



All but three of the respondents gave a positive answer to the question: How would you describe your relationship with your physician? Of the 37 people who responded, 57% or 21 indicated that they have an excellent relationship with their physician. Thirteen or 35% indicated a good relationship; 5% or two people reported their relationship as poor. The one person who left this question blank commented, " usually they are not there long enough to establish a relationship". One respondent who

described her relationship with her physician as excellent added this comment: " but he left this June".

The responses to the following question were also quite positive. What is your level of trust with your physician? Twenty-four or 65% reported a very high level of trust; 35% or 13 people reported a high level of trust. Thirty-two people indicated that their physician responds very well to their concerns; five people marked that their physician responds somewhat. One respondent who answered "very well" to this question also commented, " I had a new Dr. last year who listened very well the first time he saw me (Dr. Y)". Regarding the question relating to the patient's understanding of his/her condition and the treatment prescribed by the physician, 33 people indicated they understand very well; four people said they somewhat understand. An interesting twist occurred in the responses to the question of whether the physician tells the patient what he/she needs to know. Only five people checked the response "more than enough"; 31 checked "enough". One person did not respond to this question. Fifty-four percent or 20 people feel that their physician always listens to them; 38% or 14 people think their physician listens to them much of the time. Five percent or two people indicated their physician listens sometimes; again, one person did not answer this question.

Figure 5

Physician's Commitment to the Patient

Figure 5 illustrates the responses to the question: Do you feel your physician would go the extra mile for you?

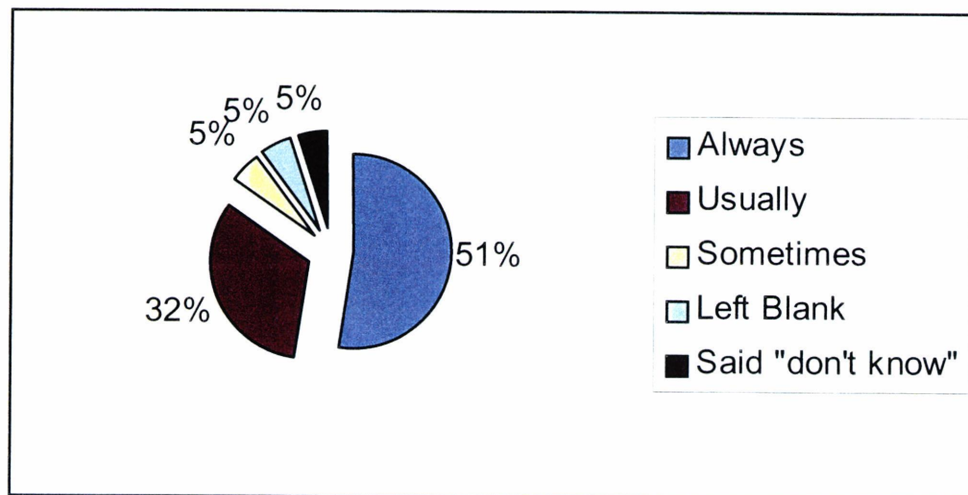
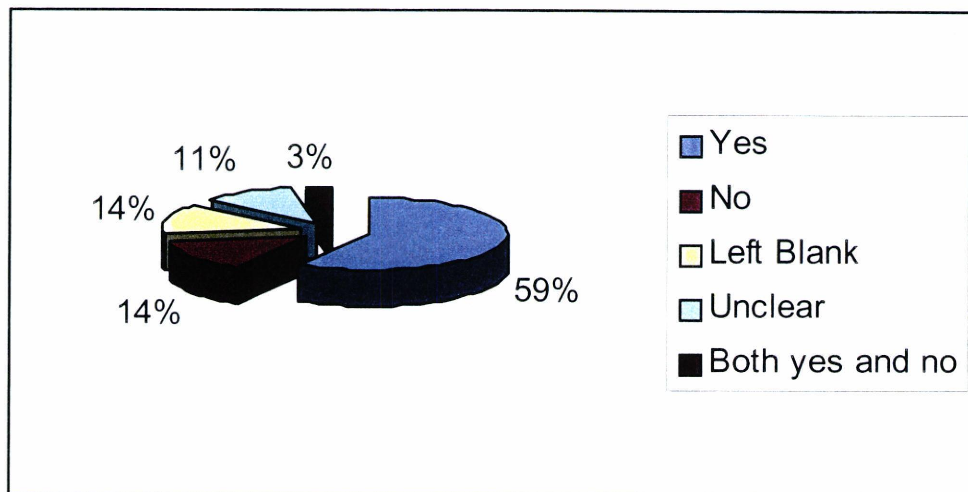


Figure 6

The Physician A Leader in the Clinic

One question addressed directly the perspective of the physician as a leader. Following are the responses to the question: Do you view physicians as leaders in the Clinic?



1= Yes

2= No

3= No response

4= Don't know, don't understand, or question not clear

5= Checked both yes and no

The researcher asked for comments to explain the answer given. A person who didn't check either yes or no wrote, " I have only seen a nurse practitioner". Another person indicated, " I don't have enough knowledge to answer tho my doctor does have other major responsibilities". One respondent who checked no stated " I am not sure I can answer this question, I think my answer would be no, doesn't mean I don't think they are competent. I am not sure they are the 'best'." These comments indicate the complexity of trying to assess leadership. The perception of leadership may vary from one person to another. Even more difficult to measure is the experience of Servant Leadership.

To someone unfamiliar with leadership theory, Servant Leadership may appear to be a contradiction in terms. Leaders are not commonly thought of as servants; similarly, servants are not seen as leaders. This is precisely why the researcher left out of the survey form any questions directly dealing with the concept of Servant Leadership. A topic for future research might be to present the concept of Servant Leadership, and try to assess the participants' experience and/or understanding of this theory.

Another respondent explained, " This is a difficult question to answer. Each individual in the clinic has their job to do and from the outside it is difficult to tell who the leader would be, but it is a well run clinic." This comment indicates that the person who wrote it feels that the physicians, nurses, and other clinic personnel work together well as a team. Perhaps this person would agree that Servant Leadership is in operation here. Other no answers were followed with the comments: " I think nurses are (leaders). They keep Dr. on track" and "I think administrators are the leaders". Another respondent gave the following comment to a negative answer- "they (physicians) are hampered by insurance requirements". Someone else commented, "If the Drs. don't lead, who will?" One person mentioned the harmony in the Clinic; another affirmed teamwork as an operating principle. Other comments to yes answers are:

"My doctors guide the staff through their wisdom, generosity and example".

" My physician found me another when care was out of her hands-they made appts for me". "I think she (physician) is one of the most thorough".

"I think they are highly trained".

"She gets things done and staff seems to respect her". One person who checked both yes and no commented, " some of the more established physicians are leaders, but others

seem to be almost unknown by the other staff". Another person qualified her positive answer with the comment " though I feel my doctor is always rushed due to time restraints on length of appointment".

The majority of the respondents reported that the Clinic is a place where they feel comfortable: 33 people checked yes, only two people checked no. The researcher again asked for comments to explain the answer given. One person who did not check either yes or no commented, " sometimes blood clinic too crowded". Another person checked both yes and no, with the following comment: "When I go for a 'check up', I have no problems, but if I suddenly need to see a doctor soon, I can't seem to get an appointment promptly...recently had to wait 3 weeks to get an ultrasound. My primary physician is a resident. When I call the Clinic, sometimes they don't even recognize his name!" One respondent who answered no to this question wrote the following comment. "I would rate the MDs much higher than the staff esp when making and/or changing appointments, impatience rules the day and little if any consideration given for work schedule. I usually have to re-schedule procedures, etc., myself since the clerk just makes them @ any available time—also appointments are re-scheduled too often!" Another person who answered no to this question stated " talking about my health with strangers (or anyone, for that matter) is uncomfortable for me". A respondent who answered yes to this question also commented as follows. "My concerns were addressed and not dismissed. The staff was courteous and respectful." Other comments from people who answered in the affirmative are: "appointment desk is the least efficient". "It seemed a little too busy-too rushed-but my N.P. is very thoughtful and thorough"; "excellent physician, good staff and equipment and referral as needed". One person qualified her yes answer

with the comment that the Clinic is "usually" a place where she feels comfortable. Another person stated, "remodeling has helped".

The final question on the survey form asked the respondents to mark answers that reflect their feelings about the Clinic. One person did not respond at all to this question. Following are the 36 responses given and comments made by the respondents.

Table 1

Patient's Thoughts and Feelings About the Clinic

	Number of responses	% of Respondents
1= Friendly physicians	32	86%
2= Helpful staff	26	70%
3= Long waits	7	19%
4= Trust	17	46%
5= Just a number	2	5%
6= Partnership	7	19%
7= Short wait	9	24%
8= Impersonal staff	5	14%
9= Advanced technology	17	46%
10= Team spirit	4	11%
11= Competent physicians	27	75%
12= Physician too busy	7	19%
13= Friendly atmosphere	17	46%
14= Helpful billing staff	9	24%

Respondents were asked to check all the items that expressed their feelings and thinking. Although comments were not asked for, several people wrote them anyway. Comments for the choice "Helpful billing staff" are as follows: " very confusing billing at the U of M department for years"; " computer problems create billing troubles".

Another respondent commented thus. " Some physicians, probably most are friendly, but I had a female physician in the medicine clinic who was horribly rude, even suggested that I imagined that I'd had blood work done a wk. earlier because she couldn't find the results". One person indicated that his choices-friendly physicians, helpful staff, trust, advanced technology, team spirit, competent physicians, and friendly atmosphere-all apply to U of M Hospital & Clinics.

SUMMARY

To summarize, out of 100 surveys sent out, 37 people responded. Eleven of the respondents are males; 25 are females. One person didn't check either sex. The ages of the respondents varied from 25 to 78 years of age. The mean age of the respondents is 54. Only two of the 37 respondents do not have insurance coverage. Thirty-five or 13 people found out about the Clinic from sources other than from a friend, family member, professional referral, the telephone directory or a newspaper ad. The other sources include self-referral, from a co-worker, or from an insurance carrier. In general, the responses to most of the survey questions were positive. The researcher feels this is evidence that Servant Leadership is already being practiced in this Clinic. The data may not be adequate to answer the questions asked in the survey, since the sample was so small, and several of the questions were not answered by a significant number of the respondents. However, from the responses that were received, the indication is that Servant Leadership is in practice.

Eighty-four percent of the respondents had no trouble finding the Clinic, and they thought that the parking facilities were satisfactory. Seventy-four percent, almost three fourths of the respondents, have been coming to the Clinic for a year or more. Ninety-two percent of the respondents rated their relationship with their physician as good to excellent, and the level of trust with the physician was also rated as high or very high. Eighty-six percent of the respondents said their physician responds very well to their

concerns, and they feel comfortable in the Clinic. More than 86% said they understand their medical condition and the treatment prescribed by their physician. All but one of the respondents stated that their physician tells them enough or more than enough of what they need to know. Over half of the respondents stated that their physician always listens to them, and half stated that they felt that their physician would always "go the extra mile" for them. While 59% or 22 of the respondents view the physicians as leaders in the Clinic, 14% or five do not. The remaining 10 respondents either checked "don't know" or indicated that they didn't understand the question. This prompts the researcher to question the validity of the data, and to think that more questions relating specifically to physicians as leaders should be included in future research surveys, perhaps with more explanation as to the ways in which a physician demonstrates leadership. The researcher also feels that several questions directly addressing the physician acting as Servant Leader should also have been included in the survey form. The stumbling block for this researcher became how to explain the theory of Servant Leadership succinctly, so that the survey participants would understand and respond to the questions. As indicated by the number of "question unclear" responses to this survey form, it is evident that more attention needs to be given to explaining and informing the participants as to exactly what information is needed in the responses to the survey questions.

These responses could also be an indication that Servant Leadership is being practiced in this Clinic. The Servant Leader is not always the person recognized as a leader, as is pointed out in Herman Hesse's (1968) Journey to the East. The character Leo is portrayed as a servant throughout much of the book, but after he disappears and the rest of the group disintegrates, it becomes apparent that Leo really was the leader.

While the results of this research show that 92% of the respondents rate their relationship with their physician as good to excellent and also report that their level of trust with their physician as high to very high, barely more than half think of their physician as a leader in the Clinic. Similarly, only 51% or 19 of the respondents felt that their physicians would always "go the extra mile" for them. While it is not realistic to expect that all of the respondents would think that their physician is totally committed to them, the responses given in this research indicate the definite need for improvement in the patient's perception of the physician-patient relationship. It is unclear from the survey form if patients would feel that their physician is more committed to them the longer they have been coming to the Clinic. Perhaps that is a question that should have been included in the survey. It seems to the researcher that patients who have been coming to see the same physician for a year or more would have a better opportunity to develop a positive relationship with that physician. It should be noted that in this small sample, nine of the 13 respondents who indicated they have been coming to the Clinic for more than five years also felt that their physician would always "go the extra mile" for them. These positive responses seem to indicate that there is a direct relationship between the length of time the patient has been coming to the Clinic and the patient's feeling that his/her physician is committed to him/her. Further exploration of this feature might be a good topic for future research.

Immediate feedback from patients after their clinic visits might provide a better insight into patients' perspectives. The researcher is aware of negative feedback from daily professional experience and suspects that many of the participants in this research who had negative experiences just didn't complete and return their survey forms, for

whatever reasons. Patient comment cards placed at the entrance/exit to the clinic might prompt people to report more informatively on their clinic experiences. Likewise, a follow up survey done six months after the initial survey might present different perspectives from the responses generated by this research.

While there were more positive responses than the researcher anticipated, it is suspected that the full data was not obtained. One must be cautious in drawing conclusions, given the small number of participants in this research sample. Negative responses point to the need for improvements, such as decreasing the patient's waiting time to see the physician and establishing a better relationship with the patient. Improvements of this nature would be a way to better serve patients. The patient would then experience a higher level of trust with the physician, because the patient would feel that the physician is listening more attentively to him/her. In effect, the physician would be more effectively practicing Servant Leadership.

CHAPTER V: CONCLUSIONS AND RECOMMENDATIONS

What is Servant-Leadership? According to the Robert K. Greenleaf Center 1996-2000), "it is a practical philosophy which supports people who choose to serve first, and then lead as a way of expanding service to individuals and institutions. Servant-Leadership encourages collaboration, trust, foresight, listening, and the ethical use of power and empowerment."

Quality of care is an important issue in health care today. Quality care equals service to patients. One of the ways to measure the quality of health care is to measure the process of care giving-what is done and how well it is done. According to Knowles 1965), one characteristic of good medicine is that the physician should do no harm to the patient. The most important qualities to patients are: 1) good doctors; 2) well-trained staff; 3) information from doctors; 4) personal interest in the patient; 5) pleasant staff; and 6) privacy (Lebow, 1974). This researcher set out to assess the level of patient satisfaction with the medical care received. The intent of the research was to measure the level of satisfaction experienced by the patient, and to see how satisfaction could be improved if physicians acted as Servant Leaders. Patient satisfaction is defined as the level of comfort a patient feels while in his/her health clinic. Increasing patient satisfaction means increasing the patient's comfort zone and being willing to *serve*. However, improving patient satisfaction takes leadership. Leadership is a skill that is essential to any organization's vitality and success. A leader is much more than a title such as Manger, President, or CEO. Leadership is a dynamic, ever-changing process.

Physicians are seen as leaders because it is they who make important decisions and control what goes on in the health care clinic; they are seen as leaders because of the way they serve their patients. Physicians as health care administrators are responsible for closing the gap between what patients want and need and what the health care organization provides. As Rosenberg and Clarke (1988) state, leaders influence and give direction to those around them.

Patient satisfaction is a process as much as it is attitude. In order to improve satisfaction, unhappy patients must be responded to in a positive way. Permanent solutions must be found for problems, not just fingers pointed to identify the one to blame. The researcher agrees with Brown, Nelson, Bronkesh and Wood (1993), who state that the patient is the customer, and patient satisfaction is not an option. Improved patient satisfaction is good for business; in fact, it is essential to survival in the competitive atmosphere of health care organizations today. The formula for success, according to Brown, Nelson, Bronkesh, and Wood (1993) is: clinical quality plus service quality equals patient satisfaction. Patient satisfaction is a central feature of the physician- patient relationship. Lebow's (1974) study found that patients want their physicians to be friendly and communicative. When this doesn't happen, patient satisfaction is decreased.

This research studied the physician-patient relationship to determine how satisfied clinic patients are with their physicians and to assess whether or not the physicians are perceived as leaders by their patients. The researcher also sought to determine if patient satisfaction could be improved if the physicians practiced Servant Leadership. As indicated by the literature review, practicing good leadership today has become much

more difficult than in past generations, and it is critical that leaders make wise decisions in order to effect positive results in the future. In short, there is a crisis of leadership today in general, and specifically in the area of healthcare. The crisis is due in part to the many and constant changes occurring in healthcare and the delivery of healthcare services. Patients and physicians alike are dissatisfied with the quality of healthcare. Patients are tired of the endless waiting, inconvenience, and depersonalization experienced in many healthcare facilities. Physicians often have to order tests on an urgent basis just to avoid having to wait a long time to get the results. The emergence of HMOs and managed care has taken much of the medical decision-making out of the hands of physicians. Often the insurance company or HMO, not the patient's physician, makes important decisions about patient care and treatment.

Among the survey questions are the following. What is your level of trust with your physician? Do you feel that your physician tells you what you need to know? Do you feel that your physician would "go the extra mile" for you? Do you feel like an active participant with your physician in your care management? Do you feel your physician listens to you? Do you view physicians as leaders in the clinic?

In general, the responses were quite positive and show that Servant Leadership is being practiced in the Clinic. The researcher is aware of some negative feedback from daily professional experience over a period of several years, but may have under-estimated the good experiences that most patients have. Most of the dissatisfaction expressed by the survey respondents related to scheduling of tests and appointments, the complexity of the billing, and the assembly line atmosphere where patients are rushed through their appointments without adequate time for discussion of problems with their

physician. Because of the small sample size, and the fact that several of the survey questions appeared ambiguous to the respondents, the researcher is uncertain that the data obtained are adequate to answer the research questions. However, the findings do show positive responses, and the practice of Servant Leadership is confirmed by several of the responses. One must be cautious about drawing conclusions from such a small sample. Further sampling should be done to confirm the findings of this research and to explore further the practice of Servant Leadership on the part of the physicians in the Clinic.

Servant Leadership is manifested not only in the physician-patient relationship; it can also be experienced in the physician's relationship with co-workers, such as nurses and other medical personnel. Servant Leadership involves teamwork, collaboration, empowerment, and above all, a willingness to serve others. Servant Leadership is about the process of working toward positive change and engaging people in working through that process. The high degree of satisfaction with and trust in the physicians expressed by the survey respondents indicates that the physicians in this Clinic are practicing Servant Leadership. The negative responses, however, indicate the need for improvement. The positive responses provide a good base on which future researchers can build, and the negative responses provide the direction for improvement. For those patients and physicians or anyone else who is interested in the results of this research, the results will be available by contacting either the Clinic or the researcher directly.

Servant Leadership is not a tidy "how to" checklist; it is a philosophy, not a prescription. Servant Leadership is a path, not a destination. Servant Leadership is a better way to manage our organizations going into the 21st century. Servant Leadership uses the team approach rather than the top down management style. To quote Robert

Greenleaf, " true leadership emerges from those whose primary motivation is a deep desire to help others" (Spears 1998). This research shows that the physicians studied have started on the path, but there is still a way to go and much to learn about serving and leading as it relates to patients.

The researcher gratefully acknowledges all those who have helped and supported her throughout this research.

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APPENDIX A

PATIENT SATISFACTION IN AN OUT PATIENT CLINIC ENVIRONMENT

Demographic Data

1. What is your age? ___ 2. Do you have health insurance? Yes __ No __
Are you 3. Male ___ 4. Female ___
Are you employed? 5. Yes ___ 6. No ___ 7. Full time ___ 8. Part time __

9. How did you find out about this clinic?
a) Friend ___ b) Family member ___ c) Professional referral ___
d) Newspaper ad ___ e) Telephone directory ___ f) Other (Please identify) _______

10. How easy was it to find the Clinic?

a) No problem ___ b) Somewhat hard ___ c) Very difficult ___ d) No directions given ___

11. Where did you park? ____________________ 12. Didn't drive _____

13. How was the parking?

a) Satisfactory ___ b) Too expensive ___ c) Too far from Clinic ___
d) Not handicapped accessible ___ e) Couldn't find any ___

14. On the average, how long do you have to wait to see your physician?

a) 15 minutes or less ___ b) 15-30 minutes ___ c) 30-45 minutes ___
d) 45-60 minutes ___ e) 1-2 hours ___ f) 2 hours or more ___

15. If you asked your physician to send you test results or a report, did this happen? a) Promptly ___ b) Later than expected ___ c) Only after you asked again ___ d) Not at all ____

16. How long have you been coming to the Clinic for care?

a) 6 months or less ___ b) 7-12 months ___ c) 1-2 years ___
d) 2-5 years ___ e) more than 5 years ___

17. Which specialty physicians have you seen at the Clinic?

a) Endocrine ___ b) Ear, nose and throat ___ c) Dermatology ___
d) Gastroenterology ___ e) Cardiology ___ f) Hematology/Oncology ___
g) Nephrology ___ h) Radiology ___ i) Neurology ___ j) Orthopedic ___
k) Other __________

SURVEY QUESTIONS

18. How would you describe your relationship with your physician?
a) Excellent ___ b) Good ___ c) Fair ___ d) Poor ___

19. Do you feel like an active participant with your physician in your care management? a) Very much so ___ b) A little bit ___ c) Not much ___
d) Not at all ___

20. What is your level of trust with your physician?
a) Very high ___ b) High ___ c) Low ___ d) None at all ____

21. How well does your physician respond to your concerns?
a) Very well ___ b) Somewhat ___ c) Not very well ___ d) Not at all ___

22. How well do you understand your condition and the treatment prescribed by your physician? a) Very well ___ b) Somewhat ___
c)Not very well ___ d) Not at all ___

23. Does your physician take a professional interest in how well you are managing your condition? a) Very much ___ b) Somewhat ___ c) Not very much ___ d) Not at all ___

24. Does your physician tell you what you need to know?
a) More than enough ___ b) Enough ___ c) Not enough ___ d) Nothing at all ___

25. Do you feel your physician listens to you?
a) Always ___ b) Much of the time ___ c) Sometimes ___ d) Not at all _

26. Do you fell that your physician would " go the extra mile" for you?
a) Always ___ b) Usually ___ c) Sometimes ___ d) Never ___

27. Do you view physicians as leaders in the Clinic? a) Yes ___ b) No __

Please explain your answer. ___________________________________

28. In your opinion, is the Clinic a place where you feel comfortable?
a) Yes ___ b) No ___ Please explain your response.

____

____

29. In the final section, please check all of the following that describe your feelings and thinking:

a) Friendly physicians __ b) Helpful staff __ c) Long waits __ d) Trust __
e) Just a number ___ f) Partnership ___ g) Short wait ___
h) Impersonal staff ___ i) Advanced technology ___ j) Team spirit ___
k) Competent physicians ___ l) Physician too busy ___
m) Friendly atmosphere ___ n) Helpful billing staff ___

2000, Minneapolis, MN: Augsburg College.

APPENDIX B

PATIENT SATISFACTION SURVEY COVER LETTER/CONSENT FORM

Dear ______________________________,

I am writing to request your participation in a research study of patient satisfaction in a clinic environment as it relates to physicians' behavior and practice. My name is Carol Saunders. I am a student in the Master of Arts in Leadership Program at Augsburg College, and this study is my thesis for that degree. You were selected to participate in this study because you are a patient in the Medicine Clinic at Fairview University Medical Center. Please read this letter carefully and contact me or my advisor with any questions of concerns before completing the enclosed survey. Your completion and return of the survey form will serve as your consent to participate in this research.

Background Information:

The purpose of this research is to describe your satisfaction with the physicians at the clinic and the care you receive. I believe that there is a relationship between physicians' behavior and practices and patient satisfaction.

Procedures:

If you agree to participate, I ask that you complete the enclosed survey, and return it in the enclosed self-addressed stamped envelope. It should take about 15-30 minutes.

Risks and Benefits of Being in the Study:

There is no payment or other benefit to you, but it is hoped that, based on information from this study, patient satisfaction can be increased. There is no physical risk, and, perhaps, minimal emotional risk to participating.

Confidentiality:

The records of the study will be kept private. In any report published, no information will be included that will make it possible to identify you or any physician. Research records will be kept in a locked file; only the researcher and her advisor will have access to the records. Raw data will be destroyed by January 1, 2001.

Voluntary Nature:

Your decision to participate in this research will not affect your relationship to Augsburg College of Fairview University Medical Center or any individual physician. If you decide to participate, I encourage you to please answer all the questions, but you may skip any you can't. Your completion and return of the survey will serve as your consent to participate in this research.

Care of Subjects in case of an accident:

In the event that this research activity results in an injury, treatment will be available, including emergency treatment and follow-up care as needed. Care for such injuries will be billed in the ordinary manner, to you or your insurance

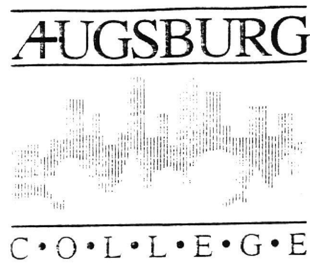
company. If you think that you have suffered a research related injury let the study researcher know right away.

Contacts and Questions:

The researcher conducting this study is Ms. Carol Saunders @ 763-782-6463. My advisor is Dr. Lucie Ferrell @ 651-772-7714. If you have any questions now or in the future, please feel free to contact us. Please keep this letter for your records.

Your participation in this study is greatly appreciated and I thank you for your consideration.

AUGSBURG



C•O•L•L•E•G•E

MEMO

9 June 2000

To: Ms. Carol Saunders

From: Dr. Sharon Patten, IRB Chair SKP
Phone: 612-330-1723

RE: Your IRB Application

Thank you for your response to IRB issues and questions. As we discussed over the phone earlier this year, your study was approved (IRB approval number 2000-38-3). Please use this number on all official correspondence and written materials relative to your study.

Your research should prove valuable and provide important insight into an issue in social work practice, planning, and policy. We wish you every success!

SKP:ka

cc: Lucie Ferrell, Ph.D., Thesis Advisor

DEPARTMENT OF SOCIAL WORK
Campus Box #51 • 2211 Riverside Avenue • Minneapolis MN 55454 • Tel. (612)330-1189 • Fax (612)330-1493

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Research Subjects' Protection Programs
Institutional Review Board: Human Subjects Committee (IRB)
Institutional Animal Care and Use Committee (IACUC)

Box 820
D528 Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, MN 55455-0392

612-626-5654
Fax: 612-626-6061
irb@umn.edu
iacuc@umn.edu
http://www.research.umn.edu/subjects.htm

May 19, 2000

Carol L. Saunders
3119 28th Ave. S.
Minneapolis MN 55406

Re: "Patient Satisfation in an Outpatient Clinic Environment and Servant Leadership"

Human Subjects Code Number: **0005E51721**

Dear Ms. Saunders:

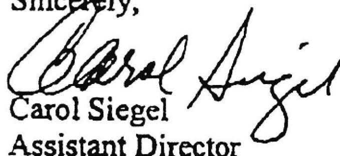
The IRB: Human Subjects Committee determined that the referenced study is exempt from review under federal guidelines 45 CFR Part 46.101(b) category #2 SURVEYS/INTERVIEWS; STANDARDIZED EDUCATIONAL TESTS; OBSERVATION OF PUBLIC BEHAVIOR.

The code number above is assigned to your research. That number and the title of your study must be used in all communication with the IRB office.

Upon receipt of this letter, you may begin your research. If you have questions, please call the IRB office at (612) 626-5654.

The IRB wishes you success with this research.

Sincerely,



Carol Siegel
Assistant Director

CS/jmr

CC: Lucie Ferrell

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