8-15-2004

Servant Leadership in Healthcare

Sean J. Porter
Augsburg College

Servant Leadership in Healthcare

Sean J. Porter

Submitted in partial fulfillment

of the requirements for the degree of

Master of Arts in Leadership

Augsburg College

Minneapolis, Minnesota

2004

Certificate Of Approval

MASTER OF ARTS IN LEADERSHIP

AUGSBURG COLLEGE

MINNEAPOLIS, MINNESOTA

This is to certify that the Non-thesis project of

Sean Porter

has been approved by the Review Committee for the Non-thesis project requirement for the Master of Arts in Leadership degree.

Date Non-Thesis Completed: 8-15-04

Committee: Velma J. Fashbrook

Adviser

Rosemary Link.

Reader

Abstract

Servant Leadership in Healthcare

Sean J. Porter

June 4, 2004

____ Thesis

____ Leadership Application Project

_X__ Non-thesis (ML597) Project

America's $1.4 trillion healthcare industry is poised to grow rapidly in volumes, revenues and expenditures. Rising healthcare expenditures signal a return of medical inflation, with double-digit premium increases for employers and consumers, and an increased threat of more government regulation and healthcare reforms. In addition, the post 9/11 economic recession and layoffs have increased the number of uninsured patients. While hospitals are investing in expansion initiatives, there is a continued workforce shortage, particularly in nursing. According to Russell Coile, Jr. (1999), healthcare is in crisis.

More focus is being placed on leadership to empower employees and create positive patient care experiences. Healthcare leadership carries enormous responsibility; effective leadership is crucial for effective, safe patient care. Servant leadership, first popularized by Robert Greenleaf in 1970, provides an effective model for healthcare leadership because it puts serving others as the number one priority. The characteristics of a servant leader include: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of the people, and building community. These characteristics mirror many values in healthcare and the successful

implementation of a servant leadership culture will enable hospitals to navigate through the current crisis. Servant leadership is being successfully implemented in many industries, but there are only a few examples in healthcare.

This paper explores the trends in healthcare and their implications for leadership. It explains the value of adopting a servant leadership model and examines how a servant leadership culture can be successfully developed and sustained.

Acknowledgements

This research paper resulted from three years of dedicated studies to achieve a Master's Degree in Leadership from Augsburg College. First, I would like to thank the faculty, staff, and students of Augsburg College for providing the foundation to expand my leadership knowledge. The program enlightened my vision, persuaded me to take risks, and encouraged my creativity. Augsburg has strengthened my skills and provided the opportunity to grow both personally and professionally.

I would also like to thank my family and my wife. Their support over these years has meant more than words can express. When I felt ready to throw in the towel, they helped me stay on track and keep focused. My family never gave up on me, and for that, I thank them. In addition to my family, I would like to thank God. I have been very blessed in my life, including my schooling opportunities.

Finally, I would like to thank Norma Noonan and Velma Lashbrook. Norma has been a support from the moment I walked on campus at Augsburg. As a member of the MAL committee and now a member of the Alumni committee, I feel very fortunate to have my opinions shared and supported. Additionally, Velma is a wonderful instructor and advisor. She provided me insight, took the time to know me as a person, and provided tremendous support throughout the MAL program.

This paper is not a result of only me. It is a result of an institution, a family, and a wonderful support system coming together. That is true leadership.

Table of Contents

Healthcare Crisis

In a real sense, there has always been a healthcare crisis in the United States and there will always be one. Because it is always changing and advancing technologically, the healthcare industry continuously faces new challenges. There is a real conflict between how much money consumers and insurers are willing to spend on healthcare, and how much care healthcare providers think is appropriate.

Healthcare is a large and complex industry. This multifaceted system is the largest industry in the United States economy at 14 percent of the gross national product (Zillars, 2004). In addition to being the largest industry, it continues to grow at a rapid pace. National healthcare expenditures climbed to $1.3 billion in 2000, increasing 7.4 percent over previous years (Coile, 2002).

Healthcare costs continue to rise at a rate higher than general inflation. Adding to the problem, over 41 million people are uninsured, while millions more are underinsured. The recession has had an impact on the number of uninsured Americans. Lawrence Gostin (cited in Gilkey, 1999, p. 52) states that, "over forty million people in the United States lack health insurance coverage at any time". This equates to approximately fifteen percent of the population. Thus, many people go without basic healthcare. This impacts their quality of care, the risks associated with not receiving proper care, and the financial stress put on healthcare organizations to pick up the expense.

Those patients that have Medicaid have additional problems. Medicaid is a particularly unstable source of coverage, and transitions off Medicaid usually result in a time uninsured. Two-thirds (65 percent) of those who lost Medicaid coverage between 2000 and 2004 became uninsured. Further, a large proportion (40 percent) of those ever on Medicaid lost coverage and then re-enrolled later, in a repeated pattern of cycling in and out of public coverage (Gostin, cited in Gilkey, 1999).

Rising costs are a function of many related issues including:

- Administrative inefficiency
- Overpricing of services
- Over-utilization of services
- Increase in the elderly population and in chronic health and societal problems.

Healthcare is paid for by three primary sources. Government pays almost 44 percent of the national healthcare bill. Over 75 percent of expenditures are paid by federal programs, such as Medicare and programs for the military and veterans, federal prisoners, and Native Americans; and state Medicaid programs to provide services to the destitute and disabled. The second source of funding is private insurance, either paid for by employers or purchased by individuals. Finally, individuals who do not have insurance may pay directly for health services or non-covered services such as home care, nursing home care, certain drugs, and outpatient therapies.

Healthcare requires high capital investment to sustain competitiveness; hence, there is significant pressure for financial accountability. Capital is necessary for healthcare to expand programs, remodel and build new hospitals, and purchase new equipment. Having access to capital is essential for the growth of the healthcare industry. In addition, the nursing profession accounts for as much as half of an organization's total expenses. Senior leadership must justify capital expenditures and operate within productivity standards. These standards must balance developing cost effective services with providing effective care.

Healthcare is also extremely complex. The healthcare system consists of hospitals, inpatient and outpatient clinics, nursing homes, rehab facilities, hospice care, on-line care and in-home care. In addition, chiropractic services, dental services, and natural healing are often grouped into

healthcare. There are for-profit and not-for-profit hospitals. Most hospitals are union based; others, such as the county hospitals, operate without union presence.

Healthcare organizations across Minnesota are complex in structure. Minnesota prevents for-profit models of healthcare and has a political legacy and community focus much more analogous to the prairie states in Canada than to the states in the rest of the region (Morrison, 2000). For-profit hospitals typically prefer working in non-union facilities, but Minnesota is predominantly a union state for healthcare. Unions increase operational expenses, especially during contract negotiations and strikes.

Health Maintenance Organizations (HMOs) were first developed in Minnesota and have quickly spread throughout the United States. Minnesota is the headquarters of United HealthCare, the leading commercial HMO. HMO's are an inexpensive way for patients to receive care, but the most restrictive. The plan only covers doctors in the network and requires referrals to see a specialist. Physicians work in a group to provide services and all prescriptions and additional care must be approved prior to service. This cost-effective option has become popular and widespread over the past 25 years as healthcare costs have continued to rise and the population has continued to age.

Healthcare is currently facing many challenges: the post 9/11 recession, Medicare reforms, increased competition, and the cost of technology, to name a few. Politically, the Republican Party often has little interest in healthcare issues and the Democratic Party very few new ideas. The Democrats have backed off from their health reform positions of earlier decades, when they seriously pursued universality, at least for the elderly and the poor. The new political debate centers more on regulating managed care than on making meaningful expansions of coverage (Morrison, 2000).

Many hospitals are challenged by the decrease in Medicare reimbursement. In fact, the Medicare program is heading towards bankruptcy. According to Medicare's own trustees (Gilkey, 1999) the Medicare trust fund would have been depleted by the year 2000 if it were not for Medicare reforms. The reforms, according to Gilkey (1999) will only delay the problems. He also states that "by the year 2045, when today's high school graduates retire, almost 53 percent of the U.S. taxable payroll will be needed to fund the Social Security and Medicare benefits promised under current law" (p. 362).

According to Coile (1999), seven critical components mark the emerging U.S. healthcare industry:

- Third-party payers are relinquishing their efforts to control health costs, focusing narrowly on marketing and customer service to demonstrate their value as more traditional intermediaries.
- Providers are assuming financial, professional, legal and moral risk for patient care in capitated payment arrangements.
- Consumers with access to extensive on-line information and patient support groups take an active role in their own health improvement.
- Information systems are linking highly decentralized provider networks to integrated care systems by providing real-time information on patient status, clinical care, and financial costs.
- The health system is refocusing on health promotion for the 85 percent of the population who are the worried well and the 15 percent who are at risk or are already chronically ill.
- On-line nurses and home health workers are providing day-to-day management for high-risk patients and the chronically ill.

- Public report cards are supplying detailed information on clinical outcomes and patient satisfaction for each health plan and provider network.

Healthcare is typically not seen as a "business" by the larger population, but instead a place to heal the sick and to provide care for those in need. Indeed, hospitals are service organizations. However, hospitals cannot schedule services like most industries because of the wide fluctuations in patient load. Hospitals "seldom use a machine shop priority system such as first come first served for treating emergency patients. They do schedule products (such as surgeries) just like a factory, even though finished goods inventories cannot be kept and capacities must meet wide variations in demand" (Heizer & Render, 1999, p. 601).

Since the business function of health care was not a priority, the non-profit healthcare sector has undergone much scrutiny from the Attorney General of Minnesota in the past few years. According to Minnesota Public Radio,

> Minnesota Attorney General Mike Hatch has released his year-and-a-half-long investigation into the state's largest health-care organization, Allina Health System. At the same time, Allina announced it has agreed to pay $16 million to settle a federal investigation into improper billing. The two actions end the state and federal probes into Allina, and the company says it's trying to move forward with new management and policies preventing wasteful spending (McCallum, 2001).

As a result, there has been more focus placed on the bottom line, and less on the patients. The consequences have become evident in recent news stories of malpractice lawsuits (Rubin, 2004).

Many hospitals and clinics desperately need to refocus their values and develop new strategies to deal with the changing environment. This requires leadership and improved employee morale to continue the patient focus while adhering to government policies and regulations. Increased focus on quality healthcare by caring employees is creating competition in tight markets.

Labor shortages continue to threaten the health industry with more than 125,000 nurse vacancies across the United States (Coile, 2000). Healthcare organizations are beginning to think creatively about how to improve patient satisfaction and continue having profitable patient volumes. These unique challenges exemplify the need for quality leadership in health care.

Recent research has suggested that job satisfaction substantially influences job performance, as well as other important areas such as health and general satisfaction. One of the most important factors that positively influences job satisfaction is "a participatory management style which emphasizes employee empowerment, a positive and non-critical approach to problem-solving, and team-building" (Wilson, 1998). Other factors are:

- A participative, "caring," supportive, and innovative organizational climate that fosters trust in management;
- Opportunities for advancement and promotion; and
- Interesting, challenging work with task variety.

Employee dissatisfaction not only leads to absenteeism, employee turnover, and decreased productivity, it also adversely affects the employee and department morale.

Healthcare leadership is under stress, because of these diverse challenges facing healthcare today. The most visible leadership role in a healthcare organization is the Nurse Manager. Given the nursing profession's unique position in healthcare systems, development of strong executive leadership is a paramount concern. Most nurses in leadership positions have been taught leadership only as part of their basic nursing education. At that time, however, they have no professional experience upon which to reflect. They can only absorb general information and principles and observe those actions of other nurses in leadership roles. Consequently, many are unprepared for their later leadership roles and responsibilities. They have excellent clinical skills, which can provide some leadership competencies, such as conflict management and teamwork, but those competencies

alone will not provide successful leadership. Leadership development will provide competencies and skills to actively work through these challenges and provide excellent service to employees and patients alike. Leadership development is essential to navigate through the healthcare crisis. It will move leaders beyond emergency intervention to leading others by serving others.

The healthcare challenge has been termed a crisis for decades. Managers have traditionally operated in crisis mode, often putting out the first fire they encounter. The external and internal pressures do not have an immediate fix. The economy, the government, the population, capital, and technology are all factors that affect the industry. However, there are options that can help leaders deal effectively with healthcare challenges. Leaders may have little influence on external factors, but there are changes within the structure that can soften the internal challenges. Examining processes for quality, developing a common leadership philosophy and structure across the organization, and creating resources to support the change management are examined further.

Purpose of the Study

The healthcare crisis presents ongoing challenges for healthcare organizations, leaders, and human resource professionals. To successfully address these challenges, effective leadership must be developed and sustained. This study examines why and how the servant leadership can be an effective model for healthcare leaders to apply in empowering employees, increasing productivity, and reducing turnover. Of specific interest is the potential application of this model for Allina Hospitals and Clinics.

This study is specifically intended to answer the following questions:

1. What human resource strategies can be employed to help healthcare organizations respond to the current challenges?
2. Why is servant leadership an effective model for healthcare?
3. How can a servant leadership culture be developed and sustained?
4. What specific recommendations are appropriate for Allina Hospitals and Clinics?

Responding to the Challenge

The rapidly expanding scope of healthcare has led to increasing complexity in its delivery. Patient satisfaction is increasingly taken as an important measure of quality by most hospitals. The expectations that people have towards medical care are ever increasing and are limited not only to the clinical outcomes, but also involve the delivery process, margin of safety, and behavior of personnel. There is a need to use the principles of quality assurance systems covering all activities of the healthcare unit. Variations in the types of healthcare make it necessary that some form of grading is incorporated into the assessment process to deliver exceptional patient care. It is clear from the foregoing that the most important factors for improving performance and inducing workers to change behavior are quality care and job satisfaction. Many leadership theories offer ways to improve quality and bring job satisfaction to employees in ways that enhance patient satisfaction with the services provided.

Since hospital management is a critical part of the healthcare industry and depends largely on its employees to deliver quality care, the Human Resources department plays a central role. It must balance the quality of care with productivity to ensure profitability. Two human resource strategies to address these needs are Total Quality Management (TQM) and leadership development. The primary TQM principles focus on satisfying the needs and expectations of customers and to constantly improve the quality of all organizational activities and processes. Leadership development focuses on establishing a culture that supports the organization's mission.

Total Quality Management (TQM) and the Malcolm Baldrige Award

In 1987, the National Institute of Standards and Technology (NIST) developed the Malcolm Baldrige National Quality Award (MBNQA) with the goal of promoting and rewarding quality awareness and practices. In 1995, award criteria specifically developed for healthcare organizations were introduced. Healthcare organizations embraced the idea, and quickly implemented processes

and procedures to earn the award. The criteria were revised in 1998, and 1999 marked the first year that for-profit and nonprofit healthcare organizations were permitted to apply for the award. However, in 1999 and 2000, there was not a winner.

The criteria consist of seven categories that together address an organization's systems and processes, its information infrastructure, and its performance. The seven categories are: (1) strategic planning; (2) focus on patients, customers, and market; (3) staff focus; (4) fact based system for measurement; (5) process management; (6) organizational performance results; and (7) driven results. Together these categories comprise Total Quality Management (TQM). Initially, industry quality experts assisted 21 healthcare organizations in using quality management methods to solve a variety of problems. Most of the participating organizations "reported positive results, providing evidence that quality management can improve business processes and service processes in healthcare organizations" (Goldstein & Schweikhart, 2002, p.64).

Yukyeong Chong (2000) investigated the perceived total quality management [TQM] performance in hospital food and nutrition service departments by surveying clinical nutrition managers and dietitians, and foodservice managers and supervisors, using a questionnaire containing items about three constructs of TQM performance and demographic characteristics. Participants from seven Council of Teaching Hospitals rated their perceptions of TQM performance. Seventy-three (57 percent) of the 128 respondents, completed the study.

The three TQM constructs - organization, information, and quality management - were evaluated by Chong (2000). The clinical nutrition manager and dietitian group had mean ratings between 3.1 and 4.7 (5-point Likert scale) and the foodservice manager and supervisor group had mean ratings from 2.7 to 4.0. Education level was significantly correlated (r=0.44) to performance of employee training in the clinical nutrition group. The number of employees directly supervised was negatively correlated (r=-0.21) to the performance of employee training in the foodservice group

(Chong, 2000). Performance of employee training is related to both education and work experience.

As healthcare providers have embraced Total Quality Management (TQM), much emphasis has been placed on education and training in the use of TQM tools. This includes statistical quality control methods and techniques, employee empowerment, and other outcome-oriented methods of the quality movement. While these methods are important, singular emphasis on these tools can result in solutions that accomplish little. TQM begins with the customer. If the customer feels their needs and expectations are met by services, the quality will increase (Jablonski, 1992).

Recognition of the importance of TQM implementation and commitment to quality improvement in food and nutrition services in hospitals is increasing. However, published research on the performance of TQM approaches in hospital food and nutrition services is limited. The Chong study found that hospitals had their own distinctive quality missions, which led to different approaches. Although communication was important in this study, Chong discovered that the communication system was rated differently by groups and positions in the nutrition department. The managers perceived higher TQM performance than the dieticians or supervisors.

Nutrition care is one of the essential roles of the clinical nutrition professional. As organizational structures of food and nutrition services are reorganized and clinical nutrition becomes one of the clinical professional services, patient feedback data about nutrition care should be collected and reflected so that there are improvements. As Cartin (cited in Chong, 2000) stated, for effective TQM implementation, satisfaction of internal customers (i.e., employees and others inside the organization) should be considered along with external customers (i.e., patients or patients' families). Customer values directed by quality leadership should be at the heart of organizational strategy to improve the quality of services of the organization.

St. Joseph's Hospital, based in the St. Louis area, was the first healthcare winner in the history of the Malcolm Baldrige award after four attempts at winning the award. The organization operates multiple locations and has over 22,000 employees. One program the organization used was a guarantee in the emergency room that patients would have a doctor visit within 30 minutes of arrival. At least 90 percent of patients are seen in that time (Jones, 2003).

Leadership Development

In today's complex and rapidly changing corporate world, there is a need for a dramatic change in the ways businesses are conducted and organizations are managed. In the past, organizations were merely concerned with making profits and achieving targets and it was the job of the leader to ensure all tasks were done on time. Although the goal of financial accountability has not changed, it must be balanced with quality care that ensures patient satisfaction. Achieving this balance requires a new form of leadership.

People have been studying the concepts of leadership and organizations for many years. The purpose is to understand two factors. First, there is a need to understand how a group effectively works. What are the group dynamics and how does a leader develop them? Second, there is a need to refine the organization of a given group so that the leaders will be able to guide it more effectively. Choosing the most appropriate leadership model for healthcare environments is critical.

Hospitals are service organizations that provide healthcare services to patients. Keeping the patients satisfied with the services is very important to the success of hospitals. By its very nature, healthcare is a service that demands the participation of all involved, those providing the service: the medical, paramedical and other staff, and the patients themselves. The key to good health service in a hospital is employees that have a high level of job satisfaction, are motivated and have high morale. The highest form of satisfaction comes from the *intrinsic* factors: the job itself, rather than

the *extrinsic* factors such as pay, status and the working conditions. The two are inter-related, to the extent that satisfied employees are able to deliver a better level of service to the patients.

Likert (cited in Mullins, 1995) describes the nature of manager-subordinate relationship in terms of a four-fold model of management systems, identified as follows:

- System 1: Exploitative authoritative
- System 2: Benevolent authoritative
- System 3: Consultative
- System 4: Participatory group

Decisions in exploitative authoritative relationships are imposed from above and are based more on fear than on positive rewards, and there is very little teamwork or communication. Responsibility is centered at the top of the organizational hierarchy.

In benevolent authoritative relationships, there is a system of rewards but the leadership is condescending (i.e., assuming that he or she knows what is best). Responsibility in this system resides at the managerial levels but not at lower levels.

In consultative relationships, there is a degree of trust in the subordinates, the system is based on rewards, and there is some involvement. Teamwork and communications are present to a fair degree both horizontally and vertically. Responsibility is also spread more widely in the organization.

In participatory group relationships, leadership involves trust and confidence in the subordinates; there is a high degree of participation and teamwork and communication. All levels of the hierarchy share responsibility. Thus, participative, interactive decision-making involves subordinate employees.

Motivation in participatory group relationships – that is servant leadership – is based on a system of rewards that includes not only financial rewards but also recognition, and responsibility.

Servant leadership, first introduced by Greenleaf (1979, 1982) will be examined in-depth. One reward system explained by Porter-O'Grady (2003) references Abraham Maslow's (1943) hierarchy of needs and claims that the higher needs of the employees are also met. In Maslow's theory, motivation is explained in terms of human needs. Physical needs such as food, clothing, shelter, and comfort are at the lowest level. Next are safety needs, which include security for self and possessions, and avoidance of risk, harm, and pain. Then come the social needs, which include companionship, acceptance, love and affection, and group membership. Higher levels include esteem needs (i.e., responsibility, self-respect, recognition, and sense of accomplishment) and self-actualization or self-realization needs (i.e., the need to develop one's potential to the full and give vent to self-expression). A participatory style of management tends to take care of higher level needs by permitting employees to take part in decision making and giving them a sense of being part of the group. Thus, while at one level it can help fulfill physical needs, at other levels it helps fulfill the higher social needs of belonging, recognition and self-esteem. It also allows the managers to identify the unmet needs of employees, improve their level of job satisfaction and, thereby, often improve job performance and the work environment.

Effective leadership involves constantly monitoring the work environment for morale and satisfaction. The leader helps others gain enthusiasm, take risks, and work toward highly focused energy. Ideally, hospital and nursing management should be a combination of both leadership and management, consisting of the development of visionary programs and resources to keep the organization viable.

Leadership involves vision, guiding opinions, influencing and motivating, anticipating the future, and having the courage to act. Management is described as directing, controlling, coordinating and supervising others to achieve the goals of the organization. Managers have the formal authority to interpret and enforce policy. Mill (1991) has proposed that employees be treated

like customers by recognizing their importance, learning how to train them, and learning how to motivate them. He suggests that while the customer should be the number-one priority for employees, the number-one priority for managers should be the employees.

There are many nursing theories that abound regarding the right and wrong way to care for a patient, but it appears commonly accepted that, when it comes to the nursing environment, there are many different patients and different requirements of those patients. There is also a widely accepted view that there may be many right ways, some of which are determined by the medical condition and others by the mental attitude and personality of the patient. Recent research describes one positive nursing theory as that of servant leadership. This servant leadership theory is new to healthcare, and can be seen as influencing not only the nursing care of the individual by the nurse, but also the way in which nursing leaders will manage their departments and react to the needs of their patients (Porter-O'Grady, 2003). It also has value for leaders in other areas of healthcare.

Servant leadership theory can be briefly described as a management technique where the leader is a facilitator making the necessary resources and facilities available to those they manage, rather than the authoritarian approach where it is the manager that determines the course of action in the first place (Porter-O'Grady, 2003). Here the action is determined at a lower level, the method of implementation may be chosen by the manager, as they may need to reallocate funds and switch around the use of facilities, but they become resource managers and overall supervisors with discretion given at lower levels. If we apply this management technique to nursing then we can see that patients will be given a great deal more discretion and autonomy in their own treatment rather then being required to fit in with what the health professionals deem necessary.

The theories that underlie this ideal and methodology is that, when individuals have control over their own condition, then there will be a positive mental response that will aid recovery. They move from being the treated and a victim of their own treatment to being seen and feeling respected

as an active partner in their recovery. They do not feel that they have no or little control over their own bodies. There will be certain medical needs for some conditions, but, even with these, there is a basic right of the individual in most circumstances to decline that treatment even if it results in their death. If the patient has control over treatment then a positive response may be seen in recovery.

In some cases, the management of patients by the servant leadership principle may mean a faster recovery; but, in others, it will not speed recovery, but will lead to a higher quality of life and a much happier patient. The needs for attention and complementary resources have been shown in many studies to be lower in happier and more contented patients than in those who are passive participants in their own treatment. The follow-up visits and needs of these patients are also lower. This means that, if the leader of the nursing division is seeing their job as one of managing resources to facilitate the required care, they may well be able to have a more productive department and reduce the level of follow-up and attention. Therefore, they either may have reduced costs for the same results, or are able to do more in the long term with the same resources.

In summary, when examining leadership development, the servant leadership theory is introduced. Servant leadership can improve employee morale, patient care, and customer satisfaction. In addition, strong leadership will assist with job satisfaction, higher levels of self-esteem, and increased job performance. This leadership theory's positive outcomes are numerous and will be examined in greater detail. There are many characteristics that define servant leadership and how they were created. In addition, there are some limitations to this theory.

Servant Leadership

The concept of servant leadership was first introduced in a 1982 essay by Robert K. Greenleaf entitled, "Servant as Leader" and arose through his near half century pursuit of shaping large institutions and by reading Herman Hesse's (1956) short novel, *Journey to the East.* In this story, the main figure, Leo, accompanies a group as their servant on a long journey. At one point, Leo disappears and without his caring spirit, the group quickly falls into a state of disarray and abandons the journey. After years of searching, the narrator finds Leo and he is taken in by the religious order that originally sponsored the journey. As the large number of League officials filled the hall, Leo disappeared among them. When the hall became silent, the Speaker called forth Hermann, the narrator, who was to stand before the High Throne and answer for having deserted the "Journey". The Speaker asked Hermann whether he would prefer judgment to be passed by the officials of the Court of Justice, or by the President of the League. He answered that either would be acceptable. To the narrators utter amazement, he watched as this man, clad in a brilliant golden robe made his way to the front of the hall. As he approached the High Throne, each row of officials rose to greet him, and Hermann looked on in shocked disbelief. It was Leo the servant; he who so willingly carried the luggage for the Journey. It was Leo, the messenger, who had summoned Hermann to this judgment hall. Leo the humble servant was, in reality, Leo the President of the League (Hesse, 1956). This reading solidified Greenleaf's concept of servant leadership – that those great leaders must first serve others and this simple notion is central to all his or her greatness.

As presented by Greenleaf, this new kind of leadership model puts serving others – including employee, customer, and community – as the number one priority. Servant leadership emphasizes the need for individuals to provide increased service to those around them, a more holistic approach and mindset toward the workplace, a sense of well being and belonging in a

community, and increased opportunities for decision-making power. The following quotation clearly outlines Greenleaf's central theme:

> Caring for persons, the more able and less able serving each other, is the rock upon which a good society is built. Whereas until recently, caring was largely person to person, now most of it is medicated in institutions – often large, complex, powerful, impersonal; not always competent, sometimes corrupt. If a better society is to be built, one that is more just and more loving, and provides greater creative opportunity for its people, then the most open course is to raise both the capacity to serve and the very performance as servant, of existing institutions by new regenerative forces operating within them (p. 14).

Larry Spears' *Insights on Leadership, Service, Stewardship, Spirit, and Servant Leadership* (1998) is a highly informative collection of essays on the subject of changing leadership needs, techniques, and styles. The book contains views of many management gurus on the theory of servant leadership that was first offered by Greenleaf in the 1970s. Since then, servant leadership has been frequently discussed and analyzed with numerous management experts offering their own definitions of this type of leadership. While it has been around for over three decades, servant leadership gained prominence in the 1990s when many companies underwent dramatic cultural changes, including greater concerns for customer and employee satisfaction, and incorporated a different style of leadership to meet new challenges.

Servant leadership refers to the style of management where the leader focuses on the well being of those under his or her supervision. Instead of getting the work done by any means possible, the servant leader is required first to take into account the welfare of his or her staff and all those who help him or her achieve the primary goal of the organization. Servant leadership stresses the importance of providing better service to those who contribute to the growth of the organization. The concept, however, goes well beyond the corporate world and can be incorporated

in other fields like politics, education, law, and healthcare. Leadership style, however, appears to play the most significant role in the corporate world where employees can no longer be treated as hired hands and are instead being recognized as human capital. One of the essays in Greenleaf's "The Servant as Leader" defines servant leadership in these words:

> The servant leader is servant first. Becoming a servant leader begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead.... The best test is this: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? (1998, p. 18-19).

In traditional leadership, a leader is required to control his employees and exercise his or her authority frequently to get the tasks done. On the other hand, in servant leadership, a leader serves his employees by focusing on their well being and addressing their grievances. This strategy helps to motivate the employees for achievement of various company goals.

Servant leadership works on the principle that a leader is there to take care of his or her people. The leader is required to act like a king who builds the entire empire on the principles of trust and care. Servant leadership literature, for this reason, focuses on everything from Jesus and the Bible to modern-day management theories to explain the significance of this kind of leadership. This is obvious from close readings of Spears' (1998) book and the essays it contains. Contributors like Steven Covey and John Lore have focused on the moral side of the issue while Ken Blanchard and Margaret Wheatley discuss the issue from purely management standpoints. In their own unique ways, all contributors sought to highlight the flaws of traditional leadership and the positive effects of this new leadership style.

Traditional leadership lacks all positive attributes of servant leadership because it follows a control-based management theory. Traditionally, leaders were required to be strong–willed powerful

individuals who could manage an organization by applying force. This style of leadership worked when organizations had a stable, centralized structure. However, with the passage of time, organizations embraced decentralized structures, thus rendering traditional styles of leadership useless. Coercion is no longer an acceptable leadership tool and organizations everywhere are required to achieve targets by motivating employees and genuinely showing consideration for their welfare.

Servant leadership is the by-product of a socially responsible organization. Ken Blanchard in his essay "Servant Leadership Revisited" (Spears, 1998) explains why servant leadership works in the 21st century: "Every manager works for his or her people. It is in relation to this responsive, serving role that the effective manager now encourages, supports, coaches, facilitates, and does everything possible to help his or her people be successful. This is where servant-leadership really takes over" (p. 26). In other words, servant leadership works because it replaces the oppressive leadership style of the past and better understands the needs of the emerging breed of employees.

Characteristics of Servant Leaders

Through his affiliation with the Greenleaf Center and personal relationship with Greenleaf himself, Spears (1998) was able to outline ten characteristics manifested by servant leaders:

- Listening - Servant leaders are not only there for their communication and decision making skills, but also to make a deep commitment to listening intently to others.
- Empathy - Servant leaders understand and empathize with others, accept them, and value them for their special unique spirit.
- Healing - Servant leaders have a tremendous potential for healing themselves and others of broken spirits and emotional hurts and scars.
- Awareness - Servant leaders, by fostering self-awareness and general awareness, can aid in the understanding of ethics and values.

- Persuasion - Servant leaders usually rely on persuasion rather than positional authority and convince rather than coerce. This characteristic highlights the difference between a traditional authoritarian leadership model and servant leadership.
- Conceptualization - Instead of the traditional manager approach and concern toward short-term operational goals, a servant leader goes beyond the day-to-day realities and dreams great dreams.
- Foresight - This is probably the only servant leadership characteristic with which one may be born, while others can be consciously developed. Foresight enables servant leaders to learn from the past, accept the present, and be in tune with the future.
- Stewardship - CEO's staff, directors, and trustees of all institutions play significant roles in holding their institutions in trust for the greater good and benefit of society.
- Commitment to the growth of people - Instead of people being valued only at their level of external or tangible contributions, servant leaders are committed to "seeing" the intrinsic value of each individual.
- Building community - Servant leaders pursue building community back into the workplace environment at the lowest level possible.

However, Spears (1998) stated, "these ten characteristics of servant leadership are by no means exhaustive" (p. 6). The overall literature written about servant leadership reveals at least 20 distinguishable attributes, which include all of Greenleaf's characteristics in some form.

Limitations of Servant Leadership

Participatory decision-making has the advantages of making greater use of the knowledge, information, experience and diversity of others, but suffers from the disadvantages that it requires more time and resources and involves more risk and is more prone to conflict. Servant leadership

could create an opening for those power hungry individuals, who may try to subvert and take over the leadership role. In addition, the cohesiveness of the group, and the consensual attainment of the decision arrived at may be just an illusion, driven more by peer pressure, or the pressure to conform than by real consensus.

Tarr (cited in Spears, 1995) discusses three potential problems or challenges faced by a servant leader. The first challenge is to be an empathic individual; it is difficult, over duration of time, to continually be a true listener and empathize with the other individual. The second possible conflict revolves around being both empathic and mutually collaborative. In this scenario, the servant leader must become vulnerable and risk sharing something of himself or herself with the other individual. The third difficulty involves the collaborative process. Since there are usually various goals, beliefs, values, or methodologies brought to the table by different people, a servant leader must exhibit great perseverance and strength.

Another possible source of difficulty for a servant leader is the ever-present epidemic of hurry sickness; that illness brought on or exacerbated by stress, rush, and constant pressure. If caught up with hurry sickness, a servant leader would be ineffective in the essential qualities of listening, understanding, empathizing, and increasing awareness with the broadening of perception. Although these difficulties could pose issues, the benefits of servant leadership outweigh these potential problems.

Successful Implementation

No organization today is immune to change. To cope with new technology, competitive and demographic forces, and new leadership challenges, every industry is altering the way their organizations do business. According to John Kotter (1998), these change efforts have come through many methods: training, restructuring, mergers, and total quality management. Producing change is about 80 percent leadership and about 20 percent management. Kotter states, "In most change efforts I have studied in the past 20 years, those percentages are reversed. Our business schools and work organizations continue to produce great managers; we need to do as well at developing great leaders" (1998, p. 33).

Changing the Culture

Many organizations are transforming their culture as they redefine their leadership philosophy. Change management can be a difficult component in the implementation process. While there are no guaranteed change strategies, there is a clear pattern to the reasons for failure. Most often, it is a leader's attempt to shortcut a critical phase of the change process. Kotter (1998) identifies eight common errors that organizations make with change:

1. Allowing too much complacency
2. Failing to create a sufficiently powerful guiding coalition
3. Not understanding the power of the vision
4. Undercommunicating the vision by a factor of 10 (or 100 or even 1,000)
5. Permitting obstacles to block the new vision
6. Failing to create short-term wins
7. Declaring victory too soon
8. Neglecting to anchor changes firmly in the corporate culture

These errors can have serious consequences on the organization. They can create resistance to change, frustration from the employees, or cause the organizational efforts to fail. Failure can damage credibility, both for the leader and the organization.

Kotter took the research one step further to create steps that will make an organization successful with change. Kotter (1998) discusses eight steps to transform an organization successfully, which are summarized as:

1. Establish a sense of urgency – examine the market and crises.
2. Form a powerful guiding coalition – assemble a powerful group and encourage them to work as a team.
3. Create a vision – develop a vision that will help direct the change and a strategy to achieve the vision.
4. Communicate the vision – effectively communicate the vision to everyone.
5. Empower others to act on the vision – remove obstacles and structures that undermine the vision and encourage risk taking.
6. Plan for and create short-term wins – plan and create performance improvements and recognize those involved.
7. Consolidate improvements and produce still more change – use increased credibility, have employees that can implement the vision, and reinvigorate with new projects.
8. Institutionalize new approaches – articulate the connections between new behavior and organizational success.

Successful change starts with the organization, however there needs to be emphasis placed on the individual as well.

Individual change is a key component of organizational change and requires a process to help the individual transform. *Primal Leadership* by Daniel Goleman, et al. (2002) discusses five

discoveries for motivational change. The first discovery is identifying your ideal self. This is learning who you want to be, realizing that to make a lasting change, the change requires a strong commitment to the future. Vision creates the passion for change. The second discovery is the real self. In other words, it involves an inventory of talents and passions and determining who you are as a leader without having self-delusions. The third discovery is to develop a learning agenda. This involves developing action plans around learning instead of performance outcomes. More specifically, this would involve goal setting to learn and practice servant leadership skills. The fourth discovery is reconfiguring the brain. For example, the brain masters the competencies of leadership through implicit learning, or strengthening a habit. The fifth and final discovery is the power of relationships. Leadership and change can be very stressful. Mentors and coaches will help navigate through these difficult times. These discoveries and developments will help identify how leaders can transform their style to be more serving.

Creating a Servant Leadership Culture

Many organizations have successfully transformed their leadership philosophy to one adopting servant leadership. Three of the five best places in *Fortune's* January 2000 "Top 100 Best Companies to Work For in America" were held by companies that lived the servant leadership philosophy. Southwest Airlines, TD Industries, and Synovus Financial were the named companies. These companies have received recognition for their profits, customer satisfaction, and employee loyalty over the years. For instance, Southwest Airlines CEO, Herbert Kelleher, had one of the most distinguished organizational cultures in America. Servant leadership principles provide the foundation for altruism, defined as the constructive, gratifying service to others, and one of the core values of Southwest's culture (Sendjaya & Sarros, 2002).

Although not featured in *Fortune's* magazine, another impressive company has their grass roots in Minnesota. The company is Toro and the CEO, Ken Melrose, has written books and

articles on the positive affects of servant leadership at Toro. Melrose (1995) believes that servant leadership requires a unique balance: you have to be a servant of the organization, you have to keep the organization focused on financial goals, and you must weigh what is best for the employees with what is best for the company, and as you do, be clear and firm. He indicates that one of the toughest challenges is knowing when to lead by taking charge, when to lead by backing off, and when to lead by giving up control and empowering the employees:

> Leaders must learn to give power away; to serve and to channel that power to produce quality results that are reliable, responsive, and conform to requirements; and to put the customer first, last, and always. Move beyond your limits. Plant the seeds today that will enable you to become the excellent leader you can be (p.190).

Successful implementation of servant leadership at Toro helped turn a struggling organization to a leader in the industry. In 1981, Toro had lost more than $13 million and today Toro has repositioned itself to be a responsible manufacturer of innovative equipment. In 1996, just fifteen years after transforming the leadership philosophy, Toro posted record earnings of $22.2 million. Clearly, this change did not happen overnight, but was a result of long-term leadership growth and innovation.

Toro promoted eight ground rules for growth of Servant Leadership and the organization.

- Ground Rule One – Seed not Sod. Involving employees for long difficult battles to establish credibility and avoid the quick fix.
- Ground Rule Two – The Team Comes First. Demonstrating the value of self-direction, empowerment, cross-functioning, and synergy.
- Ground Rule Three – Providing Guidelines and Support. Specifying the quality and quantity of desired results, the guidelines of the job, and the available resources; defining responsibility and accountability; and describing the consequences and rewards.

- Ground Rule Four – Close the Perception Gap. Identifying the perception gap between what managers thought was job satisfaction for employees and what employees actually feel are the satisfiers.
- Ground Rule Five – Select Team Members. Believing that each member has great potential, potential is best achieved when people are performing, and best performance comes from people who are inspired, motivated, and encouraged.
- Ground Rule Six – Empowering the Team Leaders and Members. Clarifying expectations, goals, schedules, parameters, roles, responsibilities, consequences, and guidelines. Empowering the team by allowing them self-direction and the freedom to fail.
- Ground Rule Seven – Killing the Seeds of Discontent. Being visible and proactively walking the talk. Employees will begin to rise to their potential and trust the supportive environment.
- Ground Rule Eight – Do Unto Others. Asking employees to make a commitment to whatever corporate or division entity they work in. Expecting them to deliver their very best work as individuals and as a team.

Through these ground rules, the management support system nurtures a vision, motivation, open communication, and participation. This model is based on a simple premise:

> If the leader focuses on the needs of the customer and employees, expects and encourages results through valuing relationships, and recognizes people for their contributions, the likely outcomes will be a greater sense of trust and accountability leading to more risk taking, creativity, and innovation; a stronger team that multiplies its ability to meet customer needs; and greater empowerment to solve problems at grassroots levels leading to better solutions, increased feelings of self-worth, and greater productivity (Melrose, 1995, p. 76-77).

Healthcare Applications

Ironically, although the purpose of healthcare is to serve those in need, serving does not translate into the way managers lead employees. Many hospitals operate under crisis management, trying to stay afloat in the face of all of the industry challenges. Power can be addictive and intoxicating, even in healthcare. The root of craving power is insecurity in the future. In the past few years, healthcare has begun to deal with fundamental change that no one controls but every one of us has to respond to effectively.

The Sisters of St. Joseph Health System, one of the largest healthcare delivery systems in one of the nation's most populous states, has hardly been immune to these pressures. This healthcare system is convinced of the argument for "making a commitment to develop a values-based organization marked by a culture of servant-leadership" (Lore, cited in Spears, 1998, p. 305). Servant leadership, defined as "the use of gifts and talents on be-half of all of us in a way that models what we can be and empowers us to try", became a value for the organization (Lore, cited in Spears, 1998, p. 300). The organization has realized that it must go beyond rethinking strategy and restructuring as an organization and must build an integrated system of organizations. This involves bringing people together from very different backgrounds so they can work together in a congruent system.

It is a challenge to have one leadership theory permeate the leadership of an organization. Sisters of St. Joseph, the Baldrige winner mentioned earlier, has an edge in this regard because servant leadership has been their management style for decades. This quote came from within the system itself:

> Servant-leadership is the power to influence rather than the power to control. We realize that when we choose to influence people rather than control them, it at first might seem like weakness, but it really calls forth an inner strength. We think it really serves to engage and

> develop the creativity, productivity, and vibrancy that already exist in the regions. It is a style that we feel will be effective in facing the challenges that are so critical in today's healthcare environment (Lore, cited in Spears, 1998, p. 307).

Another strong healthcare organization is Parkland Health and Hospital System, a major provider of healthcare to the uninsured and indigent in Dallas County, Texas. Parkland's vision is to "strive to be a community-responsive servant leader dedicated to providing high quality, low cost services that improve the health, well being, and quality of life for persons and communities entrusted to our care" (Wesley, 2004). The servant leadership model provides a framework, which allows institutional leaders at Parkland to step out of their own areas of responsibility to become accountable for the improvements in the overall community. The results of this vision are impressive. Parkland was named a member of the Solucient 100 Top Hospitals: National Benchmarks for Success Class of 2002, which is the second time the hospital has made the list (Wesley, 2004). These examples clearly articulate the success of this model in diverse healthcare organizations.

Empirical Support for Servant Leadership

Since servant leadership is nearly void of directly supporting empirical research, the merits of the model are open to debate. Future research may reveal additional attributes that are not yet prominent in the existing literature. There are simply unavoidable problems in a theory that is still in its formative years. Nonetheless, until empirical research verifies the attributes of servant leadership and its effects, the existing frameworks are useful for leadership development.

A paper by Farling, Stone, and Winston (1999) sets the stage for empirical research on servant leadership. The paper defines servant leadership, introduces a theoretical servant leadership development model that assimilates the literature, then compares and contrasts the model to Greenleaf's perspective. The paper further identifies several areas where there are opportunities to

initiate the empirical research, such as "Does one variable require the investment of more time and resources than another?" (p.62). Finally, the authors encourage other researchers interested in servant leadership to join in the empirical research needed to advance the theory.

As many corporations change to team-oriented empowered cultures, bureaucratic supervisors must adapt their leadership patterns. There are many ideas on how to nurture and guide managers to adopt servant leadership. Although not a quick fix, certain core skills and behaviors are necessary ingredients for successful servant leadership. Companies may have to provide extensive training and development to help traditional leaders accept and understand the servant role. James Clawson (2002), author of Level Three Leadership, suggests that effective managers must first "know themselves'. Once they unlock their personal motivations and values, the core characteristics can be applied.

Recommendations for Allina Hospitals and Clinics

Allina Hospitals and Clinics is one of the largest healthcare providers in Minnesota and Western Wisconsin, dating back to the 1860s. Allina consists of 14 hospitals and 42 clinics, staffing over 22,000 employees. They have undergone many mergers and acquisitions over the past few decades to emerge as a leader in cardiac services, eye care and oncology. In addition, Allina offers a variety of services and programs, which continue to grow and expand to provide a continuum of care and aftercare.

Allina Hospitals and Clinics is in a crisis. The organization has considerable challenges to overcome. Healthcare, itself is under a labor shortage. Allina has not proactively identified ways to attract or retain employees for these 'hard-to-fill' jobs. The organization operates in silos, which causes internal competition for these few candidates. In addition, the organization does not have a support and training structure in place once the employees are hired. This especially rings true for the leadership team. There is only one leadership training opportunity at each hospital; a one day orientation for leaders. New leaders are left to sink or swim, which reflects in the high Nurse Manager turnover rate of over 35 percent in the first three years.

Each operating unit within Allina has its own vision. This has prevented the organization from creating a uniform culture. According to Kotter (1998), the lack of vision is one of the eight common errors that organizations make during change. Creating a vision is also a competency that Goleman, et al. (2002) identifies for individual transformation. Leaders within Allina struggle with the tools and resources to be successful, both in creating a vision and in motivating change.

Large organizations, similar to Allina, can improve the processes and impact the quality of work, customer satisfaction, and employee engagement. Allina is the largest healthcare provider in the state of Minnesota. Allina is a progressive organization, building new heart centers, purchasing the latest equipment, and promoting an empowering environment. Allina has spent time and capital

on programs to improve patient care. Unfortunately, the capital has not been spent to improve employee satisfaction. In fact, the corporate leadership development area consists of two employees for an organization of over 22,000 employees. The numbers speak for themselves. Allina must recognize that positive change can happen with a consistent leadership model. Transition begins with letting go of something, such as letting go of old management techniques that are not "walking the servant leader talk".

Allina recently invested in a company wide engagement survey. Dick Petinghill, CEO, recently published an article on the Allina Intranet site, which stated:

> After four months of "pulse" surveying to monitor employee engagement Allina-wide, we continue to experience an improved engagement score of 55.4 percent. That's a statistically significant improvement over last year's score of 47.4 percent. While an improvement, we aren't satisfied with our overall score. We recently spent significant time at a senior management team meeting learning from one another about our efforts to create a more engaging workplace. We are optimistic about our opportunities to improvement (2004).

The increase in the score is based on increasing communication around existing company programs, having business line action plans to increase the scores, and learning from others. Although these efforts could impact the score, the lasting effects on engagement could be minimal. This could be perceived as quick fixes instead of creating opportunities to change the culture.

Kotter (1998) discusses common errors that organizations make. Allina is no exception. Allina is allowing obstacles to block the vision of engagement. Instead of focusing on improving leadership competencies and improving services, the organization is cutting approximately 10 percent of their workforce to be within the 50th percentile of productivity according to Solucient data. The messages are convoluted – is the goal to be within the 50th percentile or to increase engagement scores? It will be difficult to accomplish both objectives in a short amount of time.

Another error is failing to create a sufficiently powerful guiding coalition. Everyone needs to be committed to pulling the team together and sharing a common vision about how to address engagement issues. Instead, the survey is reintroduced on a quarterly basis. The focus then shifts again to the flavor of the month, which are currently Solucient reports.

Allina needs to create a guiding coalition, pulling together the group to establish a powerful vision. The vision should include a transformation to servant leadership and the goals to get there, including training and resources to educate leaders on the servant philosophy. Then, Allina should communicate those changes and empower the action, celebrating short-term wins such as the engagement results. Finally, those gains can produce more change, perhaps focusing on productivity. To decrease the workforce now, the organization needs to have strong leadership, not management, to carry that initiative forward. Today, strong leadership is lacking. The emphasis on leadership development has been nonexistent over the past decade. By transforming its leadership approach, Allina can adopt an empowering and supportive culture to carry future initiatives forward.

Many organizations do not have the resources to provide in-house training. Companies, therefore, rely on leadership institutes, such as the Greenleaf Center. This institute conducts various workshops and seminars to help supervisors identify the efficacy of the servant model of leadership. Many of the seminars and conferences approach $1,000 per employee. In a company the size of Allina, that would cost the organization millions of dollars. A training program designed for Allina leaders will be more cost effective, incorporate a consistent message, and encompass the Allina vision and values.

There are many challenges in creating a leadership-training program that will encapsulate the needs of the organization. Convincing senior management of the need for training can be more difficult that developing the training program itself (Gingerella, 1995). Once training has been approved, many training programs are designed ineffectively. They need to be specific to the

organization, include both training and development, and have essential measurable factors to determine the success. In addition, the timing of the training, establishing clear objectives, and determining accountability can be critical to the success. Finally, the training needs to be an enjoyable experience that fosters new ideas and promotes contact with other leaders (Nichols, 2001).

Nichols (2001) believes the current problem with training programs is that many organizations develop the wrong material, do not have consistent follow-up after the training is complete, and deliver it at a critical time when the leaders have too many other priorities. If the training is not developed specific to the needs of Allina and the program is delivered when other organization initiatives have precedence, the training will fail. Although training needs vary by each organization, the one consistent message is that training is critical to the success of the organization (Schraub & Katz, 1998).

Many researchers speculate about the best training method for organizations. Watad (1999) examines training that incorporates different levels of hierarchy and expertise to include vertical and horizontal integration in the organization. Allina, which currently operates in silos, could benefit from a similar training structure. The perception by the participants was seen as favorable in two aspects: one was the effect of the program on the relationship between the participants and their leader, and the other aspect was the continuation of team meetings after the training concluded. These results support the positive internal impact this structure of training produced.

Brown (1999) uses inductive reasoning when evaluating trends and best practices for leadership development. He focuses on the executive level; however, many of the practices discussed are useful for developing leaders at any level in the organization. Brown believes the characteristics for effective leadership training include:

- A program designed as part of an ongoing process, not a single event
- Increased emphasis on active learning

- Learning occurs anywhere, anytime through the use of distance learning technologies
- Purpose is action learning, which involves solving real business and personnel problems in an environment designed to encourage learning and reflection
- Substance more important than style
- Training providers playing the role of partner instead of specialist
- Greater use of best–practice information and future-oriented scenarios, with less reliance on historical case studies.

The research reinforces the need for individualized training based on organizational needs. Allina's leadership training should encompass Watad's (1999) structure for removing the silos, Brown's (1999) characteristics for effective leadership, and Goleman's (2002) discoveries for motivational change. The need for effective leadership training within Allina Hospitals and Clinics is evident. This training will create an individualized program that incorporates the servant leadership model and meets the organizational goals.

Conclusion

Many aspects of the healthcare system are undergoing profound change. Patient expectations, technological advances, the drive to improve the safety and quality of care, and the need for accountability are challenging traditional professional and managerial systems approaches and attitudes. The importance of leaders, teams, and organizational functions to the delivery of good, safe care, necessitates examination of the preparedness of all healthcare professionals for working within a complex system. Every individual could greatly benefit themselves and their respective workplace by boldly and faithfully incorporating the tenets of servant leadership in their lives.

Servant leadership is important for hospitals and healthcare organizations because of the special nature of the services provided by these organizations and the fluctuation in demand of the services demanded by patients. Participatory management offers more flexibility to deal with these fluctuations and the highly fluid nature and problems of the customers. In addition, it enables greater reductions in the costs of healthcare. In nursing care, which forms almost half of the cost of hospital healthcare, management innovations are needed. The rationale for differentiated nursing practice stems from the fact that optimal nursing care exists when the patient's needs are matched with the nurse's competencies. One benefit is the effective and efficient use of scarce nursing resources, combined with equitable compensation based on education, expertise, and productivity. A secondary benefit is greater loyalty to the employer, and greater job satisfaction of nurses.

Rising to the challenges of healthcare is the responsibility of strong leadership. Effective dialogue from the senior leadership team on expectations, follow-through, and desired competencies will develop the groundwork for cultivating change. Servant leadership will not solve the healthcare crisis. Instead, it will allow leaders to empower their staff in helping solve problems, model desired behavior, and serve those in need. Communication will improve, employees will think twice before

leaving the organization, and patient care satisfaction will increase. Although not a cure, servant leadership is a foundation to make positive change possible.

References

Brown, P.T. (1999). New direction in leadership development: A review of trends and best practices. The Public Manager: The New Bureaucrat, 28, 37-43.

Chong, Y. (2000, September). Clinical nutrition and foodservice personnel in teaching hospitals have different perceptions of total quality management performance. Journal of the American Dietetic Association, 1044-1050.

Clawson, J.G. (1999). Level three leadership: Getting below the surface. Upper Saddle River, NJ: Prentice Hall.

Coile, R., Jr. (1999). Millennium management: New rules for 21st century healthcare organizations. Healthcare Executive, 14, 6 - 12.

Coile, R., Jr. (2000). Hospitals in crisis: Turnaround management for America's ailing hospitals. Russ Coile's Health Trends, 12, 1 - 10.

Farling, M., Stone, G., & Winston, B. (1999, Winter-Spring). Servant leadership: Setting the stage for empirical research. Journal of Leadership Studies, 49-69.

Gilkey, R.W. (Eds.). (1999). The 21st century health care lLeader. San Francisco: Jossey-Bass, Inc.

Gingerella, L.F. (1995). Seven ways to sell management on training. Training and Development, 49, 11-14.

Goldstein, S., & Schwiekhart, S. (2002). Empirical support for the Baldrige award framework in U.S. hospitals. Healthcare Management Review, 27 (1), 62-75.

Goleman, D., Boyantzis, R., & McKee, A. (2002). Primal leadership. Boston: Harvard Business School Press.

Greenleaf, R.K. (1979). The servant teacher: A parable. New York: Paulist Press.

Greenleaf, R. K. (1982). Servant as leader. Indianapolis, IN: Robert K. Greenleaf Center.

Heizer, J., & Render, B. (1999). Operations management. Upper Saddle River, New Jersey: Prentice Hall.

Hesse, H. (1956). The journey of the east. New York: The Noonday Press.

Jablonski, R. (1992). Customer focus: the cornerstone of quality management. Healthcare Financial Management, 46 (11), 17-19.

Jones, J. (2003). Healthcare nonprofit wins Baldrige award. The Non-profit Times, 17 (1), 7-8.

Kotter, J.P. (1996). Leading change. Boston: Harvard Business School Press.

McCallum, L. (2001, August 3). Hatch's threat forced Medica board's ouster. Minnesota Public Radio News.

Melrose, K. (1995). Making the grass greener on your side. San Francisco: Berrett-Koehler.

Mill, C. (1991). The long road to employee involvement. Personnel Management, 23, 26-30.

Morrison, I. (2000). Health care in the new millennium. San Francisco: Jossey-Bass.

Mullins, L.J. (1995). Hospitality management – A human resources approach. (2nd ed). London: Pitman.

Nichols, G. (2001). Why management training doesn't work. The Business Journal – Milwaukee, 18, 43-45.

Petinghill, R. (2004). Keeping me awake: Ups and downs of employee engagement. Retrieved on April 20, 2004 from Allina intranet web-site: http://akn.allina.com.

Porter-O'Grady, T. (2003). A different age for leadership. Journal of Nursing Administration, 33, 105-110.

Rubin, R. (2004, January 19). Doctors act against malpractice premiums [Electronic Version]. USA Today.

Schraub, J.J., & Katz, D.D. (1998). Putting teeth into management training. HR Focus, 75, 13-15.

Sendjaya, S. & James C. S. (2002). Servant leadership: its origin, development, and application in organizations. Journal of Leadership and Organization Studies, 9 (2), 57-64.

Spears, L. (Eds.). (1995). Reflections on leadership: How Robert K. Greenleaf's theory of servant leadership influenced today's top management thinkers. Toronto, Canada: John Wiley & Sons, Inc.

Spears, L. (Eds.). (1998). Insights on leadership: Service, stewardship, spirit, and servant-Leadership. Toronto, Canada: John Wiley & Sons, Inc.

Watad, M. (1999). Integrated managerial training: A program from strategic management development. Public Personnel Management, 28, 185-192.

Wesley, E. (2003, October 1). Parkland among Solucient 100 top hospitals. Retrieved on May 3, 2004 from http://www.utsouthwestern.edu.

Wilson, R.T. (1998). Servant leadership. Physician Executive, 24 (5), 6-13.

Zillars, R. (2004, January). 2004 healthcare trends and forecasts. Healthcare Purchasing News, 28 (1), 54-56.