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Servant Leadership Characteristics and Empathic Care: Developing a Culture of Empathy in the Healthcare Setting

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Developing a Culture of Empathy in the Healthcare Setting

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". . .All things are possible for those who believe." Mark 9:23

Abstract

The purpose of this study was to assess the degree to which servant leadership characteristics are exhibited in medical group practices, and the degree to which servant leadership characteristics correlated with measures of empathic care. This study featured an explanatory mixed methods research design embedded in appreciative inquiry. A total of 189 mid-level practitioners consisting of nurse practitioners, physician assistants, and practice mangers responded to a 32-item scale survey that featured a six-point Likert scale to measure servant leadership items and a 10-point continuous scale to assess measures of empathic care. The servant leadership items were based on the seven pillars of servant leadership. Data analyses included assessing means, standard deviations, and percentage distributions for servant leadership statements and empathic care statements. Additionally, bivariate correlation analysis and standard multiple regression analysis were conducted to assess the degree of influence of servant leadership characteristics on measures of empathic care. Findings from this study identified Pillar 1 (Persons of Character) as the servant leadership pillar most strongly exhibited in the medical group practices. Furthermore, Pillar 5 (Has Foresight) was the strongest correlate of reported empathic care within medical group practices as well as team members' proclivity to practice servant leadership behaviors with patients more than with each other. The study also found that clinicians and non-clinicians significantly differed in their endorsement of all of the servant leadership pillars except Pillar 1 (Persons of Character). The findings of this dissertation point to strategies for promoting an environment of empathic care, and team building and organizational development and training in the medical group practices. This dissertation is available in open access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu/

Keywords: Empathy, Empathic Care, Healthcare, Mid-Level Practitioners, Mixed Methods, Servant Leadership, Healthcare Consumerism; Health Systems; Hospitals; Medical Group Practices; Nurse Practitioners; Physician Assistants; Servant Leadership Pillars

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Chapter I: Introduction

> I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.
>
> –Dr. Maya Angelou

Background

Recently, in the United States, there has been much discussion regarding the role that empathy should play in healthcare. In a world full of choices, even healthcare patients are acting more like consumers, implying that a positive customer experience should be a top priority for organizations (Miller, 2016). Patients find themselves reviewing and analyzing options to make their visit to the doctor better. In this pursuit of an enhanced patient experience, empathy becomes a driver for creating a positive patient experience (Savel & Munro, 2017).

Empathy is commonly defined as the ability to understand and share the feelings of another (J. T. Chen, LaLopa, & Dang, 2008). Within healthcare, empathy displayed by providers develops trust with patients which increases patient satisfaction and compliance, thereby producing better outcomes overall (Killam, 2014). When entire systems take on empathy as a priority, the result is an environment of empathic care where providers and staff all contribute to sharing in the experience of the patient (Patmchak, 2013).

Servant leadership is often viewed as an ideal leadership style for fostering empathy in organizations. It has been heralded by some as the most ideal leadership style for hospitals and health systems because it concentrates on the strength of the team, developing trust and serving the needs of patients (Belsky, 2016; Patmchak, 2013; Trastek, Hamilton, & Niles, 2014). Researchers have indicated that there is neither a generally accepted definition of servant leadership nor agreement on a defined set of

characteristics (Andersen, 2009; de Waal & Sivro, 2012). However, according to Sipe and Frick (2009), there are seven characteristics or behaviors of a servant leader,[1] which include: being persons of character, skilled communicators, systems thinkers, compassionate collaborators leaders with foresight, and leaders with moral authority.

Empirical evidence has outlined the importance of the link between servant leadership and empathic care (Eikeland, Ornes, Finset, & Pedersen, 2014; Hunt, 2016; Neill & Saunders, 2008). Hospitals and health systems continue to consider strategies such as promoting empathic care environments to increase patient satisfaction scores. Exploring the link between servant leadership and empathic care is important to better understanding the factors that contribute to such environments.

This dissertation explores this connection as it relates to identifying the most important servant leadership characteristics in an environment of empathic care. It contributes to an existing body of literature that focuses on improving the patient experience. It may also help to lend insight into how to enhance the climate of empathic care in hospitals and health systems.

The Context of Healthcare

The business of healthcare is a dynamic and changing industry. Calls for change are found in political debates (e.g., Zaldivar, 2009), the popular press (e.g., The Economist, 2009), reports from panels of experts (Institute of Medicine, 2001), presentations by industry leaders (e.g., Schultz & Edington, 2007), and academic publications (e.g., Spear, 2005). Healthcare systems have responded to the call for change

[1] In this dissertation, the terms "servant leadership characteristics" and "servant leadership behaviors" are used interchangeably.

with ongoing transformation. Having gone through decades of development, hospitals and health systems are constantly in search of new ways to face various challenges.

The passage of the 2010 *Patient Protection and Affordable Care Act* initiated a transformation of the United States healthcare system. The ACA fostered a preventive healthcare model that emphasized primary care, funded community health initiatives, and promoted quality care. These changes increased the need for well-prepared healthcare professionals (Lathrop & Hodnicki, 2014).

This is the context for the various challenges currently facing health systems and hospitals (Longenecker & Longenecker, 2014). These challenges include ineffective implementation planning and overly aggressive timelines, failure to create project buy-in and ownership, ineffective leadership and lack of trust in upper management, unrealistic improvement plans, and communication breakdowns (Longenecker & Longenecker, 2014). Additionally, Ritter (2011) pointed out that there is an ongoing nursing shortage that is expected to continue and will result in challenges for the healthcare system in the United States. According to the United States Department of Health and Human Services (2002), the nationwide shortage in 2000 was 6% (approximately 110,000 nurses). By 2005, that percentage increased to 10% (approximately 218,000 nurses). In 2004, California experienced a shortage of approximately 150 nurses for every 100,000 persons when compared nationally (Lin, Juraschek, Xu, Jones, & Turek, 2008).

Future predictions for the nursing shortage are grim. It is expected that the demand for nurses will increase but the supply will continue to decrease. If it continues on this path, the shortage could increase to 29% of the entire nursing population by the year 2020 (Ritter, 2011). This challenge is one of many for hospitals and health systems

that could significantly and negatively impact patient satisfaction (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004).

Empathy, Compassion and Sympathy

Healthcare providers often exhibit empathy, compassion, and sympathy in the course of providing patient care. With healthcare being a service industry, engaging personally engaging patients is important. Empathy, compassion, and sympathy are defined and conceptualized in various ways in the literature, and the terms are used interchangeably in research reports and in contemporary speech (Gladkova, 2010).

Empathy, as a concept, has evolved over the past 125 years. The origin of this concept can be traced back to the 1880s, when German psychologist Theodore Lipps coined the term *einfuhlung* (in-feeling) to describe the emotional appreciation of another's feelings (Morse & Mitcham, 1997). Empathy can also be defined as "an interpersonal quality that is considered as an understanding of others' feelings and experiences; feeling in oneself the feelings of others" (Khanjani et al., 2015, p. 80). Empathy in healthcare is now being reexamined as something that is essential to good medical practice (Hardy, 2016), as well as a competency that should be focused on during a medical student's training (Eikeland et al., 2014; Hojat et al., 2004, 2009;Suchman, Markakis, Beckman, & Frankel, 1997; Tavakol, Dennick, & Tavakol , 2012; Ward, Cody, Schaal, & Hojat, 2012). Jamison (2014) offers that empathy, unlike compassion or sympathy, is typically not something that occurs naturally within us. Rather, it is a choice that requires effort to pay attention and to extend ourselves.

Bailey (2012) pointed out that other industries, such as retail, hospitality and financial services have been raising the bar on empathy as a consumer-driven philosophy.

These industries have been successful in empathically connecting with their workforce and their customer base to improve service, enhance efficiency and fuel growth. This is done while also streamlining operations, maintaining a sensible cost structure, and realizing savings.

Additionally, Rice (2016), based on an interview with the Derek Feeley, CEO of the Massachusetts-based Institute for Healthcare Improvement, reported that patient safety challenges are another major concern for healthcare systems. Rice suggested improvements to the U.S. healthcare system to mitigate patient safety challenges. The improvements included instituting cultural changes that encourage staff to feel free to speak up thereby creating a culture of transparency and creating a learning system. Additionally, to help mitigate patient safety challenges, Rice recommended creating a learning system that helps to equip the staff with the skills that they need that is underpinned by a supportive leadership culture.

Jeffrey (2016a) asserts that empathy is a dynamic process that occurs in a reciprocal relationship with the patient, and is comprised of the following features:

- Connection: Involves emotional sharing with the patient in a two-way relationship.
- Clinical Curiosity: Involves gaining insight into the patient's concerns, feelings and distress, giving patients a sense that they matter.
- Another-orientated Perspective: Involves the doctor trying to imagine what it is like to be the patient and to see the world from the patient's perspective.
- Self–other Differentiation: Involves respecting the patient as an individual with dignity.

- Care: Involves acting appropriately on the understanding gained to help the patient.

Compassion exhibited by providers is becoming increasingly important in the pursuit of excellence in healthcare. While the importance of compassion has been exalted in fields such as psychology, social work, and theology, it is now being appreciated for its positive impact in healthcare, especially in advanced illness (Attree, 2001; British Medical Association, 2005; Canadian Medical Association, 2018; Canadian Nurses Association, 2017; Fogarty, Curbow, Wingard, McDonnell, & Somerfield, 1999; Francis, 2013; Goetz, Keltner, & Simon-Thomas, 2010; Shantz, 2007; Willis, 2015). As their significance becomes more recognizable in enhancing quality patient care, wellbeing and overall quality of life, compassion and compassionate care, are emerging as a competencies that healthcare providers are expected to deliver (Easter & Beach, 2004; Flocke, Miller, & Crabtree, 2002; Hickson, Clayton, Githens, & Sloan, 1992; Levinson, Roter, Mullooly, Dull, & Frankel, 1997; MacLean, 2014; Paterson, 2011; Stewart, 1995).

An early shift toward compassionate care occurred in the United Kingdom. The person-centered approach to care was pioneered in the late 1980's and 1990's to emphasize compassionate care. Findings from Francis's (2013) report for the Mid Staffordshire NHS Foundation Trust Public Inquiry highlighted the need for conceptual clarity if doctors are to respond to the calls to provide more 'compassionate care.' Additionally, Jeffrey (2016b) contends that a problem exists in the balance between scientific–technical and psychosocial elements of patient care and recommends the development and implementation of a broad model of empathy.

From 2005 to 2009, the Francis Inquiry report examined the causes of the substandard care at Mid Staffordshire National Health Service Foundation Trust in the United Kingdom. After an extensive review, 290 recommendations were made to improve patient care. Among those recommendations were openness, transparency and candor throughout the healthcare system (including a statutory duty of candor), fundamental standards for healthcare providers, and improved support for compassionate caring and committed care and stronger healthcare leadership were highlighted (Francis, 2013).

Sympathy is the broadest of the three terms and signifies a general feeling of fellowship. Sympathy is an emotion triggered by the realization that something bad has happened to another person (Gladkova, 2010). Stepien and Baernstein (2006) also define empathy as experiencing another's emotions, as opposed to imagining those emotions. Sympathy has also been described as exhibiting concern for the welfare of other people (Decety, Yang, & Cheng, 2010). Some authors feel sympathy is a wholly distinct concept from empathy, while others maintain that sympathy overlaps with the emotional component of empathy (Halpern, 2011; Hojat et al., 2001; Mercer & Reynolds, 2002).

One difference highlights the fact that empathy (unlike compassion and sympathy) appears to suggest a response to situations with features more subtle, imperceptible and complex. It requires both affective and cognitive skills to perceive, share, understand and put into action (Jeffrey, 2016a). Furthermore, empathy is a skilled emotional response, while sympathy and compassion are reactive emotional responses; as such, developing the skill of empathy is a more realistic goal for medical education, whereas teaching compassion seems to be counterintuitive (Maxwell, 2008).

Additionally, while compassion does not necessarily involve cognition in the understanding of a patients' views, empathy is a form of emotional engagement that seeks both cognitively and affectively to make sense of another's experience while preserving and respecting difference (Jeffrey, 2016b).

In the healthcare setting, Maxwell (2008) argues that empathy should be the preferred term to replace sympathy and compassion. Furthermore, Pedersen (2009) suggested that research into compassion and its influences in healthcare is less developed than that into empathy; this provides a pragmatic reason for selecting empathy as the construct of choice. Empathy is the ability to understand the emotional states and cognitive processes of others (Silva et al., 2018), and Empathic Care is an active two-way process between providers and patients that involves connection, clinical curiosity, another-oriented perspective, self-other differentiation, and care (Jeffrey, 2016a).

Purpose and Significance of the Study

This study is a systematic investigation of servant leadership characteristics and empathic care at Crestdale Health Care (pseudonym). The primary purpose was to assess which servant leadership characteristics are most critical to promoting an environment of empathic care. This assessment included a comparison of responses from clinicians and non-clinicians. The overarching significance of this research is three-fold:

1. to expand research within servant leadership and empathic care scholarship,
2. To better prepare healthcare leaders to practice in empathic care environments.
3. To provide hospitals and health systems with a deeper understanding of how an empathic care environment can enhance the patient experience.

To accomplish these objectives, an electronic survey was designed to collect data. on the most important servant leadership characteristics that promote an environment of empathic care. A target of population comprised of clinicians and non-clinicians working at CHC completed the survey. Survey responses were supplemented by interviews.

This research assesses the servant leadership behaviors that are most important to promoting an environment of empathic care. As such, the theoretical contribution and uniqueness of this study is reflected in the analysis of the most important servant leadership characteristics in promoting an environment of empathic care. Prior research has shown correlations between empathic care, patient satisfaction, market share, and financial vitality (Hojat, 2009). However, research that discusses the ranking of individual servant leadership characteristics vis-à-vis an environment of empathic care has been sparse. Understanding which servant leadership characteristics are most important for promoting an environment of empathic care will benefit hospitals and health systems that are moving from providing volume-based care to value-based care as a response to healthcare consumerism and due to their goal to improve patient satisfaction scores. Rather than including a general, one-size fits all training on servant leadership characteristics, these organizations can become more efficient in their training and development programs through specialized instruction on servant leadership characteristics. Corporate education trainers and facilitators will be able develop more focused and consistent training curricula because of the special emphasis on the most important servant leadership characteristics in an empathic care environment.

Furthermore, the findings from this study will assist organizations with their strategic planning. They will be able to specifically target the important servant

leadership characteristics in an empathic care environment as they seek to enhance patient satisfaction scores. Additionally, healthcare consultants will have the opportunity to enhance their professional practices through recommendations of specific servant leadership characteristics that should be introduced into the empathic care environment.

Research Questions

This study aimed to investigate the relationship between servant leadership characteristics and empathic care. Specifically, the study examined the importance of each of the servant leadership characteristics to an environment of empathic care. As a result, this dissertation answered the following questions:

1. How do mid-level health care practitioners describe servant leadership and empathic care in their medical group practices?
2. To what extent are the servant leadership characteristics correlated with measurements of empathic care? Additionally, which of the seven pillars of servant leadership characteristics most strongly influence perceptions of empathic care?
3. In what ways are the views of the non-clinical and clinical staff of the medical group practices similar or different with respect to servant leadership characteristics in their medical group practices?"

Research Design

The focus and target population of this study was Crestdale Health Care (pseudonym). Crestdale Health Care is a health system comprised of 16 acute care facilities, 420 medical group practices, and approximately 26,000 employees; Crestdale Health Care has operations across the southern United States. Crestdale Health Care's

vision focuses on delivering the best patent experience every time the opportunity presents itself. Crestdale Health Care's values are compassion, diversity and inclusion, personal excellence, teamwork, and courage.

Along with the organization's core values, the executive team at Crestdale Health Care promotes certain principles of servant leadership with its managers, mid-level leadership, senior leadership, and executive leadership. Greenleaf (1970) described a leadership philosophy that advocates the servant as leader:

> It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead. The difference manifests itself in the care taken by the servant—first to make sure that other people's highest priority needs are being served. The best test is: Do those served grow as persons; do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants. (p. 4)

To analyze which servant leadership characteristics are most important to an environment of empathic care that will help to improve the patient experience, this study utilized a mixed methods research model. While quantitative research methodology refers to any type of research that summarizes thoughts and ideas into categories that can be counted (Hanley, Lennie, & West, 2013), qualitative research, developed in the social sciences to enable researchers to study social and cultural phenomena, is designed to help us understand people and the social and cultural contexts within which they live (Myers & Avison, 2002). Mixed methods research leverages the advantages of both quantitative and qualitative data, as qualitative data adds meaning to quantitative results, and quantitative data adds precision to qualitative findings (Johnson & Onwuegbuzie, 2004).

Study participants included clinicians—nurse practitioners, physician assistants—and practice managers who are non-clinicians. Collectively, they can be referred to as *mid-level practitioners*. Mid-level practitioners constitute an ideal target population

because, within the organizational structure, they are positioned to frequently engage patients, physicians, and support staff. The primary role of nurse practitioners and physician assistants is to provide direct clinical care to patients and, in doing so they frequently engage physicians. They also frequently engage the support staff and practice managers as it relates to the operational aspects of the medical group practice. Because the primary role of the practice managers involves the administration of operational aspects of the medical group practice, they frequently engage physicians, nurse practitioners and physician assistants, support staff, and patients as well.

Overview of the Literature

The servant leader possesses a number of distinct character traits that are focused on serving people. Likewise, the empathic leader also possesses various and distinct character traits that are people focused. In particular, those health care leaders who incorporate empathy into their leadership style, can empower healthcare professionals in providing quality patient care.

Servant leadership. In highlighting the characteristics of a servant leader, Sipe and Frick (2009) described the servant leader as a person of character who puts other people first. They are also skilled in communicating, as well as a compassionate collaborator who has foresight. The servant leader is also a systems-thinker and leads with moral authority (Sipe & Frick, 2009). The servant leader is a dynamic leader because he or she has the ability to think analytically while incorporating the needs of others into their calculus. Because the servant leader puts people first, they are comfortable not being out front and visible; they are often unsung heroes and heroines to

observers. The literature on servant leadership is expansive and will be discussed in greater detail in Chapter II.

Empathy. Empathy is generally considered to be important. It is also considered to be positive in assisting patients emotionally, and empirical research on medical students' and physicians' empathy is advancing. For example, many studies have shown that empathy may be stunted or reduced during medical training, and these tendencies have catalyzed considerable concern (D. Chen, Lew, Hershman, & Orlander, 2007; Newton, Barber, Clardy, Cleveland, & O'Sullivan, 2008; Pederson, 2009)

The American Association of Medical Colleges described empathy as an essential learning objective; it is believed to significantly influence patient satisfaction, adherence to medical recommendations, clinical outcomes, and professional satisfaction (Stepien & Baernstein, 2006). However, health professional educators wrestle with how to cultivate empathy, especially at a time of increasing professional burnout among its trainees and graduates (Ekmana & Krasnerb, 2016).

Ekmana and Krasnerb (2016) suggested that empathy in the medical setting is comprised of the appreciation of the patient's emotions and the expression of that awareness to the patient. Kerasidou and Horn (2016) posited that the medical profession necessitates doctors to not only be clinically proficient, but also empathic towards their patients. Further, empathy should not only be an expectation of doctors, but it should also be promoted, assisted and cultivated in the medical profession (Kerasidou & Horn, 2016). Additionally, regardless of the role of empathy in patient outcomes, empirical research on empathy among health professionals is scarce (Fields et al., 2004). In short, in the healthcare setting, empathy should touch all facets of the enterprise to be effective.

Study Significance

This study is significant to theory, research, and practice because the results and analysis of the data have implications for education and training in both medical schools and in the healthcare setting in general. Additionally, this study offers health systems and hospitals a potential strategy for increased market share and financial vitality as a function of improving patient satisfaction vis-à-vis a better understanding of servant leadership and empathic care. Furthermore, the survey can be administered by health systems and hospitals as a part of a toolkit to assess the favorability of a work environment to empathic care.

Study Limitations

Because of intra-organizational politics and accessibility to physician leaders, medical group practice physicians were not a part of this study. Physicians play an important leadership role and carry much more influence than physician assistants, nurse practitioners, and practice managers in and beyond the medical group practice setting. Assessing the humanistic attitudes and behaviors of medical group physicians and how they compare and/or contrast with physician assistants, nurse practitioners, and practice managers are important to an environment of empathic care. Additionally, how medical group physicians view which individual servant leadership characteristics is important to environment of empathic care. Both would have added additional significance to this study.

Another limitation to this study was access to stratified patient satisfaction data. My request for this level of data for Crestdale Health Care was denied. Having access to stratified data versus aggregated data for Crestdale Health Care would have enabled this

study to benchmark and track annual trends for patient satisfaction scores by medical group practice. This information could be used for strategy development, targeted training and development, and best practice sharing among Crestdale Health Care medical group practices.

Positioning the Researcher

As a native of London, England and an immigrant to New York City in 1980, my life's journey thus far has principally been one of academic, professional, and cultural diversity. I graduated from Martin Luther King, Jr. High School as a business major where I experienced the challenges of socialization as well as the richness of diversity found in what I saw as a microcosm of New York City's gritty urban environment. Subsequently, I completed the degree of Associate of Applied Science in Business Management from the Borough of Manhattan Community College while simultaneously working as a financial analyst at Moody's Investors Service. During this tenure at Moody's, the northeast U.S. began to experience an economic recession. As such, Moody's decided to relocate some of its divisions to Charlotte, NC. They selected a skeleton staff to relocate to be a part of the startup of operations, and I accepted relocation to Charlotte where I also resumed my academic career by completing a Bachelor of Science in Business Administration at Pfeiffer University.

At this juncture, I began to contemplate completing a Master of Business Administration as well as a possible career change from the financial services industry. After discussions with faculty at Pfeiffer University, I decided that I would begin the process of transitioning to a career in healthcare administration. I felt that I wanted to work in a field where I could tangibly help people in need. My Christian faith and its

tenets were extremely useful in informing this decision. As a follower of Jesus Christ, I have always felt that the servant leadership style employed by Christ had the most potential to develop and grow followers into maximizing their potential. In order to begin to make the career transition, I decided to pursue a Master of Business Administration as well as a Master of Health Administration. I graduated in 2001 with the dual Master's degree and began to pursue a position in healthcare.

In 2005, I secured my first role in an acute care facility. My role primarily involved strategic planning, particularly on improving patient care. This opportunity stoked my curiosity about how important an environment of compassion is improving the patient experience, and how patients and staff could benefit from an environment where leaders employ servant leadership characteristics that feature compassion for both patients and staff. In my current role as Senior Director of Value Based Care and Innovation, I continue to work toward identifying strategies and tactics for improving the patient experience. Moving beyond providing compassionate care to creating an environment of empathic care has become a more prominent topic of conversation.

Overview of Chapters

Chapter I of this dissertation provides background information about the need for research into the relationship between servant leadership and empathic care. It further denotes both the purpose and the significance of this study. The research questions are formally stated, and the research design is discussed. The chapter concludes with a discussion of the limitations of this research project and a discussion of my background positionality.

Chapter II, “Review of Literature,” covers issues related to healthcare consumerism and the changing healthcare marketplace. It identifies the emergence of the construct of servant leadership and compares servant leadership to other leadership styles. Healthcare consumerism is also discussed, and empathy, compassion, and sympathy are compared and contrasted. The review of literature highlights the importance of servant leadership to health systems and hospitals, the identity of the servant leader, and previous attempts at measuring servant leadership. Chapter II also introduces the construct of empathy and identifies the link between servant leadership and empathy. The review of literature also includes a discussion on the importance of the empathy construct to health systems and hospitals, as well as the link between servant leadership and empathy.

Chapter III, “Research Methodology”, describes the rationale for selecting a mixed methods research design. It also describes the application of the research methods, formal research questions, survey construction, interview methods, and data analysis methods. It also outlines Internal Review Board (IRB) considerations are all covered in this chapter.

Chapter IV, “Data Analysis,” presents the quantitative analysis from the surveys. Additionally, it discusses the conclusions that were drawn as a result of analyzing the data from the surveys. Finally, it presents analysis from participant interviews.

Chapter V, “Findings and Recommendations,” presents the results of the data analysis, major emergent themes, and the study limitations. It also presents proposals for healthcare constituents and stakeholders, as well as health policymakers. It also outlines the implications for future research into servant leadership and empathic care.

Chapter II: Literature Review

Rising costs of healthcare and health policy changes have amplified the need to improve the patient experience. In the last decade, a movement toward healthcare consumerism in the U.S. healthcare system has created a focus on humanism in medicine along with the quality of the relationship between physician and patient. Health systems and hospitals continue to address the notion of healthcare consumerism as a market influencer.

This literature review covers issues related to healthcare consumerism and the changing market place. It also compares servant leadership to other leadership styles. Moreover, the review examines the servant leadership construct, the importance of servant leadership to health systems and hospitals, the identity of the servant leader, assessing servant leadership. Finally, it highlights the construct of empathy, the link between servant leadership and empathy, and how empathy is assessed.

In all, utilizing Boolean search codes (macro) along with targeted individual (micro) database searches, the literature search produced 502 sources from peer-reviewed literature on the topics of servant leadership, empathy in healthcare, and consumerism in healthcare. The majority of these sources were peer-reviewed journal articles. The databases included in the macro and micro searches were PsychINFO, Medline with Full Text, CINHAL Plus, Education Research Complete, and Consumer Health Complete. The literature search was then refined to exclude studies that were not aligned with the definitions of servant leadership, empathic care, patient satisfaction, healthcare, consumerism, market share, regulatory requirements, and healthcare costs that guided

this research. The Boolean search codes for the macro literature search of the databases are listed in Appendix A.

The overall literature search strategy area is outlined in Figure 1.0. This research investigated the influence of servant leadership – a model that emphasizes moral, emotional, and relational dimensions of leadership behavior – on health care providers' assessment of an empathic workplace climate. Because of the interdisciplinary nature of this dissertation, scholarly literature from several related fields was reviewed. How this literature relates to the formation and function of creating an environment of empathic care through servant leadership behaviors was also explored.

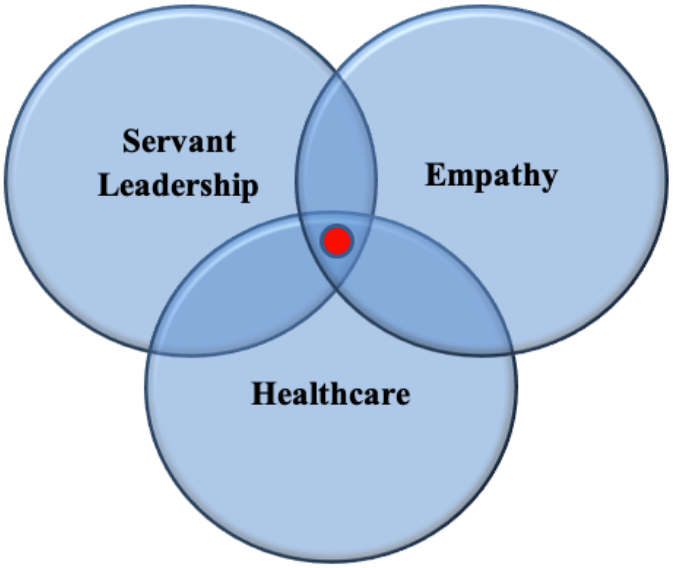

Figure 2.1. Literature search strategy areas.

Eight specific areas were reviewed that are relevant to servant leadership and empathic care:

1. Healthcare consumerism;
2. The importance of empathy to health systems and hospitals;
3. The empathy construct;

4. The importance of servant leadership to health systems and hospitals;
5. Servant leadership construct;
6. The link between servant leadership and empathy;
7. Measuring servant leadership;

Additional search strings focused on healthcare consumerism and other leadership models.

Healthcare Consumerism

Merisalo (2018) posited that the onset of consumerism in healthcare is disrupting the industry. As a result, healthcare providers are focusing more on improving the patient experience. As patients become more discerning in their choices of healthcare providers, providing a superior patient experience plays an important role in which healthcare provider they choose. Patients expect more from their providers. While patients now view high-quality care as baseline standard for an encounter, they also anticipate personalization, convenience, digital know-how, timeliness, follow-up, compassion and courtesy. These are the types of characteristics that outline the expectations of a good experience for the contemporary patient. Merisalo (2018) further asserted that when a patient has a good experience with a provider, they are more likely to treat the provider well. This can take the form of simple acts such as the patient paying their bill when it's due.

Merisalo (2018) warned of social media as a way for patients to hold providers accountable for a subpar patient experience. Patients can visit various sites online and record their grievances. This has the potential to harm the reputation of providers thereby potentially reducing patient volume, market share, and patient revenue.

Falk (2018) states that "Rising costs and changing attitudes about convenience and the ability to personalize life choices are driving a trend toward greater consumer purchasing power and individual responsibility in health care services."

The Deloitte Center for Health Solutions (2018) reported the following in its 2018 *Survey of Healthcare Consumers*: “Our findings suggest that healthcare consumers are less focused on 'bells and whistles' and more on convenience, cost, and bedside manner” (Betts & Korenda, 2018, p. 3). For most consumers, the system of care in the U.S. is complicated and often frustrating. When making purchasing decisions, most rely on perceptions of service, quality, and costs based on their personal experiences with doctors, hospitals, insurance companies, and others, although consumers' use of more objective information is on the rise.

Providers who segment patients into various categories may reveal data points that are enlightening. However, each individual segment may contain many more options for consideration. In essence, each patient is different which means that the thinking around providing care should be “One Size Fits One” rather than “One Size Fits All” (Cooper, 2010).

Fifer (2013) argued that the terms patient and consumer are often used interchangeably, but they are not the same. He points out that the difference in the terms is that while patients receive care, consumers make decisions that have important consequences for their individual health. Furthermore, Fifer points out that there are a number of healthcare organizations that recognize that consumerism in healthcare is here for the long haul, and it goes beyond only price transparency. At Geisinger Health System, consumerism is addressed in how they engage with dissatisfied patients. Its

ProvenExperience program offers copayment refunds to patients whose expectations during an encounter were not met. As healthcare continues to mirror other consumer markets, these types of novel ideas will become more normative.

Fifer (2013) discussed healthcare organizations choosing to take a holistic approach to the financial aspects of health care, or simply focusing on mundane tasks such as securing payment for hospital bills or an insurance claim settled. An example of taking the holistic approach was when a patient couldn't afford his medication and was ineligible for Medicaid. In taking the holistic approach to this financial issue, the hospitals' financial counselor worked to secure presumptive eligibility for Medicaid for the patient and connected him with resources to cover his pharmacy expenses. As a result, the patient expressed his deep gratitude for the assistance and shared that previously, no one had taken the time to help him. In this example, patient satisfaction was attained, likely patient loyalty was established, and the patient will likely recommend the healthcare organization to other patients.

Importance of Servant Leadership to Health Systems and Hospitals

The federal government has expressed a three-pronged vision to providing health care in a "triple aim" design: improving the individual experience of patient care; improving the health of the populations; and reducing the cost per capita cost of providing care (Berwick, Nolan, & Whittington, 2008). The chief driver of any business is the quality of the product and/or the quality of the service rendered. As such, in the healthcare industry, the creation of value is measured by patient outcomes rather than patient volume (Berwick et al., 2008). Shifting focus to providing quality outcomes remains the core challenge to health systems and hospitals (Porter, 2010). The critical

responsibility for leaders in healthcare is to understand their customers and provide the best possible patient care (Capoccia & Abeles, 2006; Porter, 2010).

Healthcare systems and hospitals are searching for leadership styles and structures to support an organizational culture that is focused on the patient and the quality of care, as well as a meaningful work environment for healthcare providers. The servant leadership style has been deemed suitable for the healthcare industry. Schwartz and Tumblin (2002) expressed the need for healthcare systems and hospitals to adopt the servant leadership model because such care ‘‘has an inherent servant nature” (p. 1426). Campbell and Rudisill (2005) suggested that servant leadership has particular relevance in healthcare today that is connected to the dynamic work environment, complex leadership challenges, and diverse teamwork relationships. Some existing literature suggests that additional follower outcomes related to servant leadership include job attitudes, organizational citizenship behavior (OCB), and performance (Liden, Panaccio, Meuser, Hu, & Wayne, 2014; Van Dierendonck, 2011) as well as outcomes at the team (Ehrhart, 2004; Hu & Liden, 2011; Schaubroeck, Lam, & Peng, 2011) and organizational (Peterson, Galvin, & Lange, 2012) levels.

Waterman (2011) explored the notion of service in contemporary healthcare and social care. Practicing servant leadership means shouldering the idea of being a servant first when decisions are made, and action is taken. Care and concern for others should be the mainstays of the healthcare setting (Waterman, 2011). Furthermore, healthcare leaders have to find ways to meet the needs of their patients. Health systems and hospitals are experiencing rapid change and development that is driven mostly by economic factors. There is more of an expectation of ‘doing more with less’ as health systems and

hospitals are moving from being a predominantly interventionist activity to one that involves strategies centered on supporting patients to take responsibility for their own health (Waterman, 2011).

There are advantages and disadvantages associated with servant leadership. Waterman (2011) states that the advantages of servant leadership include:

- Values people and treat them as ends rather than means.
- Enables others to develop and flourish.
- Shows commitment to the community.
- Expresses a human face in an often and impersonal environment.
- Puts back the concept of caring into care.
- Seeks to improve care through encouragement and facilitation, rather than through power and authority.
- Improves performance by developing and nurturing followers.

The disadvantages of servant leadership include:

- Similarity to transformational leadership approaches.
- Falls into a target-fixated system.
- Disturbs the concept of hierarchy.
- Can be perceived as a ‘religious’ concept and therefore alien to modern sensitivities.
- The title of servant can be seen as detrimental to nurses.
- Humility can be perceived as weakness.
- Some workers may not respond to this approach.

Overall, Waterman (2011) asserted that the concept of service takes nurses back to their roots. It also reminds them about what they do and for whom they do it, notably, patients and community. Furthermore, a broader awareness of the service aspect of healthcare, and adherence to servant leadership principles, can realign nursing leadership to show more compassion and understanding to patients to ensure a better patient experience.

Servant leadership principles are important to the performance of health systems and hospitals. Traditionally, the CEO or executive leader has borne the brunt of the organization's performance (Gamble, 2013). However, a shift in perspective is occurring. Petrey (2013) states: "In large, complex organizations, managerial responsibilities are unlikely to be one individual's exclusive domain; top management teams' ability to work together effectively should also be considered" (para. 6). Research has indicated that organizations with leaders who report a high number of low-performing employees also have lower HCAHPS scores (Gamble, 2013).

Bowsell and Cannon (2005) contributed two salient ideas about relationships in health care. First, healthcare systems, hospitals, patients, and providers benefit when collaboration is applied. Second, environments that encourage collaborative partnerships require strong leadership. Regardless of the role the individual nurse or physician holds within an organization, collaboration between team members of these professions is important for quality patient care (Garber, Madigan, Click, & Fitzpatrick, 2009).

The success of communication and collaboration is dependent upon individual commitment and organizational support (Tschannen, 2004). Researchers have supported the value of collaboration in relation to patient outcomes and/or quality of work life for

the provider. The collaboration between nurse and physician has been a prominent topic of discussion within professional organizations (Baggs & Gedney, 2005).

Communication among healthcare providers is important to patient safety. Lack of communication among healthcare providers has been linked to patient care errors. This cause and effect relationship has been a catalyst for research studies related to communication and collaboration. One of the most prolific studies is the Institute of Medicine (2000) report, *To Err is Human: Building a Safer Health System.* The report linked a lack of communication among healthcare providers to patient care errors and thus served as an impetus for studies related to communication and collaboration (Barrere & Ellis, 2002). In addition to governmental policies and patient safety initiatives, collaboration has been identified as an important component of the quality of the work environment that can affect the patient experience.

According to the American Association of Critical Care Nurses (2003), 90% of their members reported collaboration among nurses, physicians and administrators as one of the most important aspects in perceptions of a healthy work environment. Furthermore, the association also identified core competencies for health professionals that include skilled communication, and collaboration. They also reported that effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership as the most important aspects of perceptions of a healthy work environment.

Transparency about goals and processes in tandem with implementing a servant leadership style can serve as a catalyst for powerful teams. Hu and Liden (2011) "investigated goal and process clarity and servant leadership as three antecedents of team potency and subsequent team effectiveness operationalized as team performance and

organizational citizenship behavior" (p. 851). In relation to goal and process clarity and team effectiveness, Hu and Liden state: "in order to fully complete one's task roles, one needs to have clear expectations about one's own sub-goals, the paths to accomplish those sub-goals, and the link between one's work and the work of others" (p. 851–852). They also propose "goal and process clarity contribute the most to the emergence of team potency when accompanied by servant leaders, whose employee-centered focus is beneficial for facilitating team confidence and effective team behaviors" (p. 859).

The World Health Organization (2006) lists unmotivated healthcare workers as one of the top 10 leading causes of inefficiencies of the healthcare system. The practice of servant leadership incorporates three dimensions: motives, means, ends or outcomes. Servant leadership encompasses the "triple bottom line" (sustaining people, profit, and the planet) and incorporates moral symmetry to balance the needs of all affected (San Facon & Spears, 2010). The effects of servant leadership are closely linked to employee satisfaction and organizational profits. Various studies have alluded to a direct causal relationship between leadership and customer satisfaction, employee satisfaction, and financial vitality (Jones, 2012; Obiwuru, Okwu, Akpa, & Nwankere, 2011).

Importance of Empathy to Health Systems and Hospitals

Empathy in healthcare has played a role in patient care and there has been much dialog in recent years concerning the role that empathy should play in medicine. Both patients and health systems and hospitals practice benefit when healthcare providers practice empathic care, and empathy in healthcare is important to patients and improving the patient experience. To support healthcare providers practicing empathic care, medical

schools, health systems and hospitals will need to be intentional about effective empathic care training and development for students and for staff.

The topic of empathy in healthcare is being revisited as something essential to good medical practice (Hardy, 2016). Developing a culture of empathy can be challenging and requires ongoing attention. However, the effort is valuable because empathy improves the patient experience, staff satisfaction, and enhances the bottom line (Care Transformation Center, 2016). Parrish et al. (2016) asked 112 orthopedic patients to assess their healthcare experience for their initial office visit with their hand surgeon. The number one rated aspect of care was empathy from their healthcare provider. Neither the duration of visits, or observations that the surgeon was rushed, correlated with patient satisfaction; empathy was the key factor.

Further, Uhas, Camacho, Feldman, and Balkrishnan (2008) administered a cross-sectional survey to a convenience sample of 20,901 patients who rated their recent outpatient visit to a healthcare provider. The survey results were used for research related to patient advocacy and contributed to patient satisfaction report cards for physicians. The survey results indicated that perceived empathy was the strongest correlate of patient satisfaction with their healthcare provider. In light of various changes in the contemporary health care marketplace, the theme of empathy in health provider-to-patient relations, and among managers, deserves closer analysis. Patient populations benefit when all members of the health care staff provide and contribute to an environment of empathic care (Fields et al., 2004).

Hojat (2009) posited that empathy in the healthcare environment can be the catalyst for positive patient outcomes. These outcomes include improved patient

satisfaction and compliance, lower rates of malpractice litigation, lower cost of medical care, and lower rate of medical errors. Further, Hojat found that staff members' health and wellbeing is associated with higher empathy. Additionally, multiple tools have been utilized to measure the decline in empathy. These measures include the Jefferson Scale of Physician Empathy (henceforth JSPE), the Interpersonal Reactivity Index, questionnaires (Hojat et al., 2004, 2009), and semi-structured interviews (Eikeland et al., 2014).

Eikeland et al. (2014) and Hojat et al. (2009) argued that medical students are actually trained to lack empathy, not explicitly in their curriculum, but rather as a side-effect of the attitude required to get through medical school. This decline in empathy appears to be related to the education of medical students that occurs around the third year of medical training (Eikeland et al., 2014; Hojat et al., 2009). A number of features of medical education have been credited with dampening a student's ability to empathize. Among these are the inadequate amount of time for students to learn profuse amounts of information (Eikeland et al., 2014; Hojat et al., 2009), the belief that emotions sidetrack physicians from making good decisions (Eikeland et al., 2014), and the development of cynicism as a necessary coping method intended to avoid attachment and professional burnout (Eikeland et al., 2014; Halpern, 2011; Testerman, Morton, Loo, Worthley, & Lamberton, 1996).

As a result of these different features, empathy is not only put aside in favor of more pressing concerns, but it is also actively trained away in medical and nursing students. It is interpreted as something unnecessary and dangerous for physicians, and unimportant to nurses. However, culpability for the decline in empathy should not be entirely placed on the intensity of medical education. Others have also noted that

empathy is weakened in medical students because of the lack of role models who exemplify the positive role of empathy in medicine (Eikeland et al., 2014; Koren, 2010; Marcus, 1999; Reynolds & Scott, 2000; Skeff & Mutha, 1998).

For patients, empathy is an important part of caregiving. Patients at Mayo Clinic identified empathy as one of the important ingredients in the ideal physician (Bendapudi, Berry, Frey, & Parish, 2006). Because of the effect of empathy on patient outcomes and physician well-being, enhancement of empathic understanding of colleagues and patients is considered one of the major tasks of medical education (Marcus, 1999).

Hospitals and health systems can work toward enhancing the patient experience through promoting an environment of empathic care by conducting research that segments the populations that they serve. Khanjani et al. (2015) conducted a research study where the population sample was segmented by age. These age groups included adolescence, young adulthood, middle adulthood, and late adulthood. The study consisted of a population of 196 individuals (92 males and 104 females) ranging in age from 14 to 85 years. The participants were asked to complete the Empathy Quotient, the Revised Eyes Test, and Social Functioning Scale. The population was stratified into adolescents, young adults, middle adults, and older adults. Results of the study revealed that substantial differences exist between older adults and other groups. Interestingly, emotional empathy increased in older adults while there were a few deficiencies in aspects of cognitive empathy. Khanjani et al. noted that other studies have highlighted the fact that older adults exercised less recognition and understanding of certain facial expressions such as sadness or anger than younger adults (e.g., MacPherson, Phillips, & Della Sala, 2002). Khanjani et al. suggested that this may be because the recognition of

emotion could be instinctive for younger adults, but not for older adults. This means that older adults may need to apportion additional resources to mental processing to achieve accuracy. In short, because of old age, older adults should attempt to voluntarily process emotional cues because they lack the instinctive processing of younger adults (Isaacowitz & Stanley, 2011).

Khanjani et al.'s (2015) assertion that older adults are linked more closely to cognitive empathy while younger adults are linked more closely to emotional empathy, is interesting one. It is interesting because one could assume that with older age comes a deeper sensitivity to the needs and issues of others. That is because older adults having more life experiences than younger adults would be linked more closely to emotional empathy than younger adults.

Both empathy and compassion toward the patient in healthcare have been promoted as means to improve the patient experience. Kerasidou and Horn (2016) identified an interesting dynamic in those physicians who are typically held in high regard by both patients and staff for their expertise in providing care. They identified that, although the physicians are held in high regard for their professional expertise, they have also developed an image of being clinical or emotionless in their demeanor. Curiously, the picture of an expert and emotionally detached physician has dominated the profession and inhibits the physician from engaging on an emotional level with the patient and their own feelings. These feelings are the basis for empathy. Further, emotional expressions in the medical practice are deemed as unprofessional and have an adverse impact on both patients and physicians. As such, many physicians learn to subdue and even ignore their emotional feelings. Hence, when faced with stressful situations, these physicians are

more likely to be subjected to depression and burnout rather than those who engage with and reflect on their emotional feelings (Kerasidou & Horn, 2016).

Kerasidou and Horn (2016) suggested that a shift is necessary in healthcare that would create room for physicians to acknowledge and reflect on their feelings and would make resources available to support them in their emotional work. Empathy is an important part of providing clinical care. However, the emotional labor that's required is not insignificant. The ability to join into another's feelings and emotions, presupposes a high level of self-awareness of one's own emotions Further, within the field of medical professionalism, empathy is offered as the ideal balance between emotional over-involvement and detachment.

Displaying little to no emotion while treating patients supports the perception of professionalism in physicians. However, clinicians must learn to express their emotions rather than suppressing them; suppressing those emotions can accelerate burnout and depression in physicians that can have adverse effects on patient care, patient satisfaction, and organizational performance. Not only should empathy be expected from doctors but also, it should be actively promoted, assisted, and cultivated in the medical profession (Kerasidou & Horn, 2016).

Enhancing empathic engagement in patient care has training and development implications for medical education. Hojat (2009) outlines 10 strategies for enhancing empathy in the healthcare environment: improving interpersonal skills, audio- or video-taping encounters with patients, exposure to role models, role playing (aging game), shadowing a patient (patient navigator), hospitalization experiences, studying literature and the arts, improving narrative skills, theatrical performances, and the Balint Method

(Hojat, 2009). The Balint Method is a training program based on the idea that medical students need to be more exposed to opportunities to develop interpersonal aspects of healthcare. It has also been reported that empathic interpersonal engagement in the clinical environment leads to greater patient satisfaction, better compliance, and lower rates of malpractice litigation (Moore, Adler, & Robertson, 2000; Stewart et al., 1999; Zachariae et al., 2003) (see Appendix B for a list of additional literature specific to this issue).

Some research indicated that higher cognitive empathy correlates with more positive well-being among therapists (Linley & Joseph, 2007) and among internal medicine residents (Shanafelt et al., 2005). Conversely, lower empathy correlates with professional burnout in medical students (Thomas et al., 2007), resulting in self-perceived medical errors (West et al., 2006). Understanding the impact of empathy on different cultures is important to health systems and hospitals that seek to serve patients from diverse cultural backgrounds in their patient population.

Amador, Flynn, and Betancourt (2015) examined cultural and interpersonal psychological factors related to healthcare interactions that may improve the detrimental effects of negative encounters. Utilizing a mixed-methods approach, they assessed the interactions among positive cultural beliefs about health professionals, perceived professional empathy, interpersonal emotions, and continuity of cancer screening among 237 Latin American (Latino) and non-Latino White (Anglo) American women who reported a negative health care encounter. A multi-stage stratified sampling research model to obtain nearly equal proportions of self-identified Mexican-origin Latino and Anglo women of varying demographic backgrounds. Demographic projections for

ethnicity, education, income, and age were anticipated for a number of recruitment settings including churches, markets, universities, mobile home parks, and community settings in Southern California based on U.S. Census tract data. Permission was obtained from the sites to post a Spanish and/or English language recruitment flyer that described the study, eligibility criteria, and the time and onsite location for participation. Amador et al. found that Latino and Anglo-American women experienced better continuity of care with cancer screenings following a negative encounter when they perceived that the provider was being empathic during the encounter. Additionally, patients were more likely to perceive the provider involved in the negative encounter was being empathic when they generally harbored positive cultural beliefs about the providers

The findings from the research indicated the cultural and interpersonal psychological factors involved in interactions that may ameliorate or improve the detrimental effects of negative health care encounters such as disruptions in the continuity of care. Great value might be found through intervention efforts designed to improve culturally diverse patients' perceptions of health professionals. The empathy skills of the healthcare professional might have important implications for improving patient–professional relations, avoiding some of the deleterious consequences of negative experiences with the health care system, and reducing cancer screening health disparities among low socioeconomic status and ethnic minority populations.

The U.S. Government advocates for eliminating existing barriers to effective nurse–physician collaboration because it is an essential ingredient in improving patient safety (e.g. Institute of Medicine, 2000, 2003). Collaboration is a characteristic of a servant leader and may be a contributing factor to an environment of empathic care,

quality of care and patient safety. Practicing empathy in the healthcare setting is not without risks to the organizational performance of healthcare systems and hospitals. The Joint Commission standards service recovery "involves the service provider taking responsive action to 'recover' lost or dissatisfied customers and convert them into satisfied customers" (Bendall-Lyon & Powers, 2001, p. 278). Healthcare systems and hospitals have realized that service recovery has been a cost-effective mitigation strategy for improving patient satisfaction scores (Starr, 2013). With the current climate of high acuity patients, overcrowding in hospitals and lengthy emergency department visits, practicing service recovery that includes empathy can be a useful strategy for the direct care nurse, the relief charge nurse, and the department manager (Starr, 2013). Displaying empathy through an apology for a missed diagnosis from a high-level leader can persuade a patient's family to settle a lawsuit for much less than a jury award (Curtis, 2010, as cited in Starr, 2013).

Empathy Construct

Empathy is a vague construct. Some researchers have suggested that empathy means so many things that it really doesn't amount to much (Pigman, 1995). Some have concluded that empathy really doesn't mean anything (Reik, 1948). Levy (1997) argued that because of these anomalies, the word empathy should be abolished or replaced by a less ambiguous term. Because of this ambiguity and confusion, empathy has been seen as a concept that is hard to define and hard to measure (Kestenbaum, Farber, & Sroufe, 1989).

Hojat (2009) defines empathy as "a predominantly cognitive attribute that involves an understanding of experiences, concerns and perspectives of another person,

combined with a capacity to communicate this understanding" (p. 413). Hojat asserted that a culture of empathy in the healthcare setting has implications for the health of health professionals in that higher empathy is connected with improved wellbeing. Autry (2004) posited that leaders need to have "empathy as well, the ability to put yourself in the other's shoes, to view the world of the situation from the other's viewpoint" (p. 16). Burns (1978) stated that empathy is "the vital leadership quality of entering into another person's feelings and perspectives; that is the beginning of moral leadership" (p. 100). Goleman, Boyatzis, and McKee (2002) noted that empathy is something that followers want from leaders explaining, "followers also look to a leader for supportive emotional connection—empathy" (p. 5)

The *Cambridge English Dictionary* defines empathy as "the ability to share someone else's feelings or experiences by imagining what it would be like to be in that person's situation" (Empathy, n.d.). Dal Santo, Pohl, Saiani, and Battistelli (2014) and Scudder (2012) characterize empathy as a complex and multidimensional construct that is defined in many different ways in the context of healthcare. Empathy, in this context, is frequently considered elusive and hard to measure but is central to the nursing role (Dal Santo et al., 2014; Scudder, 2012).

Empathy is different from sympathy. In health and human services cultures, empathy is an intention to help and alleviate pain and suffering. Sympathy, however, is primarily an affective or emotional attribute that involves strong feelings for a patient's pain and suffering. Regardless of the differences in conceptualization, the two notions are not entirely independent (Hojat et al., 2001). The two terms are often used interchangeably, and the differences may be inconsequential in social psychology. It is

important, however, to separate the terms in the context of patient care. The two concepts lead to various and, at times, opposing outcomes in patient care. In the realm of social psychology, empathy and sympathy can lead to a similar outcome (e.g., prosocial behavior), although for different behavioral motivations. For example, empathically induced prosocial behavior is more likely to be elicited by a consciousness of altruism, and sympathetically stimulated prosocial behavior is more likely to be activated by egoistic motivation (Hojat, 2009).

Sinclair et al. (2017) analyzed sympathy, empathy, and compassion in utilizing direct patient reporting. Data were collected via semi-structured interviews from 53 advanced cancer inpatients and subsequently analyzed independently using the three stages and principles of Straussian grounded theory. The analysis indicated that the constructs of sympathy, empathy, and compassion, feature specific themes and sub-themes. Patients described sympathy as an unwanted, pity-based response to a distressing situation that was characterized by a lack of understanding and self-preservation of the observer. Empathy was experienced as an effective response that acknowledges and attempts to understand individual's suffering through emotional resonance. Compassion enhanced the key components of empathy while adding distinct features of being motivated by love, the altruistic role of the responder, action, and small, supererogatory acts of kindness. Patients reported that empathy and compassion, unlike sympathy, were beneficial. Although sympathy, empathy, and compassion are often used interchangeably and are frequently combined in healthcare literature, patients differentiate and experience them uniquely. Understanding patients' perspectives is important and can guide practice, policy reform, and future research.

Servant Leadership Construct

There is an implied paradox in the term "servant leader." Wong and Page (2003) assessed that the concern that servant leadership implies ceding power, stems from the seeming oxymoron of being a humble servant and, at the same time, wielding power. The apparent contradiction in terms can be resolved by recognizing that servant leaders utilize a variety of social powers; they will resort to coercive power only in dealing with immature and irresponsible workers.

Wong and Page (2003) also addressed the underlying anxiety of ceding power and losing the coveted position of leadership. Leaders who are opposed to the servant leadership practice of sharing power and empowering others fear that followers may use this newfound freedom and power against them. In order to feel secure in their position, leaders resort to coercive tactics to keep subordinates under control. Paradoxically, abuse of power only increases their sense of insecurity. They eventually discover that their potential to attract and influence followers actually decreases in proportion to their attempt to control followers through intimidation, deception and manipulation.

Conventional leadership versus servant leadership. As a broad theory, leadership has existed from the dawn of the first interactions of humankind. As far back as 5,000 years ago, various ancient written documents indicate concrete principles regarding leader behavior (Bass, 1981). However, Bennis (1989) states that leadership is still one of the most studied and least understood aspects of the social sciences. Specifically, the lack of discernment of when and why certain leader behaviors should be offered has left leadership scholars dissatisfied with many current views and they

continue to search for greater understanding of the relationship between leader behavior and various follower outcomes (Humphreys, 2005).

While leadership scholars have asserted that there is no clear or universal understanding of leadership (Alvesson & Sveningsson, 2003; Northouse, 2010), various definitions of leadership do emphasize the influential nature that leaders have upon followers. S-S. Chen (2005) defines leadership as "relationship among organization members who intend to influence each other and to have real changes that reflect their mutual purpose" (p. 48). Northouse (2010) asserted that leadership is a very valuable and highly desired commodity. He defined leadership as follows:

> A process whereby an individual influences a group of individuals to achieve a common goal." Further, defining leadership as a process necessitates that leadership is not a trait or characteristic per se that resides in the leader, but it is really a transactional event that occurs between the leader and the followers. (p. 3)

A leader is described by Nahavandi (2006) as an individual who influences other individuals and groups within an organization, with the objective of helping them to establish goals while guiding them toward achievement of those goals. Leadership is seen as more than just a title or position. Freifeld (2014) believes that leadership is a skill that is not necessarily just about fulfilling a position. As a result, employees at every level and in every position are able to develop, grow, and perfect their leadership skills to the utmost. Within their position, they are able to influence themselves, others, the organization, and even their industry as they attain higher levels of leadership competency.

Some see leadership as a sophisticated construct. Scholtes (1998) state, "leadership is an art, an inner journal, a network of relationships, a mastery of methods" (p. 374). Finally, leadership is described as a skill used to influence followers in an

organization to work enthusiastically towards goals and objectives that are specifically identified for the common good (Barrow, 1977; Cyert, 2006; Plsek & Wilson, 2001).

Although the healthcare industry has evolved into a vibrant market economy that is governed by a various internal and external forces, healthcare organizations continue to be dominated by leaders who practice an outdated transactional style of leadership. These organizations and their hierarchies are typically intrinsically stagnant (Schwartz & Tumblin, 2002).

Servant leadership greatly contrasts with the traditional command-and-control transactional leadership theories of the mid-20th century; it requires that to lead others, one must change within one's self (Schwartz & Tumblin, 2002, p. 1424). Furthermore, servant leadership principles align well and support the caring disposition inherent in nursing practice (Neill & Saunders, 2008, p. 396). As such, this research will focus on the frequency of servant leadership behaviors exhibited by mid-level staff at Crestdale Health Care and how they impact an environment of empathic care.

History of servant leadership. Robert Greenleaf (1970) was one of the first and best-known scholars to introduce the concept of the servant leader into literature on management and organizations. Greenleaf defined servant leadership as a leader's desire to motivate followers, guide followers, offer hope, and provide a more caring experience through established quality relationships. The notion of caring for others is a key tenet of the servant leader. Hoveida, Salari, and Asemi (2011) noted that servant leadership is based upon the core values of caring and serving others, and focuses on the values of trust, appreciation of others, and empowerment.

The practice of servant leadership is not a new construct; it dates back to ancient teachings of the world's great religions, as well as to statements of numerous great leaders and thinkers (Sendjaya & Sarros, 2002). The notion of servant leadership echoes the messages of Mother Theresa, Moses, Harriet Tubman, Lao-tzu, Mohandas Gandhi, Martin Luther King, Jr., Confucius, and many other religious, historic, and current leaders (Keith, 2008). Various scholars model Jesus Christ's teachings to his disciples as the ultimate example of servant leadership (Ebener & O'Connell, 2010; Lanctot & Irving, 2010; Winston, 2004).

Some view the words *servant* and *leader* as being diametrically opposed (Spears, 2010). In purposefully linking the two words in a meaningful way, Greenleaf created the paradoxical term servant leadership. Since that time, many of today's most creative thinkers are writing and speaking about servant leadership as an emerging leadership paradigm for the 21st century. Some of today's cutting-edge leadership authors and advocates of servant leadership cited by Spears include: Autry (2004), Bennis (2009), Block (2013), Carver (1999), Covey (1992), De Pree (2001), Jaworski (2011), Kouzes and Posner (2006), Matusak (1997), Palmer (2011), Peck (1994), Senge (2006), Vaill (1996), Wheatley (2006), and Zohar (1997). Zohar (1997) states that, "Servant-leadership involves practicing the essence of quantum thinking and quantum" (p. 146).

Farling, Stone, and Winston (1999) called for empirical studies of servant leadership. Three streams of research have emerged: conceptual research, measurement research, and model development research. Conceptual research relates to theory; measurement research relates to assessment tools and methods, and model development research relates to construct (Van Dierendonck & Patterson, 2011). Parris and Peachey

(2013) note that empirical studies that explore servant leadership theory in a given organization are absent from the streams outlined by Van Dierendonck and Patterson (2011).

While servant leadership principles are important to top management across industries that are large, complex organizations, some scholars have noted an absence of a generally accepted definition of servant leadership. Some scholars also report an an absence of generally accepted measurement tools for servant leadership (Andersen, 2009). Washington, Sutton, and Feild (2006) also assert that there is a lack of empirical research on servant leadership.

Servant leadership is widely viewed as having a positive impact on organizational performance. Management behaviors such as sharing information, knowledge exchange and learning, involving the organizational members in important processes, and allowing them to make mistakes contribute to the positive impact on organizational performance (de Waal & Sivro, 2012). Overall, regardless of the growing amount of research on servant leadership, the theory of servant leadership is still poorly defined, with various authors wrestling with definitions (Andersen, 2009).

Characteristics of a servant leader. Researchers have identified various key servant leadership behavior characteristics. Based on Greenleaf's (1970, 1977) ideas, Spears (2010) distinguished 10 characteristics that are generally quoted as the essential elements of servant leadership: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment, and building community. Additionally, Laub (1999) identified six servant leadership behaviors that are valuing people, developing people, building community, displaying authenticity, providing

leadership, and sharing leadership. Further, Sipe and Frick (2009) pinpointed seven key characteristics of servant leadership that they describe as "pillars" of servant leadership (p. 6). These Pillars were used as a key component for this research study rather than other assessment tools because they were developed to be sustainable and measurable competencies that are better suited for further empirical study.

Servant leadership compared to other leadership styles. Several comparisons of servant leadership to other leadership styles have been made. C. Y. Chen, Chen, and Li (2013)'s survey study compared servant leadership with transactional leadership and assessed the role that a leader's spiritual values play in promoting employee's autonomous motivation and eudemonic well-being. Chen et al. found that servant leadership contributes more than transactional leadership to influence subordinate motivation. They also found that servant leadership can satisfy the different psychological needs of employees, as well as enhance both high and low autonomous motivations.

Transformational leadership is composed of four dimensions: idealized influence, inspirational motivation, individualized consideration, and intellectual stimulation (Bass & Riggio, 2006). When leaders exhibit idealized influence, they behave as role models and stimulate the trust and respect of followers. Leaders, who engage in inspirational motivation, and communicate high expectations, are optimistic vis-a-vis what followers can achieve and invigorate others to go beyond minimally accepted standards. When leaders engage in intellectual stimulation, they inspire followers to think independently and contribute their own thoughts and ideas. Lastly, leaders who exhibit individualized consideration recognize and adapt to others' individual needs and abilities.

Although the principles of servant leadership and transformational leadership are closely aligned, there is a key difference. With transformational leadership, the dimension of idealized influence places an emphasis on the leader's charisma (Bass, 1996; Den Hartog, Van Muijen, & Koopman, 1997; Smith, Montagno, & Kuzmenko, 2004; Stone, Russell, & Patterson, 2004). Allen et al. (2016) opined that, arguably, the most important characteristic of a transformational leader is charisma. Conversely, the servant leader is one who leads from behind by supporting the development of individuals in the organization. In fact, the ultimate commitment of the servant leader is the enduring investment of the leader's life in the lives of those who follow (Blanchard, 2004). Trastek et al. (2014), along with Shalaby (2015), have argued that servant leadership should be considered a prominent leadership model for the healthcare setting. Servant leadership emphasizes trust and empowerment in inter-professional relationships including relationships with patients and the community. In short, with major challenges affecting the health care system, servant leadership may stimulate necessary change so that all healthcare stakeholders can focus on serving the patient, team, and community (Marchman, 2015; Shalaby, 2015; Trastek et al., 2014). Through servant leadership theory, engaging stakeholders to serve others produces sustainability by providing an improved value proposition that enhances the quality of care and reduces costs (Trastek et al., 2014). Enhancing the quality of care improves the patient experience, and reducing costs helps health systems and hospitals meet the challenges of the financial headwinds that are a result of a dynamic and changing healthcare environment.

Servant leadership and ethics. Given the prevalence of recent scandals in business, government, sports, nonprofits, and other institutions, questions have been

raised regarding the quality of organizational leadership. The worldwide recession that erupted in mid-2008 has challenged organizational scholars to question deeply held assumptions about effective business strategy and to define new models of ethical leadership that can more sufficiently respond to the demands of a more interdependent global society (L. L. Reed, Vidaver-Cohen, & Colwell, 2011, p. 415). Contained within this new paradigm is an alternative model of organizational leadership that moves beyond the competency inputs and performance outputs that are traditionally utilized to assess leader effectiveness—emphasizing instead the moral, emotional, and relational dimensions of leadership behaviors (Bolden & Gosling, 2006)

L. L. Reed et al. (2011) found that, couched in the ongoing conversation regarding ethical leadership, is the notion that leaders hold tremendous power, and that those leaders who perceive organizations and people beyond the competency inputs and performance outputs traditionally used to measure leader effectiveness are increasingly important in a profoundly interdependent society. As this perspective challenges most established models of business management, ethical leadership also requires profound psychological and moral courage from business leaders. Servant leadership embodies such courage but is not a fast remedy or quick fix. Servant leadership is a developmental process for executives, employees, and organizations as a whole. Leaders must determine if this paradigm is consistent with who they really are or rather, an idealized representation of who they would like to be (L. L. Reed et al., 2011).

Dion (2012) investigated the notion that ethical theories could be related to some leadership approaches. In general, researchers do not attempt to expound upon a philosophical link between ethical theories, and ethical leadership. In fact, some writers

attempt to combine various ethical theories within the same leadership approach. Dion found that servant leadership as well as transformational leadership could be connected with various ethical theories. In particular those theories are deontology, philosophical egoism, and ethics of responsibility.

Servant leadership and follower trust. Joseph and Winston (2005) analyzed the correlations between employee perceptions of servant leadership, leader trust, and organizational trust, and reported a strong correlation between servant leadership and organizational trust. There was also a positive correlation between employee perceptions of organizational servant leadership and leader trust. The findings support Greenleaf's (1977) notion that servant leadership is an antecedent of organizational trust.

Additional evidence suggests servant leaders value empathy (Spears, 1998), integrity (Russell, 2001), and the ability to lead with competence in an effective manner (De Pree, 2001; Greenleaf, 1977; Russell & Stone, 2002). The ability to visibly appreciate, consider, and care for followers is considered to be a valuable attribute of servant leaders (Greenleaf, 1977; Pollard, 1996; Russell, 2001). Researchers have suggested servant leaders also value integrity and competence in order to develop interpersonal trust which is an essential ingredient in servant leadership (Russell, 2001; Russell & Stone, 2002).

Servant leadership and change management. Kool and van Dierendonck (2012) contributed to the change management literature by providing additional insight into how leadership encourages commitment to change. They suggested that most organizations operate in a dynamic environment. Rapidly increasing competitive targets and economic instability are a few of the reasons for the need of organizations to adjust

with an increasing frequency and severity (Fedor, Caldwell, & Herold, 2006). The complexity of work and organizational life has increased extensively because of technological developments, globalization, and other changes. The internal environment is also changing because human dynamics within an organization are constantly fluctuating and the organization needs to find a solution to deal with those shifts (Vermeulen, Puranam, & Gulati, 2010). A particular challenge to organizations is the need to keep employees committed throughout these change processes where communication usually plays an important role (Van den Heuvel, Demerouti, Schreurs, Bakker, & Schaufeli, 2009).

Kool and van Dierendonck (2012) focused on the joint influence of people-focused leadership (i.e., servant leadership), along with a task-focused leadership, that is the contingent reward element of transactional leadership. The research involved participants from a reintegration company with a target population of 211 people of which 135 completed a survey resulting in a 64% response rate. The average age of participants was 45 years and the sample consisted of 58% men and 42% women. All participants were assured that their participation in the study would be held in confidence. Servant leadership was measured using a 14-item servant leadership survey with a Cronbach's alpha of 0.93 as developed by Ehrhart (2004). Contingent reward was assessed with five items from the leadership scale with a Cronbach's alpha of 0.92, as developed by Podsakoff, MacKenzie, Moorman, and Fetter (1990). Organizational justice was assessed with nine items from the organizational justice scale of Colquitt (2001). Both subscales had a Cronbach's alpha score of 0.88. Optimism was assessed with the ten-item scale with a Cronbach's alpha score of 0.69 that was developed by Scheier,

Carver, and Bridges (1994), and commitment to change was assessed with the six-item scale of Herscovitch and Meyer (2002) with a Cronbach's alpha score of 0.84.

Kool and van Dierendonck (2012) suggested that their results underline the importance of combining a people-oriented and a task-oriented approach. In short, leaders who had the ability to combine servant leadership with contingent reward leadership were more likely to create an environment that helps their followers to embrace change in a positive way. This finding has implications for health systems and hospitals as they seek to manage change in an ever-evolving marketplace.

Servant leadership and employee retention. Jaramillo, Grisaffe, Chonko, and Roberts (2009) conducted a study that consisted of a confirmatory factor analysis measurement model. The model was utilized to assess the properties of latent variables (Anderson & Gerbing, 1988). Model parameters were estimated using the maximum likelihood method (Jaramillo et al., 2009). As prescribed by Ehrhart (2004), servant leadership was handled as a second-order construct with seven elements.

Jaramillo et al. (2009) concluded that servant leadership affects turnover intention through a complex moderated and mediated chain-of-effects. The chain-of-effects involves ethical level, person–organization fit, and organization commitment. The study also showed that servant leadership increases in importance when the organization is perceived by the team member as unethical.

Servant leadership and other cultures. The servant leadership style, as studied in the United States, possesses characteristics that parallel other cultures, but also, has characteristics that are unique to U.S. culture. Hale and Fields (2007) examined how followers from Ghana, West Africa, and the United States of America have experienced

three servant leadership dimensions in a work situation, and the degree to which these followers relate servant leadership dimensions to judgments about leadership effectiveness in each of their respective cultures. While there is a shortage of literature that relates to leadership in the African context, Sandbrook and Oelbaum (1997) described contemporary Ghanaians national leadership as neo-patrimonial. Neo-patrimonialism involves the use of governmental powers to reward political insiders; acquiescence of the ruler if not active involvement in the misdirection of state funds; distributions of state jobs by political patrons to followers who accept bureaucratic corruption; and private property threatened by rule of law. Hale and Fields (2007) found that Ghanaians reported experiencing servant leadership behaviors much less than North Americans. Their research also revealed that vision had a stronger correlation with leader effectiveness for Ghanaians compared to North Americans. Also, both Ghanaians and North Americans relate service and humility with leader effectiveness.

Han, Kakabadse, and Kakabadse (2010) explored the notion that the Western idea of servant leadership possesses the same meaning in the public sector of the cross-cultural context of China. They also inquired whether an alternative term exists in the Chinese language that closely aligns with the concept of servant leadership. They found that the idea of servant leadership does have a parallel meaning between China and the Western world, and that the Chinese concept of servant leadership can be described specifically as public servant leadership in the public sector and servant leadership in the non-public sector. Han et al. also reported that the specific types of servant leadership in the Chinese context include the following: putting people first, being dutiful, displaying devotion to political party policies and state laws, and listening.

Hale Öner (2012) administered an adapted servant leadership survey in Turkey to explore the relationship between perceptions of servant leadership and paternalistic leadership styles in the Turkish business context. The paternalistic leader can be described as a nurturer, guide, and protector much like a father would behave toward his children. Hale Öner reported that Turkish employees perceived a high correlation between paternalistic and servant leadership styles.

This review of cross-cultural leadership demonstrates that leadership practices held by employees are acutely culture-specific. The servant leadership construct highly correlated with the paternalistic leadership construct. Servant leadership characteristics, as perceived by Turkish employees, reflected a higher degree of orientation toward people.

Identity of the servant leader. The prominence of the servant identity is determined by the extent to which being a servant is central to one's sense of self. It is the consistent desire to be identified as a servant, both intra-personally through self-categorization and inter-personally through recognition from others as someone who serves (Liden, Wayne, Zhao, & Henderson, 2008). Because of their focus on others, servant leaders are viewed as moral leaders (Graham, 1995); their leadership approach is to raise the moral and ethical behaviors of their followers (Greenleaf, 1977). Servant leaders who are cognitively sophisticated are able to determine a group of consistent attributes (calling, humility, empathy, and agape love) that define their identity as servants. These types of individuals who possess these attributes are motivated to adjust their behaviors to align with their servant attributes (Sun, 2013).

There is a link between personality traits and servant leadership. Understanding and identifying the link can be important to healthcare hiring managers seeking to add servant leaders to their teams. Evidence suggests that those who are more likely to practice servant leadership behaviors possess certain character traits. The five-factor model of personality (i.e., "Big Five"), neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness, has been utilized to describe various aspects of personality (Costa & McCrae, 1998; Goldberg, 1990).

Further evidence suggests that servant leaders hold attributes congruent with the Big Five personality factor of agreeableness. Both the agreeable individual and servant leader stress altruism (Costa & McCrae, 1998; Joseph & Winston, 2005). An agreeable leader is described as a fundamentally altruistic individual who is sympathetic, generous, and eager to assist others (Costa & McCrae, 1985). Such descriptions of agreeableness are akin to servant leadership's hallmarks of stewardship, service, and the growth of followers (Spears, 1995, 1998).

Physician assistants and nurse practitioners are more likely to have more interaction and engagement with patients than the physician. They perform several diagnostics, etc. with the patient in support and/or relief of the physician's case load (Brush & Capezuti, 1997; Rudy, 1995). Data indicates that nurse practitioners can provide approximately 90% of the primary care services that are routinely provided by physicians (Bauer, 2010). A patient is likely to build more of a rapport with physician assistants and/or nurse practitioners than the attending physician (Horrocks, Anderson, & Salisbury, 2002; Newhouse et al., 2011). Communication and listening are not only collaborative behaviors, but are also servant leadership behaviors, core components in

developing an empathic environment in the healthcare setting. Nair, Fitzpatrick, McNulty, Click, and Glembocki (2012) examined the delineation of frequently from infrequently used collaborative behaviors of nurses and physicians in order to generate data to support specific interventions for improving collaborative behavior. The location for data collection was an acute care hospital, and participants included 114 RNs and 33 MDs with active privileges. The Nurse–Physician Collaboration Scale (NPCS) was used to assess the frequency of use of nurse–physician collaborative behaviors self-reported by nurses and physicians (Nair et al., 2012). While physicians and nurses sharing patient information on a collaborative basis is an expectation, the study found that nurses reported sharing patient information as the most frequently occurring activity between nurses and physicians. This may be due to the necessity of nurses ensuring that physicians have relevant patient information in order to advocate for patients and act as a liaison between the patient and physician. Consequently, when information sharing is not consistently practiced, patients can be at an increased risk for medical errors.

Link Between Servant Leadership and Empathy

Neill and Saunders (2008) discussed the nexus between servant leadership behaviors and the advancing of a caring environment to improve employee satisfaction and the patient experience. Servant leaders endeavor to understand the position and circumstance of others, make a purposeful effort to consider other's viewpoints, and work with followers to realize their dreams. Servant leadership features a strong skill set that is very effective in implementing a team approach to the delivery of patient care through nursing practice. This model advances the professional growth of nurses while promoting improved delivery of healthcare services through an amalgamation of interdisciplinary

teamwork, shared decision making, and ethical behavior. The servant leader assumes that coworkers have good intentions and recognizes and accepts them for their distinctive contributions. An important point of clarification is that this does not imply that undesirable behavior or performance is ignored, but rather that it is the undesirable behavior that is held accountable and not the individual.

Neill and Saunders (2008) pinpointed the fact that servant leadership principles align well with the caring nature that is inherent within nursing and has a positive effect on patient and employee satisfaction. In doing so, it is clear that the benefits of creating a culture of empathy in the healthcare environment not only benefit the patient, but also positively impact employee satisfaction and organizational performance. The research findings have implications for training and development of healthcare providers, healthcare organizational development (employee retention), and financial vitality of healthcare institutions.

Hunt (2016) outlined how servant leadership behaviors, that include empathy, should be modeled in the healthcare setting. Hunt outlines Robinson's (2009) 10 servant leadership behaviors/attributes that should be demonstrated among team members and with patients. These behaviors/attributes are: "listening skills, empathy, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, healing, and ability to build community," (Robinson, 2009, p. 2). Of these key servant leadership behaviors/attributes, Hunt (2016) groups listening skills, empathy, and awareness together because they are intimately linked. Robinson (2009) also states "Listening promotes democracy and shared governance. It also provides a pathway to understanding and problem solving and is a prerequisite of empathy" (p. 11). Even

though a servant leader may not have the same opinion as their subordinates, it is vital for the leader to practice active listening coupled with empathy and compassion. Hunt (2016) suggests that practicing servant leadership behaviors in the healthcare setting may lead to an environment of caring or a state of empathic care.

Judge and Bono (2000) suggested that an agreeable type of individual is one who is motivated primarily by an altruistic orientation; that is, a concern-with-others interest and empathy for their condition. These types of descriptions of agreeableness are analogous to servant leadership's hallmarks of stewardship, service, and the growth of followers (Spears, 1995, 1998). Because there is no generally accepted agreement of servant leadership characteristics, empathy is not considered to be a fixed component of servant leadership characteristics. The link between servant leadership behaviors and empathy is important because various scholars have noted and deliberated on the difficulty of current medical students and professionals to empathize with patients (Eikeland et al., 2014; Hojat et al., 2004, 2009; Suchman et al., 1997; Tavakol et al., 2012; Ward et al., 2012).

Measuring servant leadership. There is no generally accepted definition of the characteristics of the servant leader (Andersen, 2009). However, instruments have been developed to measure the characteristics of a servant leader. These instruments can be attributed in part to Patterson (2003)'s servant leadership theory and Dennis and Bocarnea (2005)'s Servant Leadership Assessment Instrument (SL–7) (based on Patterson's constructs, identified as agape love, humanity, altruism, vision, trust, service, and empowerment). These constructs were utilized to construct items for a servant leadership instrument. Patterson had used DeVellis' (2003) Guidelines in Scale

Development to create an instrument for a new theory of servant leadership. The participants in Dennis and Bocarnea's (2005) study were comprised of a stratified sample taken from the study response database; the surveys were developed and administered using an online survey (Surveysuite). The SL–7 was found to be consistent and reliable with a Cronbach-Alpha Coefficient Alpha of 0.89–0.92.

Page and Wong (2000) developed a Servant Leadership Profile (SLP-R) solely on a prior conceptual analysis of servanthood. The SLP-R is comprised of 62 items grouped into seven factors. Six of those factors represent the presence of servant leadership characteristics while one represents attributes antithetic to servant leadership (autocratic leadership). The SLP-R was found to be reliable and stable with a Cronbach-Alpha Coefficient Alpha: 0.92.

Liden et al. (2008) developed a servant leadership assessment tool by identifying nine dimensions. From these dimensions, relevant items were developed and subjected to factor analysis with a sample of 298 students, resulting in a seven-factor solution. The scale development consisted of two phases: in the first, servant leadership items were generated from a review of the relevant literature. Drawing from widely accepted scale development methods (e.g., Rahim & Magner, 1995), these items were combined, subjected to content validation, and pilot-tested with a large and diverse sample of students. An exploratory factor analysis of the pilot study results showed the emergence of seven distinct dimensions of servant leadership. The four highest-loading items on each of these dimensions were aggregated to create a 28-item scale of servant leadership.

In phase 2 of Liden et al.'s (2008) project, the 28-item scale was validated by a confirmatory factor analysis utilizing an organizational sample. Hierarchical linear

modeling (Raudenbush & Bryk, 2002) was utilized to assess whether the dimensions of servant leadership (at both the individual and group level) could explain variance in subordinate-level outcomes, beyond that explained by transformational leadership and leader-membership exchange (LMX) theory. The results suggest that servant leadership is a multidimensional construct. At the individual level, servant leadership makes a unique contribution beyond transformational leadership and LMX in explaining community citizenship behaviors, in-role performance, and organizational commitment. Additionally, no between-leader (group-level) differences were found in the outcome variables (Liden et al., 2008).

Utilizing an ex-post facto research design, Schneider and George (2011) investigated whether transformational and servant leadership was positively related to club member satisfaction, commitment and intentions to stay in the club. A sample of 110 participants completed either a printed or an online survey on the leadership style of their current club president and their attitudes toward the club in general. The club presidents completed the leadership surveys. Findings included the fact that although perceptions of transformational leadership and servant leadership styles were highly correlated, servant leadership was identified as a better predictor of the voluntary club members' commitment, satisfaction, and intentions to stay. Club members' perceptions of empowerment mediated the relationship between servant leadership and satisfaction, commitment, and intentions to stay in the volunteer service organizations. Practical implications of the study were that service club leaders should consider adopting a servant leadership style (Schneider & George, 2011).

Winston and Fields (2015) conducted a study that had two goals. The first was to clarify the nature of how servant leadership is established and conveyed among members of an organization. The second goal was to identify and evaluate the unique actions by a leader essential to establishing servant leadership. The authors' efforts resulted in identification and validation of 10 leader behaviors that seem to be essential to servant leadership. Methodology consisted of two stages. In the first stage, an item pool of 116 items drawn from previously developed operationalization of servant leadership was developed. A panel of 23 researchers attending a conference focused exclusively on the study of servant leadership for evaluation. In the second stage, the authors developed a questionnaire that assessed transformational leadership behaviors, transactional leader behaviors, servant leadership as measured by the instrument developed by Liden et al. (2008), and a measure of leadership effectiveness developed and used by Ehrhart and Klein (2001). The 10-item scale accounts for 75% of the variance with a scale reliability of $\alpha = 0.96$. Convergent validity was determined by comparison to Liden et al.'s (2008) study that measured servant leadership. Discriminant validity was established through confirmatory analysis of leader effectiveness, transformational leadership's four dimensions, a measure of transactional leadership, and an alternative multi-dimensional assessment of servant leadership.

Reed et al. (2011) introduced a new scale to measure executive servant leadership, situating the need for the scale within the context of ethical leadership and its influences on followers, organizations and the greater society. They reviewed literature on servant leadership and compared this to other concepts that share facets of ethical leadership (e.g., transformational, authentic, and spiritual leadership). Further, they introduced the

Executive Servant Leadership Scale (ESLS). Fridell, Belcher, and Messner (2009) sought to apply discriminate analysis to determine differences in the leadership styles of principals of public schools in the mid-west. This study was stratified by gender. A distinction was made between servant leadership (seen as aligned with emotional intelligence) and "traditional" (or top-down) leadership.

According to Russell and Stone (2002), the needs of others are primary for the servant leader; self-interest is secondary to the basic motivation to serve others. They note that the literature supports the gendered assignment of the command (or traditional) leadership style to men and the assignment of servant leadership styles to women. Views of traditional leadership see men as having been raised to hide their feelings, but perhaps "too much has been made of the gender differences in this regard" (Autry, 2004, p. 16). Both genders have exercised capabilities in demonstrating the top-down approach; both genders are equally likely to be strong servant leaders (Fridell et al., 2009). During the last half of the 20th century, women have increasingly joined the ranks of educational leadership. Frustration occurred early in this effort and was significant enough that by 1977, Guido-DiBrito, Noteboom, and Nathan (1996) perceived that women have increasingly broken-down organizational structures, and that women no longer mimic masculine leadership styles.

The research conducted by Fridell et al. (2009) consisted of electronic surveys from 445 responding public school principals composed of men (n=265) and women (n =180) that were quantitatively analyzed. The self-selected sample for the study was ascertained from public schools in three Midwest states in the USA. The survey instrument had 40 content items prepared on a five-point Likert scale and one

demographic question. Content and construct validity were assessed, and significant difference tests were performed. The study sought to clarify which cluster of items from the Servant Leadership Styles Inventory (SSI) most effectively depicted gender membership and, thereby, proffered possibly gender-oriented servant leadership styles utilizing discriminant function analysis methods (Fridell et al., 2009). The findings established that SSI items identified with servant leadership dimensions are both reliable and valid. On the other hand, items aligned with traditional leadership dimensions were found to be less reliable and valid. Furthermore, these results have shown that servant leadership items can be effective in differentiating between principals of both genders. Both genders equally reported that they were reluctant to use traditional leadership styles, and no differences between genders in traditional leadership styles usage were found. However, there were substantial differences between men and women's practice of the servant leadership style (Fridell et al., 2009). Although both men and women report the frequent practice of the servant leadership style, women were found to uniquely differentiate from men principals in four servant-leadership styles: (1) daily reflection, (2) consensus building, (3) healing relationships, and (4) drive and sense of self-worth.

Each of the previously discussed assessment instruments was designed to measure servant leadership in some form. The literature on servant leadership varies and Andersen (2009), de Waal and Sivro (2012) assert that there is no generally accepted definition of servant leadership or defined set of characteristics. As a result, the opportunity existed to create an assessment instrument to achieve the objectives of this dissertation research study. The characteristics that comprise the pillars in Sipe and Frick (2009) and their

corresponding sub-categories afforded opportunities for specific research and analysis of servant leadership behaviors and their impact on empathy.

Chapter Summary

A theme of this literature review is that healthcare consumerism is being discussed and analyzed by the health systems and hospitals. Patients are behaving more like consumers and are increasingly considering alternative healthcare providers to improve the likelihood of an improved patient experience, improved clinical outcomes, and value for service. Furthermore, an environment of patient centered care involving empathic care is viewed as a compelling strategy for enhancing patient satisfaction, improved compliance, and reduced rates of malpractice litigation.

Healthcare consumerism is the notion that consumers of healthcare are exercising more choice in their selection of a healthcare provider (Butcher, 2016). As such, the healthcare market place for providers has become more fluid and competitive due to consumerism. A renewed focus on patient satisfaction and improving the patient experience are challenging healthcare providers to lead in more effective ways while remaining financially viable. In light of the challenges faced by health systems and hospitals in the market place, empathy in healthcare is being reevaluated and reassessed. It is being reassessed as being vital to good medical practice (Hardy, 2016). Empathy is important to health systems and hospitals because patients benefit when healthcare providers promote an environment of empathic care (Fields et al., 2004).

Healthcare leaders should explore and implement alternative leadership styles to engage the 21st century challenges of an evolving and dynamic marketplace (American College of Healthcare Executives, 2011) that may help to promote empathic care. Servant

leadership can be traced back to the teachings of the great religions of the world as well as ancient thought leaders and philosophers (Sendjaya & Sarros, 2002). With a characteristic of putting others first, the servant leadership construct is different from the hierarchal-driven traditional command and control leadership styles (Schwartz & Tumblin, 2002). Much like the word *leadership* itself, there is not a generally accepted definition of servant leadership. However, servant leadership is widely viewed as having a positive effect on organizational performance (Andersen, 2009; de Waal & Sivro, 2012).

There are multiple assessments designed to measure servant leadership characteristics (Barbuto & Wheeler, 2006; Ehrhart, 2004; Laub, 1999; Liden et al., 2008; Sendjaya, Sarros, & Santora, 2008; van Dierendonck & Nuijten, 2011). Sipe and Frick (2009) outlined seven characteristics of servant leaders with corresponding subcategories of servant leadership behaviors. Sipe and Frick (2009) argued that measurable competencies are assigned to each of their proposed servant leadership pillars. However, the literature review did not identify an assessment tool to measure the servant leadership characteristics identified by Sipe and Frick (2009). Nevertheless, given the potential utility of Sipe and Frick (2009)'s competency model, I elected to conduct an empirical analyses of servant leadership based on their framework's pillars.

As a result of this review, gaps in the literature vis-a-vis the impact of servant leadership behaviors and empathic care have been identified. Extant research has not established which individual servant leadership behaviors are most important to promoting an environment of empathic care. Furthermore, there is little evidence of a generally accepted definition for servant leadership or empathy. This mixed-methods

dissertation study endeavors to probe the connection between servant leadership and empathy, and to outline steps towards increased understanding of how to use servant leadership and empathy together in medical care practice.

Chapter III: Research Methodology

Chapter III of this dissertation presents and discusses the methodology/guiding research questions and research procedures. It also discusses the rationale for selecting a mixed methods sequential explanatory research design. Chapter III details the application of the research methods, stated research questions, data collection, data analysis, and Institutional Review Board (IRB) ethical considerations.

This study sought to analyze which individual characteristics of servant leader are key to promoting an environment of empathic care by surveying and interviewing clinical and non-clinical mid-levels in medical group practices. Understanding the nuances of clinical and non-clinical staff, this study compared responses between the two groups to assess differences and similarities. The research questions were:

1. How do mid-level health care practitioners describe servant leadership and empathic care in their medical group practices?
2. To what extent are the servant leadership characteristics correlated with measurements of empathic care? Additionally, which of the seven pillars of servant leadership characteristics most strongly influence perceptions of empathic care?
3. In what ways are the views of the non-clinical and clinical staff of the medical group practices similar or different with respect to servant leadership characteristics in their medical group practices?"

Research Design

This study used a mixed method research design. The present section describes quantitative, qualitative, and mixed method research methodologies. Quantitative

research involves the use of numerical calculations to summarize, describe, and explore relationships among traits. Specifically, in social research, it involves counting and measuring those human behaviors that are plausibly quantifiable, as well as applying these data as evidence in the interpretation and analysis of the issues being addressed (Payne, 2011).

Quantitative researchers actively seek to ensure objectivity through a variety of means, including the consistency of testing procedures and the minimization of flexible data analysis and interpretation. As such, research projects from this perspective should be uncontaminated by researcher characteristics and therefore repeatable (Given, 2008). Types of quantitative methods include descriptive, correlational, causal-comparative/quasi-experimental, and experimental (McMillan & Wergin, 2010).

In contrast to quantitative research, qualitative research largely acknowledges and embraces subjectivity. Qualitative researchers are commonly identified as co-authors and/or co-constructors of reality with their research project participants; they are more likely to identify as integral research instruments and/or even passionate advocates for a specific cause (Given, 2008). In qualitative research, the emphasis is on conducting studies in natural settings using mostly verbal descriptions, resulting in stories and case studies rather than statistical reports. Research employing mixed methods has qualities of both quantitative and qualitative designs (McMillan & Wergin, 2010). Types of qualitative methods include interpretive, ethnographic, grounded theory, phenomenology, narrative, case study, content and historical studies (McMillan & Wergin, 2010)

In the approximate 30-year history of mixed methods research (Greene, 2008), the landscape of this field has developed dramatically (Tashakkori & Teddlie, 2003a, 2003b).

The progression of interest can be acknowledged through various social and health science disciplines. These disciplines have embraced this form of research, new journals exclusively devoted to this approach, conferences hosting symposia and paper presentations on utilizing this form of research, and support from funding agencies for mixed methods projects (Creswell, 2003).

In the last few years, an extensive discussion has developed about how mixed methods research should be defined. The definition of mixed methods research has experienced considerable revision since the early definition by Greene, Caracelli, and Graham (1989) who focused on the use of multiple "methods." Subsequently, the conversation moved on to a "methodology" orientation (Tashakkori & Teddlie, 2003a). The distinction between the use of multiple methods and an orientation toward methodology is the difference between a research tool and the justification for research overall (Clough & Nutbrown, 2012).

At the core of recent discussion has been the article on definitions of mixed methods research by Johnson, Onwuegbuzie, and Turner (2007). They asked 21 researchers to define mixed methods research and received 19 definitions. These definitions differed in multiple ways, including: in terms of what was being mixed (e.g., methods or methodologies, or types of research); the stage of the research process in which mixing occurred (e.g., data collection or data analysis); the breadth of the mixing (e.g., from data to worldviews); the purpose for mixing (e.g., breadth or corroboration); and the drive for the research (e.g., bottom-up, top-down, or the core component). As a result of their review, Johnson et al. (2007) offered a composite definition:

> Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches

> (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purposes of breadth and depth of understanding and corroboration. (p. 123)

Both quantitative and qualitative research methodologies are effective individually, but each can fall short of maximizing research goals and fail to give a full understanding of the problem (Creswell, Plano-Clark, Gutmann, & Hanson, 2003). By utilizing mixed methods research and integrating the quantitative and qualitative approaches to data collection, the researcher develops a more complete understanding of the research problem than either one by itself would net (Creswell, 2003). Mixed methods research designs include sequential explanatory or exploratory, or transformative designs, or concurrent triangulated, nested (embedded), or transformative designs (Creswell, 2003).

For this dissertation, I used a two-phased sequential explanatory research design where survey data (QUAN) was collected and analyzed, followed by collection and analysis of narrative interview data (qual). The questions on the survey asked respondents to reflect on servant leadership behaviors and empathic care in their medical group practices.

Phase 1 was followed by qualitative Phase 2 interviews—qual (Creswell, 2003). The narrative Phase 2 data provided further explanations and interpretations of the results from the initial survey phase (Bergman, 2008). Figure 3.1 illustrates this QUAN→qual sequential explanatory study.

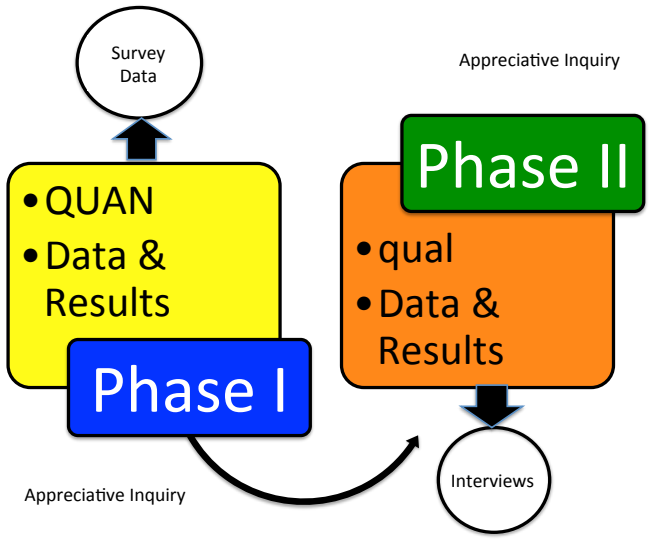

Figure 3.1. Mixed methods sequential explanatory design.

Appreciative Inquiry

This dissertation employed an appreciative inquiry approach to both phases of the research. According to Mathison (2005), this method and approach to inquiry endeavors to comprehend what is best about a program, organization, or system, to create a better future. The fundamental assumptions of appreciative inquiry are that: what people focus on becomes their reality; there are multiple realities and values that need to be acknowledged and included; the very act of asking questions influences their thinking and behavior; and people will have more enthusiasm and motivation to change if they see possibilities and opportunities for the future.

Appreciative inquiry is based on five principles (Mathison, 2005):

1. Knowledge about an organization and the destiny of that organization are interwoven.
2. Inquiry and change are not separate but are simultaneous. Inquiry is intervention.

3. The most important resources we have for generating constructive organizational change or improvement are our collective imagination and our discourse about the future.
4. Human organizations are unfinished books. An organization's story is continually being written by the people within the organization, as well as by those outside who interact with it.
5. Momentum for change requires large amounts of both positive affect and social bonding—things such as hope, inspiration, and sheer joy in creating with one another.

J. Reed (2007) explains appreciative inquiry as a simple but far-reaching approach to understanding the social world. This approach focuses on exploring ideas that individuals have about what is valuable in what they do and then tries to conceive ideas in which this can be built on; the emphasis is firmly on appreciating the activities and responses of people, rather than focusing on their problems. Furthermore, there are two central themes of appreciative inquiry: (a) inclusivity (as many people as possible are involved in the study in a collaborative way), and (b) discovering the positive (conversations and stories told are about achievements and successes) (J. Reed, 2007).

Utilizing an appreciative inquiry approach and employing generous listening, which does not prohibit problem talk, but frames questions that help move problem talk toward appreciation and possibilities will enable this study to focus on positive scholarship as a vehicle to discovering more about the servant leadership characteristics and how they promote and environment of empathic care (J. Reed, 2007). This study incorporated the philosophy of appreciative inquiry by framing the statements in the

survey from a positive perspective and conducting interviews that centered on positive, innovative ideas vis-a-vis patient engagement, to improve the knowledge and understanding of Crestdale Health Care. Furthermore, this study promoted inclusivity of key groups (clinical nurse practitioners, physician assistants, and non-clinical practice managers) in the data collection process and creating momentum for change.

Target Population

The target population for this study consisted of nurse practitioners, physician assistants, and non-clinical practice managers. The nurse practitioner and physician assistant job function has been existence for approximately 50 years. Nurse practitioners and physician assistants are categorized as mid-level clinical managers in the medical group setting and have been delivering care to patients since the 1960s (Sullivan-Marx, McGivern, Fairman, & Greenberg, 2010; Vorvick, 2013). While the nurse practitioner and physician assistant job function is similar, differences exist in training and development for both roles. Nurse practitioner programs generally target a specific population (i.e., pediatrics or adults), with the exception of training for family nurse practitioners, which covers the lifespan; the nurse practitioner clinical setting is decided by the area of specialty and may also either target one setting (e,g., outpatient) or multiple settings. Physician assistant training and development programs include various clinical environments in both the inpatient and outpatient settings for all age groups (Colvin et al., 2014).

Physician assistants practice in almost every medical and surgical specialty area, and many practice within areas that include family practice (Vorvick, 2013). Other common practice areas are general surgery, surgery specialties, and emergency medicine

while the rest are typically involved in teaching, research, administration, or other nonclinical roles (Vorvick, 2013). Additionally, physician assistants can practice in any setting in which a physician provides care; in doing so, this allows physicians to focus their skills, knowledge, and experience in more advanced medical care and treatment. Physician assistants practice in both rural and inner city communities and the ability and willingness of physician assistants to practice in rural areas has improved the supply of health care providers throughout the general population (Vorvick, 2013).

Practice managers, also referred to as mid-level practitioners, are non-clinical personnel that focus on the operations of the medical group practice. The United States Department of Labor (2018b) describes practice managers as healthcare administrators that plan, direct, and coordinate medical and health services. In the medical group setting, their overall responsibility is the management of an entire a medical practice of healthcare providers. They work closely with physicians and surgeons, registered nurses, medical and clinical laboratory technologists and technicians, and other healthcare workers. Most medical and health services managers have at least a Bachelor's degree before entering the field. However, Master's degrees are common and often preferred by employers. Educational requirements may vary by facility (United States Department of Labor, 2018a). Table 3.1 compares nurse practitioner, physician assistant, and clinic administrator/manager roles:

Table 3.1

Nurse Practitioner, Physician Assistant, and Practice Manager Roles Compared

Attribute	Nurse Practitioners	Physician Assistants	Practice Managers
Education and Training	Master's degree in nursing is minimum requirement. American Association of Colleges of Nursing and other organizations have recommended in future requirement of Doctor of Nursing Practice, but current nursing shortage has made this impractical for the time being.	Typically complete a three-year graduate program that includes clinical rotations and results in a Master of Science in Physician Assistant Studies.	Minimum Bachelor's degree.
Function/ Role	Diagnose and treat various illnesses and injuries. Place a strong emphasis on preventative care and health promotion.	Diagnose and treat various illnesses and injuries. Place a strong emphasis on preventative care and health promotion. In a growing number of states, they are permitted to practice and prescribe completely independently without any kind of physician collaboration required.	Work to improve efficiency and quality in healthcare services, develop departmental goals and objectives, ensure regulatory compliance, supervise staff, manage facility finances, create work schedules, maintain, organize facility service records, communicate with members of the medical staff and
Specialties	Receive primary certification in a particular patient population (family, adult-gerontology (acute or primary), women's health, neonatal, pediatrics (acute or primary), or psychiatric-mental health). Can further specialize by practice setting (i.e., emergency medicine) and disease type (i.e., oncology).	Specialize in many areas that typically center on disease type or area of medicine (i.e., everything from dermatology to emergency medicine or surgery).	Implement policies, goals, and procedures for their departments; evaluate the quality of the staff's work; and develop reports and budgets.
Accreditation	Commission on Collegiate Nursing Education or the Accreditation Commission for Education in Nursing.	Accreditation Review Commission on Education for the Physician Assistant.	None
Median Salary (2016)	$107,460	$101,480	$96,540

Note: Descriptions based on United States Department of Labor Bureau of Labor Statistics (2018b) and NP Schools (n.d.).

At Crestdale Health Care, the medical group practice organization structure consists of three major categories: physician partners, clinical team members, and non-clinical team members. The organizational structure is depicted in Figure 3.2.

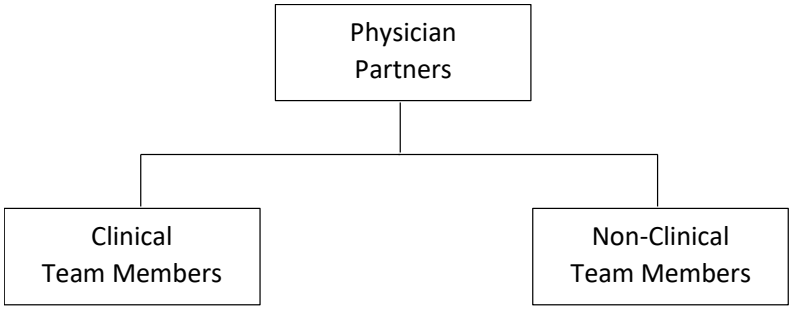

Figure 3.2. Crestdale Healthcare Medical Group Practice organizational structure.

The Clinical and Non-Clinical Team Dynamic

Relationships among clinical providers (physicians and/or nurse practitioners and physician assistants) and non-clinical providers (health and healthcare administrators) can be positive and respectful; they usually share similar goals and work together to accomplish shared goals and objectives (Dovidio, Saguy, & Shnabel, 2009). However, there can be rifts in the working relationships between these two groups that can have negative effects. Ferlie and Shortell (2001) identified a cultural divide in the working relationship between clinical and non-clinical managerial cultures in healthcare that is a deterrent to quality improvement work. For example, clinicians do not always trust healthcare administrators to understand the role of the clinician or appreciate their needs (Ramirez & Bartunek, 1989). Furthermore, nurses are, at times, afraid of reporting errors due to concerns about healthcare administrators' responses (Elder, Brungs, Nagy, Kudel, & Render, 2008). Additionally, when clinicians do encounter problems, they may solve them but may not communicate the solutions to non-clinical staff (Tucker & Edmondson,

2003). As described by Fiol, Pratt and O'Connor (2009) medical staff at a particular U.S. hospital complained that the CEO and her administrative team hindered initiatives and recommendations vital to improving clinical quality. As such, after reading about this type of situation, my interest was piqued into conducting a study that compared survey responses for clinical and non-clinical staff.

Because of the important role of empathy and how it positively affects the patient experience, mid-level practitioners in the medical group setting are an appropriate group to study because they traditionally have more contact and engagement with patients than physicians (Hojat, 2009). Clinical mid-level practitioners provide about 90% of the medical group practice services that are normally provided by physicians (Bauer, 2010). They administer diagnostic testing and perform other clinical duties for the patient population, serving as a support/relief for physician caseload reduction (Brush & Capezuti, 1997; Rudy, 1995). Clinical mid-level practitioners are more likely than the physician on duty to develop a connection with the patient (Horrocks et al., 2002; Newhouse et al., 2011). Within Crestdale Health Care, there are 933 clinical and non-clinical mid-level practitioners and they are located in three U.S. states. These mid-level practitioners served as the survey target population.

Data Collection

The survey was developed utilizing qualitative data from the Sipe and Frick's (2009) book, *Seven Pillars of Servant Leadership.* This decision was based on Sipe and Frick's conversion of selected servant leadership characteristics into sustainable and identifiable competencies. They wanted to make sure that they were not overlooking the

matters of the heart and soul that are integral to the servant leadership construct. Specifically, they stated that:

> This book was born of a desire to be concrete about how to implement servant leadership, without turning Robert Greenleaf's formulation – leading by serving first – into a collection of 'tips and tricks.' This aspiration arose from our frustration over searching for – and never finding – help in converting the characteristics of servant leadership into sustainable, measurable competencies, without neglecting matters of the heart and soul, which make leading by serving truly worthwhile. (Sipe & Frick, 2009, p. xii)

The Seven Pillars of Servant Leadership is particularly unique and different from the items generally found in a servant leadership scale in that each of the pillars features a set of specific characteristics comprising it. As such, these characteristics can be readily measured as well as implemented by organizations, consultants, etc. through training and development.

The seven pillars are:

Pillar 1 (Persons of Character) Makes insightful, ethical, and principle-centered decisions:

- Maintains Integrity
- Demonstrates Humility
- Serves a Higher Purpose

Pillar 2 (Putting People First) Helps others meet their highest priority development needs:

- Displays a Servant's Heart
- Is Mentor-Minded
- Shows Care & Concern

Pillar 3 (Skilled Communicators) Listens earnestly and speaks effectively:

- Demonstrates Empathy
- Invites Feedback
- Communicates Persuasively

Pillar 4 (Compassionate Collaborators) Strengthens relationships, supports diversity, and creates a sense of belonging:

- Expresses Appreciation
- Builds Teams & Communities
- Negotiates Conflict

Pillar 5 (Has Foresight) Imagines possibilities, anticipates the future, and proceeds with clarity of purpose:

- Visionary
- Displays Creativity
- Takes Courageous & Decisive Action

Pillar 6 (Systems Thinkers) Thinks and acts strategically, leads change effectively, and balances the whole with the sum of its parts:

- Comfortable with Complexity
- Demonstrates Adaptability
- Considers the "Greater Good"

Pillar 7 (Leaders with Moral Authority) Worthy of respect, inspires trust and confidence, and establishes quality standards for performance:

- Accepts & Delegates Responsibility
- Shares Power & Control
- Creates a Culture of Accountability

For example, while Servant Leadership Pillar 4 relates to compassionate collaborators who strengthen relationships, support diversity, and create a sense of belonging, the more specific characteristics of expresses appreciation, build teams and communities, and negotiates conflict can be further analyzed for measurement and training and development.

Phase 1: Data was collected through a survey administered through SurveyMonkey. Permission to distribute the survey to the mid-level practitioners was ascertained from Walter Smith (pseudonym), President of Crestdale Health Care's Physician Network. A "Save The Date" email was sent to the target population to give them advanced notice about the research project and that the survey would be arriving in their email inbox. Additionally, the Save The Date email was also intended to improve the survey response rate. The survey was distributed to the target population that consisted of nurse practitioners (N = 358) and physician assistants (N = 338) for a total of 696 members of the clinical target population. In addition, there were 237 non-clinical practice managers in the target population. Overall, the target population was comprised of 933 mid-level practitioners.

The Phase 1 survey contained 13 closed-end questions. The 13 quantitative closed-ended questions included 35 statements to which survey respondents were asked to indicate their level of agreement/disagreement as it pertained to their medical group practice.

The survey began with an "Introductory/Consent Form" section that identified me as the primary investigator, described the purpose of the survey, the importance of the research, the importance of the survey participant's role in the research, confidentiality,

informed consent, and the expected amount of time to complete the survey. See Appendix C for the full survey and introduction.

Section I of the survey, entitled "Job Function," followed the Introduction and it featured a filter question that asked the participant to select their job function from a list. Following the initial filter question there were two other filter questions that asked the respondent to indicate whether or not they worked in a Crestdale Health Care medical group practice and to indicate their role within the organization. The survey terminated for any participants who selected job functions other than nurse practitioners, physician assistants, or practice managers.

Section II of the survey, entitled "Leadership Characteristics," consisted of 25 closed-end statements grouped by pillar and placed under three (3) overarching questions related to servant leadership characteristics. The three overarching questions were the same and asked, *"Thinking about your role in your medical group practice, please indicate how strongly you disagree or agree with each of the following statements."* The statements covered both team and patient focused concepts. Survey participants were asked to reflect on the statements with respect to their medical group practice. Response options ranged from (1) *strongly disagree* to (6) *strongly agree*.

Section III of the survey, entitled "Empathic Care," consisted of four statements. Participants were asked to reflect on their role in their medical group practice and to indicate their level of disagreement or agreement with each statement on a continuum of 1 to 10. Each statement was related to empathic care. For example, participants were asked to indicate their level of agreement with the statement, "In my medical group practice, empathic care is reflected in organizational policies and procedures."

Section IV, entitled “Demographics,” included three closed-ended questions related to gender identification, age group, and facility location. Coding options included *male* and *female for gender*, the age categories of *18-34 years old*, *35-54 years old*, *55-74 years old*, and *75+ years old*, and *Greater Charlotte*, *Greater Winston-Salem*, *Coastal*, *Northern Virginia*, *Triangle*, and o*ther* for service market. The survey concluded with a “Thank You” statement. The statement included a reminder to the participants that all responses would be kept confidential.

Phase 2: The qualitative narrative data was collected through two interviews with a nurse practitioner and a practice manager. The purpose of the interviews was to share the aggregate data and analysis from the survey and to initiate a discussion on their experiences with empathic care and their recommendations for promoting an environment of empathic care in the medical group practice setting. The interview questions were framed from a positive point of view in keeping with positive scholarship and the appreciative inquiry approach used for this study. The interviews were conducted with semi-structured questions, a frequently used strategy for qualitative data collection. With this strategy, the researcher asks informants a series of predetermined, but open-ended questions. Utilizing this strategy allows the researcher more control over the parameters of the topics covered but encourages the interviewee to tell their own story (Given, 2008). The questions were developed based on emergent themes from the responses collected from the open-ended questions in the Phase 1 survey.

Data Analysis

After data collection, data analysis was undertaken. Data analysis refers to the processes associated with making meaning and surfacing understanding from the various

data sets collected during a research project (Coghlan & Brydon-Miller, 2014). Quantitative data collected through the Phase 1 survey was analyzed utilizing IBM SPSS. Descriptive statistics including frequency and percentage distributions for all variables and mean scores, standard deviations, and measures of skewness and kurtosis were run for all servant leadership and empathic care statements.

Correlation and regression analysis were conducted. The purpose of the analysis was to identify which servant leadership concepts influenced measures of empathic care. Comparative analysis, including t-tests comparing clinical (nurse practitioners and physician assistants) and non-clinical practice managers, were run for all measures of servant leadership and empathic care. Narrative data collected through Phase 2 interviews was recorded and subsequently transcribed verbatim. Interviewee questions were designed to invite participants to review the quantitative findings and offer their thoughts on these data as well as their experiences with an environment of empathic care.

Informed Consent

An initial phone conversation with the Assistant to the President of Crestdale Health Care Physicians Network was made to seek to inform and explain the research project occurred. The Assistant to the President of Crestdale Health Care Physicians Network subsequently relayed the details of our phone conversation directly to the President of Crestdale Health Care Physicians Network. Written permission to conduct the research study with Crestdale Health Care personnel, that included distribution of the survey and confidentiality related documents, was sought and obtained directly from the President of Crestdale Health Care Physicians Network

The Institutional Review Board at Antioch University approved the survey and data collection process. Survey participants were informed about confidentiality in the introductory section of the survey. The Introduction also states that the identity of respondents would be kept anonymous, and data would only be reported in the aggregate. Additionally, participants were also informed that, at any time, they could decide not to submit the survey.

The interviewees received, by email, the informed consent form shown in Appendix F. They signed and dated the informed consent form and at the outset of the interviews, the interviewees confirmed their names and titles. The narrative responses of the interviewees were attributed anonymously in the analysis and participants were informed that unless the study participant granted specific written permission, individual responses would not be reported. Finally, Crestdale Health Care (the target population's organization) is a pseudonym as is Walter Smith, President of Crestdale Health Care Physician Network.

Chapter IV: Data Analysis

Chapter IV presents the quantitative and qualitative results of this mixed-methods study. A two-phased sequential explanatory research design was administered in which survey data (QUAN) were collected, followed by interviews (qual). The questions on the survey asked respondents to reflect on servant leadership behaviors and empathic care in their medical group practices.

The purpose of this study was to address the following three research questions:

1. How do mid-level health care practitioners describe servant leadership and empathic care in their medical group practices?
2. To what extent are the servant leadership characteristics correlated with measurements of empathic care? Additionally, which of the seven pillars of servant leadership characteristics most strongly influence perceptions of empathic care?
3. In what ways are the views of the non-clinical and clinical staff of the medical group practices similar or different with respect to servant leadership characteristics in their medical group practices?"

This chapter first describes the data cleaning process used to generate the data file for analysis. Participant characteristics are then presented, followed by correlational, regression, and t-test analyses related to each of the four research questions. The chapter concludes with a summary of the interview themes and integrated analysis.

Data Cleaning and Preparation

The survey data collected during Phase 1 via SurveyMonkey® were meticulously reviewed and cleaned prior to analysis, as advised by Van den Broeck, Cunningham,

Eeckels, and Herbst (2005). The narrative "Other (please specify)" responses to the following survey questions were sorted into appropriate categories:

- Question #1: Are you a nurse practitioner, physician assistant, or practice manager?
- Question #3: Please indicate your role within the organization.

Survey responses that were captured in SurveyMonkey were migrated to IBM SPSS for analysis. The overall number of total opened and completed surveys was 223. However, respondents who were not a nurse practitioner, a physician assistant, or practice manager, or did not work in a Crestdale Health Medical Group practice were eliminated from the dataset. Cases with incomplete responses to the servant leadership and empathic care items were also removed from the dataset used for analysis. Table 4.1 shows the elimination process that resulted in 189 eligible completed surveys.

Table 4.1:

Surveys Eligible for Analysis

Total Open Surveys	223
Total Ineligible Respondents	11
Subtotal	212
Total Incomplete Cases	23
Final Total	189

New variables were also created to facilitate data analysis. For the servant leadership characteristics, three of the seven pillars of servant leadership characteristics were modified to measure the characteristic as it relates to patients as well as to team members. Overall averages were calculated across all the servant leadership statements within each Pillar and also by patient and team focus.

Phase 1, quantitative participant demographics. The largest group (48.7%) of survey respondents was practice managers, or non- clinical staff, while the other 51.3% indicated they were clinical staff, either physician assistants (27.5%) or nurse practitioners (23.8%). Table 4.2 shows the results for demographic statistics for respondent roles.

Table 4.2

Descriptive Statistics for Study Respondent Role (N=189)

Demographic		Frequency	%
Actual Role	Nurse Practitioner	45	23.8
	Physician Assistant	52	27.5
	Practice Manager	92	48.7
	Total	189	100.0

More than 90% of the survey participants worked in one of Crestdale Health Care's two largest markets—Greater Charlotte (50.0%) and Greater Winston-Salem (44.4%). A small number of participants worked in the Brunswick-Coastal (2.2%), Northern Virginia (2.2%), and Triangle markets (1.1%). In terms of gender identification, the majority (83.5%) of participants identified as female compared with 15.9% who identified as male. Additionally, the majority (56.0%) of the participants were in the 35–54 years old category, with an additional 25.3% between the ages of 18-34. Table 4.3 presents descriptive statistics for gender, age, and market.

Table 4.3

Descriptive Statistics for Study Respondent Demographics: Gender, Age, and Market

Demographic		Frequency	%
Gender (n=182)	Female	152	83.5
	Male	29	15.9
	Other	1	0.5
	Total	182	99.9
Age (n=182)	18-34	46	25.3
	35-54	102	56.0
	55-74	34	18.7
	Total	182	100.0
Market (n=180)	Charlotte	90	50.0
	Winston-Salem	80	44.4
	Brunswick (Coastal)	4	2.2
	Northern Virginia	4	2.2
	Triangle	2	1.1
	Total	180	99.9

Research Question 1: Health Care Practitioners Descriptions of Servant Leadership

Respondents were asked to think about the leadership practices of their team in their medical group practices, to explore the first research question: "How do mid-level health care practitioners describe servant leadership and empathic care in their medical group practices?" Participants indicated the strongest level of agreement with Servant Leadership Pillar 1 Persons of Character, with a mean score of 5.37 on a 6-point Likert scale, ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Conversely, Pillar 4 Compassionate Collaborators—had the lowest level of agreement, with a mean score of

4.83. Interestingly, all of the pillars had mean scores above the midpoint of 3.50. Table 4.4 shows the mean scores for the servant leadership pillars in descending order.

Table 4.4

Mean Scores for Servant Leadership Pillars in Descending Order

Servant Leadership Pillars		Mean Scores
Pillar 1	Persons of Character	5.37
Pillar 6	Systems Thinkers	5.28
Pillar 2	Puts People First	5.22
Pillar 7	Leaders with Moral Authority	5.05
Pillar 3	Skilled Communicators	5.00
Pillar 5	Has Foresight	4.85
Pillar 4	Compassionate Collaborators	4.83

Individual servant leadership pillar item mean scores and percentage distributions. The four individual servant leadership statements that had the highest mean scores of agreement were:

- "In my medical group practice, our team members seek to show care and concern with patients" from Pillar 2 Puts People First (*M* = 5.99);
- "Maintaining professional integrity is important to our team norms in my medical group practice" from Pillar 1 Persons of Character (*M* = 5.69);
- "Team members demonstrating understanding with patients is important in my medical group practice" from Pillar 3 Skilled Communicator (*M* = 5.57), and
- "Our team members are expected to demonstrate adaptability in my medical group practice" from Pillar 6 Systems Thinker (*M* = 5.42).

The high mean scores for these four statements showed that respondents felt strongly that these servant leadership behaviors were a part of their medical group practices.

The five individual servant leadership statements that had the lowest mean scores of agreement were:

- "Team members invite feedback from each other in their medical group practices" from Pillar 3 Skilled Communicators (*M* = 4.38);
- "Team members seek to build teams and impact communities in their medical group practices" from Pillar 4 Compassionate Collaborators (*M* = 4.70);
- "Team members valuing creativity is important in my medical group practice" from Pillar 5—Has Foresight (*M* = 4.75)
- "Team members are intentional about inviting feedback from patients in their medical group practices" from Pillar 3 Skilled Communicators (*M* = 4.81), and
- "Team members express appreciation of each other as a team norm in their medical group practices" from Pillar 4 Compassionate Collaborators (*M* = 4.81).

These relatively lower mean scores for statements related to team member communication and collaboration compared to the more patient-focused statements with the highest mean scores. These scores suggest that respondents felt that inviting feedback from each other, building teams, and expressing appreciation of each other were not as

evident as in the professional behaviors represented by the more patient-focused statements with the highest mean scores.

Table 4.5 shows mean scores, standard deviations, and percentage distributions for pillars, with mean scores across all servant leadership items within each pillar. Over 50% of survey respondents *strongly agreed* with three statements that had mean scores between 4.81 and 5.42; these were:

- "Team members displaying a servant's heart is important in my medical group practice" (Pillar 2 statement d)
- "Demonstrating understanding with each other as team members is important in my medical group practice" (Pillar 3 statement h)
- "In my medical group practice, it is important that our team members be comfortable with complexity and change" (Pillar 6 statement t)

These statements suggest that team members strongly agree with team members displaying a servant's heart, demonstrating understanding, and being comfortable with the complexity and change in their medical group practices. Also, as could be expected, the four low mean score statements with means equal to or less than 4.81 had less than 30% of the survey respondents *strongly agreeing* with the statement. These statements refer to inviting feedback from team members and patients, appreciating each other and building teams.

Table 4.5

All Servant Leadership Pillars: Means, Standard Deviation, and Percentage Distribution

STATEMENTS	M	SD	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
Pillar 1: Person of Character	5.37	0.70	1.1%	0.3%	1.6%	11.1%	29.8%	56.1%
(a) Maintaining professional integrity is important to our team norms in my medical group practice (n=189)	5.69	0.71	1.1%	0.0%	0.0%	3.2%	20.6%	75.1%
(b) In my medical group practice, our team members are expected to demonstrate humility (n=189)	5.20	1.00	1.6%	0.5%	2.6%	14.8%	32.8%	47.6%
(c) In my medical group practice, our team members seek to serve a higher purpose (n=189)	5.22	0.88	0.5%	0.5%	2.1%	15.3%	36.0%	45.5%
Pillar 2: Puts People First	5.22	0.74	0.8%	1.3%	2.9%	12.3%	35.5%	47.2%
(d) Team members displaying a servant's heart is important in my medical group practice (n=189)	5.28	0.98	1.1%	0.5%	4.2%	11.1%	30.2%	52.9%
(e) Being mentor-minded is an expectation of team members in my medical group practice (n=189)	4.88	1.11	1.1%	3.2%	5.8%	21.7%	33.3%	34.9%

STATEMENTS	M	SD	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
(f) In my medical group practice, our team members seek to show care and concern with each other (n=189)	5.13	0.90	0.5%	1.6%	1.6%	14.8%	43.4%	38.1%
(g) In my medical group practice, our team members seek to show care and concern with patients (n=189)	5.99	0.62	0.5%	0.0%	0.0%	1.6%	34.9%	63.0%
Pillar 3: Skilled Communicator	5.00	1.01	0.9%	3.1%	5.5%	15.6%	35.1%	39.7%
(h) Demonstrating understanding with each other as team members is important in my medical group practice (n=189)	5.32	0.88	0.5%	0.5%	2.6%	11.1%	33.3%	51.9%
(i) Team members demonstrating understanding with patients is important in my medical group practice (n=189)	5.57	0.75	0.5%	1.1%	0.0%	3.7%	29.1%	65.6%
(j) Our team members are intentional about inviting feedback from each other in my medical group practice (n=188)	4.38	1.22	1.6%	7.4%	10.6%	30.9%	30.3%	19.1%
(k) Our team members are intentional about inviting feedback	4.81	1.12	0.5%	5.3%	5.9%	18.7%	39.6%	29.9%

STATEMENTS	M	SD	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
from patients in my medical group practice (n=187)								
(l) In my medical group practice, our team members seek to communicate with each other in a persuasive way without intimidation, bullying, or manipulation (n=187)	4.92	1.07	1.6%	1.1%	8.6%	13.4%	43.3	32.1%
Pillar 4: Compassionate Collaborator	4.83	0.96	1.4%	2.78%	6.0%	19.3%	39.5%	31.0%
(m) Expressing appreciation of each other is a team norm in my medical group practice (n=187)	4.81	1.14	2.1%	2.7%	5.9%	20.9%	38.5%	29.9%
(n) Expressing appreciation of patients is an expectation of team members in my medical group practice (n=187)	5.02	1.05	1.6%	2.1%	3.2%	15.5%	40.6%	36.9%
(o) In my medical group practice, our team members seek to build teams and impact communities (n=187)	4.70	1.12	2.1%	2.1%	7.5%	24.6%	39.0%	24.6%

STATEMENTS	M	SD	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
(r) Negotiating conflict is an important activity in my medical group practice (n=187)	4.82	1.17	1.6%	3.7%	8.0%	16.0%	38.5%	32.1%
Pillar 5: Has Foresight	4.85	1.03	2.1%	3.2%	6.1%	17.5%	38.4%	32.7%
(p) In my medical group practice, visionary thinking by physicians and mid-levels is essential (n=187)	4.97	1.23	3.2%	2.7%	5.3%	12.8%	34.8%	41.2%
(q) Team members valuing creativity is important in my medical group practice (n=187)	4.75	1.21	2.1%	4.3%	7.5%	19.3%	36.4%	30.5%
Pillar 6: Systems Thinker	5.28	0.83	1.4%	1.8%	1.3%	9.0%	37.3%	49.2%
(t) In my medical group practice, it is important that our team members be comfortable with complexity and change (n=185)	5.35	0.94	1.6%	3.2%	0.0%	6.5%	34.6%	54.1%
(u) Our team members are expected to demonstrate adaptability in my medical group practice (n=186)	5.42	0.85	1.1%	0.5%	1.6%	4.8%	36.0%	55.9%
(v) In my medical group practice, our team members seek to consider	5.06	1.01	1.6%	1.6%	2.2%	15.6%	41.4%	37.6%

STATEMENTS	M	SD	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
the "greater good" when making decisions (n=186)								
Pillar 7: Leads with Moral Authority	5.05	0.91	1.6%	2.5%	2.9%	15.1%	38.0%	39.9%
(w) In my medical group practice, our team members are expected to accept as well as delegate responsibility (n=186)	5.12	0.97	1.1%	1.6%	2.2%	15.1%	39.8%	40.3%
(x) It is important that our team members share power and control in my medical group practice (n=186)	4.85	1.12	1.6%	3.8%	3.2%	21.0%	39.8%	30.6%
(y) In my medical group practice, our team members are expected to create a culture of accountability (n=186)	5.18	1.11	2.2%	2.2%	3.2%	9.1%	34.4%	48.9%

Servant leadership pillars: Patient- and team-focused descriptive and comparative statistics. The means, standard deviations, and percentage distributions for the pillars were aggregated into two categories: patient-focused and team-focused. Only three of the pillars included patient-focused items. Thus, the aggregation applied to these three pillars: Pillar 2 Shows Care and Concern, Pillar 3 Skilled Communicator, and Pillar 4 Compassionate Collaborators. When the three pillars, consisting of 13 items, were aggregated into team-focused and patient-focused, a comparison of the mean scores using independent samples t-tests showed that the overall patient-focused mean score of 5.26 was significantly higher than the overall team-focused mean score of 5.05, with $t(183) = -7.014$, $p < .001$). Consistent with this difference, a higher percentage (48.9%) of respondents *strongly agreed* with the patient-focused servant leadership items than those (40.4%) who strongly agreed with the team-focused category. Table 4.6 shows the means, standard deviation, and percentage distribution for the combined team-focused and the patient-focused servant leadership items.

Table 4.6

Team-Focused and Patient-Focused Servant Leadership Pillars: Means, Standard Deviation, and Percentage Distribution (N=184)

Servant Leadership Pillars Combined Statements	M	SD	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
Team-Focused	5.05	0.77	1.5%	2.2%	4.3%	15.4%	36.2%	40.4%
Patient-Focused	5.26	0.72	0.8%	2.1%	2.3%	9.9%	36.1%	48.9%

In the three pillars that had both patient-focused and team-focused items, the patient-focused mean scores were higher than the team-focused mean scores for the same pillar. The highest mean score was recorded for Pillar 2 Shows Care & Concern for patients ($M = 5.99$), as compared to $M = 5.09$ for team members; based on a t-test, the difference was statistically significant, with $t(188) = -.942$, $p < .001$. Pillar 3 Skilled Communicators toward patients had a mean score of 5.19 as compared to 4.87 for team members; this difference was also statistically significant, with $t(185) = -7.165$, $p = <$ .001. Additionally, the 5.00 mean score for Pillar 4 Compassionate Collaborators with patients was higher than the 4.78 mean score for team members. Again, this difference was statistically significant, with $t(186) = -4.042$, $p < .001$.

These differences in mean scores indicated that the respondents felt that in their medical group practices the servant leadership behaviors of skilled communication and compassionate collaboration were exhibited more with patients than amongst their team members. Furthermore, the aggregate percentage distributions of the patient-focused and team-focused items suggested that mid-level practitioners might have a stronger focus on exhibiting servant leadership behaviors with patients than with their team members in their medical group practices. For example, for Pillar 2 Puts People First a higher percentage of respondents (63%) *strongly agreed* with the use of servant leadership with patients than with the team-focused category (42.0%). For Pillar 3 Skilled Communicators a higher percentage of respondents *strongly agreed* with the patient - focused (47.8%) than for the team-focused category (34.4%). For Pillar 4 Compassionate Collaborators a greater percentage of respondents *strongly agreed* with the patient-focused (40.6%) than with the team-focused category (38.7%). A few individual

statements had particularly high percentages of *strongly agree* responses. Table 4.7 shows items with high *strongly agree* percentages for team-focused items.

Table 4.7

High Frequency Distribution Scores for Servant Leadership—Team-Focused

Servant Leadership Pillar	Statement	Strongly Agree
Pillar 1—Persons of Character	Maintaining professional integrity is important to our team norms in my medical group practice.	75.1%
Pillar 2—Puts People First	Team members displaying a servant's heart is important in my medical group practice.	52.9%
Pillar 3—Skilled Communicators	Demonstrating understanding with each other as team members is important in my medical group practice.	51.9%
Pillar 6—Systems Thinkers	In my medical group practice, it is important that our team members be comfortable with complexity and change.	54.1%
Pillar 6—Systems Thinkers	Our team members are expected to demonstrate adaptability in my medical group practice	55.9%

Table 4.8 shows items with high *strongly agree* percentages for patient-focused items. The results indicated that respondents strongly agree that team members in their medical group practices seek to show care and concern with patients. The results also indicated that respondents strongly agreed that it is important that team members demonstrate understanding with patients in their medical group practices.

Table 4.8

High Frequency Distribution Scores for Servant Leadership—Patient-Focused

Servant Leadership Pillar	Statement	Strongly Agree
Pillar 2—Puts People First	In my medical group practice, our team members seek to show care and concern with patients	63.0%
Pillar 3—Skilled Communicators	Team members demonstrating understanding with patients is important in my medical group practice	65.6%

Table 4.9 shows the percentage distributions by pillar and item for separate team and patient-focused aggregates. All items are included on this table.

Table 4.9

Servant Leadership Pillars (By Team & Patient-Focus): Means, Standard Deviations, and Percentage Distributions

	M	SD	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
Team Focused Pillars								
Pillar 1: Person of Character (Team)	5.37	0.70	1.1%	0.3%	1.6%	11.1%	29.8%	56.1%
(a) Maintaining professional integrity is important to our team norms in my medical group practice (n=189)	5.69	0.71	1.1%	0.0%	0.0%	3.2%	20.6%	75.1%
(b) In my medical group practice, our team members are expected to demonstrate humility (n=189)	5.20	1.00	1.6%	0.5%	2.6%	14.8%	32.8%	47.6%
(c) In my medical group practice, our team members seek to serve a higher purpose (n=189)	5.22	0.88	0.5%	0.5%	2.1%	15.3%	36.0%	45.5%
Pillar 2: Puts People First (Team)	5.09	0.84	0.9%	1.8%	3.9%	15.9%	35.6%	42.0%
(d) Team members displaying a servant's heart is important in my medical group practice (n=189)	5.28	0.98	1.1%	0.5%	4.2%	11.1%	30.2%	52.9%

	M	SD	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
(e) Being mentor-minded is an expectation of team members in my medical group practice (n=189)	4.88	1.11	1.1%	3.2%	5.8%	21.7%	33.3%	34.9%
(f) In my medical group practice, our team members seek to show care and concern with each other (n=189)	5.13	0.90	0.5%	1.6%	1.6%	14.8%	43.4%	38.1%
Pillar 3: Skilled Communicator (Team)	4.87	0.89	1.2%	3.0%	7.3%	18.5%	35.6%	34.4%
(h) Demonstrating understanding with each other as team members is important in my medical group practice (n=189)	5.32	0.88	0.5%	0.5%	2.6%	11.1%	33.3%	51.9%
(j) Our team members are intentional about inviting feedback from each other in my medical group practice (n=188)	4.38	1.22	1.6%	7.4%	10.6%	30.9%	30.3%	19.1%
(l) In my medical group practice, our team members seek to communicate with each other in a persuasive way without intimidation, bullying, or manipulation (n=187)	4.92	1.07	1.6%	1.1%	8.6%	13.4%	43.3%	32.1%

	M	SD	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
Pillar 4: Compassionate Collaborator (Team)	4.78	1.01	1.9%	2.8%	7.1%	20.5%	38.7%	28.9%
(m) Expressing appreciation of each other is a team norm in my medical group practice (n=187)	4.81	1.14	2.1%	2.7%	5.9%	20.9%	38.5%	29.9%
(o) In my medical group practice, our team members seek to build teams and impact communities (n=187)	4.70	1.02	2.1%	2.1%	7.5%	24.6%	39.0%	24.6%
(r) Negotiating conflict is an important activity in my medical group practice (n=187)	4.82	1.17	1.6%	3.7%	8.0%	16.0%	38.5%	32.1%
Pillar 5: Has Foresight (Team)	4.85	1.16	2.1%	3.2%	6.1%	17.5%	38.4%	32.7%
(p) In my medical group practice, visionary thinking by physicians and mid-levels is essential (n=187)	4.97	1.23	3.2%	2.7%	5.3%	12.8%	34.8%	41.2%
(q) Team members valuing creativity is important in my medical group practice (n=187)	4.75	1.21	2.1%	4.3%	7.5%	19.3%	36.4%	30.5%

	M	SD	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
(s) In my medical group practice, our team members are expected to take courageous and decisive action (n=186)	4.83	1.04	1.1%	2.7%	5.4%	20.4%	44.1%	26.3%
Pillar 6: Systems Thinker (Team)	5.28	0.93	1.4%	1.8%	1.3%	9.0%	37.3%	49.2%
(t) In my medical group practice, it is important that our team members be comfortable with complexity and change (n=185)	5.35	0.94	1.6%	3.2%	0.0%	6.5%	34.6%	54.1%
(u) Our team members are expected to demonstrate adaptability in my medical group practice (n=186)	5.42	0.85	1.1%	0.5%	1.6%	4.8%	36.0%	55.9%
(v) In my medical group practice, our team members seek to consider the "greater good" when making decisions (n=186)	5.06	1.01	1.6%	1.6%	2.2%	15.6%	41.4%	37.6%
Pillar 7: Leads With Moral Authority (Team)	5.05	1.07	1.6%	2.5%	2.9%	15,1%	38.0%	39.9%
(w) In my medical group practice, our team members are expected to accept as well as delegate responsibility (n=186)	5.12	0.97	1.1%	1.6%	2.2%	15.1%	39.8%	40.3%

	M	SD	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
(x) It is important that our team members share power and control in my medical group practice (n=186)	4.85	1.12	1.6%	3.8%	3.2%	21.0%	39.8%	30.6%
(y) In my medical group practice, our team members are expected to create a culture of accountability (n=186)	5.18	1.11	2.2%	2.2%	3.2%	9.1%	34.4%	48.9%
Patient Focused Pillars								
Pillar 2.1 Puts People First (Patients)	5.99	0.62	0.5%	0.0%	0.0%	1.6%	34.9%	63.0%
(g) In my medical group practice, our team members seek to show care and concern with patients (n=189)	5.99	0.62	0.5%	0.0%	0.0%	1.6%	34.9%	63.0%
Pillar 3.1: Skilled Communicator (Patients)	5.19	0.80	0.5%	3.2%	3.0%	11.2%	34.4%	47.8%
(i) Team members demonstrating understanding with patients is important in my medical group practice (n=189)	5.57	0.75	0.5%	1.1%	0.0%	3.7%	29.1%	65.6%
(k) Our team members are intentional about inviting	4.81	1.12	0.5%	5.3%	5.9%	18.7%	39.6%	29.9%

	M	SD	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
feedback from patients in my medical group practice (n=187)								
Pillar 4.1: Compassionate Collaborator (Patients)	5.02	1.05	1.6%	2.1%	3.2%	15.5%	40.6%	36.9%
(n) Expressing appreciation of patients is an expectation of team members in my medical group practice (n=187)	5.02	1.05	1.6%	2.1%	3.2%	15.5%	40.6%	36.9%

Servant leadership pillar correlations. Correlation analyses were run to determine if there was a statistically significant relationship between the individual servant leadership pillars. Table 4.10 shows the bivariate correlations between the aggregate mean scores for the seven servant leadership pillars. There were strong statistically significant correlations between several of the pillars of servant leadership. These included the correlations between: Pillar 3 Skilled Communicator and Pillar 4 Compassionate Collaborator ($r = .836$, $p < .001$), Pillar 2 Puts People First and Pillar 4 Compassionate Collaborator ($r = .823$, $p < .001$), and Pillar 5 Has Foresight and Pillar 4 Compassionate Collaborator ($r = .827$, $p < .001$).

These results indicated that as respondents thought about their medical group practices, they felt that the team members in their medical group practices that are characterized as compassionate collaborators were also more likely to be skilled communicators in their medical group practices. Additionally, medical practices characterized as putting people first were also viewed as being compassionate collaborators; likewise, those that demonstrated the characteristics of having foresight were also viewed as compassionate collaborators.

There were also moderately strong statistically significant correlations between the aggregate mean scores for the other pillars. Pillar 1 Persons of Character was significantly correlated with Pillar 6 Systems Thinkers ($r = .601$, $p < .001$), Pillar 7 Leads with Moral Authority ($r = .622$, $p < .001$), and Pillar 5 Has Foresight ($r = .630$, $p < .001$). In addition, Pillar 3 Skilled Communicators and Pillar 7 Leaders with Moral Authority had a moderately strong correlation ($r = .680$, $p < .001$). In essence, there was at least a

moderately strong correlation for each of the pillars with all other pillars, suggesting overlap in meaning for the pillars as a whole.

Table 4.10

Bivariate Correlations for Individual Servant Leadership Pillars

	Pillar 1	Pillar 2	Pillar 3	Pillar 4	Pillar 5	Pillar 6
Pillar 1 Person of Character	-					
Pillar 2 Puts People First	.767**	-				
Pillar 3 Skilled Communicator	.650**	.773**	-			
Pillar 4 Compassionate Collaborator	.646**	.823**	.836**	-		
Pillar 5 Has Foresight	.630**	.755**	.756**	.827**	-	
Pillar 6 Systems Thinker	.601**	.727**	.724**	.752**	.772**	-
Pillar 7 Moral Authority	.622**	717**	.680**	.780**	.780**	.765**

** Correlation is significant at the 0.01 level (2-tailed) $p < 0.01$ for all cases.

Elements of empathic care that were most present in the medical group practices. To measure empathic care, participants were asked to indicate their level of disagreement or agreement from 0 (*strongly disagree)* to 10 (*strongly agree*) for each of four statements. Most respondents agreed on some level with the statement, "In my medical group practice, empathic care is reflected in the organizational policies and procedures," as indicated by a mean score of 8.19 and a 32.2% *strongly agree* response in the percentage distribution.

Respondents had a wider range of views with respect to the "In my primary care practice, leaders and staff receive monthly formal training (i.e. corporate education, continuing education units, etc.) on empathic care" statement, with a mean score of 5.27 and a 14.0% *strongly agree* and an 11.1% *neutral* response in the percentage distribution.

Responses also varied with respect to the statement, "In my primary care practice visual evidence of empathic care promotional items are displayed in patient waiting areas, exam rooms, and general office areas," with a mean score of 5.94, a 14.8% *strongly agree* response, and a 19.1% neutral response in the percentage distribution. Most respondents agreed on some level with the general statement, "Overall, my medical group practice promotes an environment of empathic care," with a mean score of 7.88 and a 30.1% *strongly agree* response in the percentage distribution. Table 4.11 shows the means, standard deviation, and percentage distributions for the empathic care statements.

The overall average mean score for all empathic care variables was 6.16 and the percentage distribution indicated that 22.8% of the respondents *strongly agreed*, 4.9% *strongly disagreed*, and 11.8% chose *neutral*. The results indicate that respondents tend to agree that their medical group practice is an environment of empathic care.

The respondents tended to strongly agree that their medical group practices promoted an environment of empathic care. This was supported by the frequency of selecting responses (8, 9, or 10), towards the strongly agree end of the continuum. A high percentage (73.1%) tended to strongly agree that overall empathic care is reflected in the organization's policies and procedures. Participants tended to strongly agree (69.5%) that empathic care is promoted overall in the medical group practices. A much lower percentage tended to strongly agree (31.6%) that they are consistently receiving formal empathic care training in their medical group practices, or that they are generally aware of marketing and promotional items being displayed in the office (37.2%). When the four individual empathic care items were averaged together, the positive overall view on policies and procedures was diminished by the lack of training and visual displays. On average, 52.9% selected the response of 8, 9, or 10, or tended toward strongly agree across all of the empathic care statements.

Table 4.11

Empathic Care Statements: Means, Standard Deviations, Percentage Distributions

(a) "In my medical group practice, empathic care is reflected in the organizational policies and procedures." (N=183)

M	SD	Strongly Disagree 0	1	2	3	4	Neutral 5	6	7	8	9	Strongly Agree 10
8.19	1.94	0.5%	0.0%	1.6%	1.6%	2.2%	3.8%	3.3%	13.7%	24.0%	16.9%	32.2%

(b) "In my primary care practice, leaders and staff receive monthly formal training (i.e. corporate education, continuing education units, etc.) on empathic care." (N=171)

M	SD	Strongly Disagree 0	1	2	3	4	Neutral 5	6	7	8	9	Strongly Agree 10
5.27	3.28	11.1%	8.2%	7.6%	3.5%	5.3%	16.4%	9.9%	6.4%	12.3%	5.3%	14.0%

(c) "Visual evidence of empathic care promotional items are displayed in patient waiting areas, exam rooms, and general office areas." (N=183)

M	SD	Strongly Disagree 0	1	2	3	4	Neutral 5	6	7	8	9	Strongly Agree 10
5.94	3.08	7.7%	4.9%	6.0%	4.4%	1.6%	19.1%	8.2%	10.9%	13.1%	9.3%	14.8%

(d) "Overall, my medical group practice promotes an environment of empathic care." (N=183)

M	SD	Strongly Disagree 0	1	2	3	4	Neutral 5	6	7	8	9	Strongly Agree 10
7.88	2.29	0.5%	2.7%	1.6%	1.6%	1.1%	7.7%	5.5%	9.8%	21.9%	17.5%	30.1%

All Empathic Care

6.16	2.85	4.9%	3.9%	4.2%	2.8%	2.6%	11.8%	6.73%	10.2%	17.8%	12.3%	22.8%

Research Question 2: Servant Leadership Characteristics and Empathic Care

In the context of the respondents thinking about their role in the medical group practices, Research Question 2 asks, "To what extent are the servant leadership characteristics correlated with measurements of empathic care? Additionally, which of the seven pillars of servant leadership characteristics most strongly influence perceptions of empathic care?"

Pillar variable correlation with empathic care variables. Bivariate correlation analyses were run to determine if there were any statistically significant correlations between the servant leadership pillars and the empathic care variables. Table 4.12 lists the variables for each of the servant leadership pillars, and Table 4.13 lists the variables for each of the Empathic Care variables.

Table 4.12

Servant Leadership Pillar Variables

Servant Leadership Pillars	**Variable Names**
Pillar 1—Persons of Character	P1 Person of Character
Pillar 2—Puts People First	P2 People First
Pillar 3—Skilled Communicators	P3 Skilled Communicators
Pillar 4—Compassionate Collaborators	P4 Compassionate Collaborators
Pillar 5—Has Foresight	P5 Has Foresight
Pillar 6—Systems Thinkers	P6 Systems Thinkers
Pillar 7—Leaders with Moral Authority	P7 Leaders with Moral Authority
All Team-Focused Variables Combined	All Team-Focused
All Patient-Focused Variables Combined	All Patient-Focused
All Servant Leadership Variables Combined	All Servant Leadership

Table 4.13

Empathic Care Variables

Empathic Care	Variable Names
All Empathy Variables Combined	EC All
Empathy Reflected in Organizational Policies & Procedures	EC Policies and Procedures
Empathy Formal Training	EC Training
Empathy Promoted Visually	EC Visual Promotion
Empathy Promoted Overall	EC Overall Promotion

Five of the seven pillar variables had correlations of equal to or less than .500 with at least one of the empathic care variables. These were Pillar 2 People First, Pillar 4 Compassionate Collaborator, Pillar 5 Has Foresight, Pillar 6 Systems Thinker, and Pillar 7 Leaders with Moral Authority. The correlations of Pillar1 Persons of Character and Pillar 3 Skilled Communicator with all empathic care variables were in the weak to weak moderate range of .226 to .468.

Pillar variables with most moderately strong correlations with empathic care variables. Of the seven pillar variables, Pillar 5 Has Foresight had the most moderately strong correlations with any of the five empathic care variables. Pillar 5 Has Foresight had correlations equal to or greater than .535 with three of the five empathic care variables. The strongest correlation ($r = .593$, $p < .001$) was between Pillar 5 Has Foresight and EC Policies and Procedures. This correlation indicated that as respondents thought about their medical group practices, they perceived that the Pillar 5 Has Foresight servant leadership behaviors of being a visionary, displaying creativity, and taking courageous and decisive action in their medical group practices, were most closely related to having empathic care reflected in organizational policies and procedures.

Similarly, Pillar 5 Has Foresight had a moderate correlation with the EC All ($r = .535$, $p > .001$) and EC Overall Promotion ($r = .547$, $p < .001$) variables

Pillar variables with most moderately strong correlations with empathic care variables. Of the seven pillar variables, Pillar 5 Has Foresight had the most moderately strong correlations with any of the five empathic care variables. Pillar 5 Has Foresight had correlations equal to or greater than .535 with three of the five empathic care variables. The strongest correlation ($r = .593$, $p < .001$) was between Pillar 5 Has Foresight and EC Policies and Procedures. This correlation indicated that as respondents thought about their medical group practices, they perceived that the Pillar 5 Has Foresight servant leadership behaviors of being a visionary, displaying creativity, and taking courageous and decisive action in their medical group practices, were most closely related to having empathic care reflected in organizational policies and procedures. Similarly, Pillar 5 Has Foresight had a moderate correlation with the EC All ($r = .535$, $p > .001$) and EC Overall Promotion ($r = .547$, $p < .001$) variables

The results indicated that the Pillar 5 Has Foresight servant leadership behaviors that included being a visionary, displaying creativity, and taking courageous and decisive action correlated with the overall environment of empathic care reflected in policy and procedures, training on empathic care, visual promotion of empathic care, and overall promotion of empathic care in their medical group practices.

Pillar 7 Leadership with Moral Authority had the second most moderately strong correlations with the empathic care variables. These were again with EC Policies and Procedures ($r = .574$, $p < .001$) and EC Overall Promotion ($r = .531$, $p < .001$).

Correlation between the all team-focused and all patient-focused variables and each empathic care variables. Further analysis assessed the strength and statistical significance of correlations between the All Team-Focused variable and each of the empathic care variables. The correlation between All Team-Focused and EC All was r = .527, p < .001, similar to the correlation between All Patient-Focused and EC All *(*r = .511, p < .001).

Table 4.14

Bivariate Correlations for Overall Servant Leadership and Empathic Care Variables

Variable	Pillar 1 Char.	Pillar 2 People First	Pillar 3 Skilled Comm.	Pillar 4 Comp. Collab.	Pillar 5 Foresight	Pillar 6 Sys. Thinker	Pillar 7 Moral Auth.	SL All Team	SL All Patient	EC Pol.	EC FT	EC VP	EC OP	EC All
Pillar 1	-													
Pillar 2	.742	-												
Pillar 3	.614	.722	-											
Pillar 4	.652	.797	.824	-										
Pillar 5	.630	.741	.728	.795	-									
Pillar 6	.601	.702	.690	.740	.772	-								
Pillar 7	.622	.716	.667	.759	.780	.765	-							
SL-Team	.781	.886	.864	.920	.902	.864	.874	-						
SL- Patient	.641	.738	.778	.760	.768	.727	.679	.837	-					
EC-Pol	.468	.491	.436	.503	.593	.474	.574	.583	.473	-				
EC-FT	.237	.366	.305	.352	.378	.240	.310	.367	.382	.363	-			
EC-VP	.226	.360	.342	.409	.432	.305	.396	.411	.431	.421	.693	-		
EC-OP	.339	.500	.424	.549	.547	.513	.531	.564	.527	.671	.550	.615	-	-
EC-All	.338	.487	.412	.495	.535	.401	.488	.527	.511	.678	.851	.868	.832	-

Note. Correlation is significant at the 0.01 level (2-tailed); all items were significantly correlated.

EC All. The seven pillars of servant leadership variables that most highly correlated with EC All (i.e., all of the empathic care variables combined) were the Pillar 5 Has Foresight variable with (r = .535, p < .001) and the Pillar 4 Compassionate Collaborators variable with (r =. 495, p < .001). There was also a moderately strong correlation found between the Empathic Care All variable and the Pillar 7 Leaders with Moral Authority variable with (r = .488, p < .001).

The results revealed that respondents felt that in their medical group practices, the servant leadership characteristics of being a visionary, displaying creativity, and taking courageous and decisive action that are found in the Pillar 5 Has Foresight variable were the most important to promoting an maintain an environment of empathic care in their medical group practices. In addition, the results indicated that the characteristics of expressing appreciation, building teams and communities, and negotiating, conflict that are found in the Pillar 4 Compassionate Collaborators variable, were the most important to promoting and maintaining an environment of empathic care in their medical group practices. Respondents also indicated that the Pillar 7 Leaders with Moral Authority characteristics of accepting and delegating responsibility, sharing power and control, and creating a culture of accountability were somewhat important to promoting and maintaining an environment of empathic care.

EC Policies and Procedures. The four servant leadership pillars that most strongly correlated with the EC Policies and Procedures variable were Pillar 5 Has Foresight (r = .593, p < .001), Pillar 7 Leaders with Moral Authority (r = .574, p < .001), Pillar 4 Compassionate Collaborator (r = .503, p < .001), and Pillar 2 People First (r =

.491, $p < .001$). Table 4.15 shows the correlations between servant leadership pillar variables and measures of individual empathic care variables.

The correlation results revealed that respondents felt that in their medical group practices, the Pillar 5 Has Foresight servant leadership characteristics of being a visionary, displaying creativity, and taking courageous and decisive action were consistent with empathic care being included in the organizational policies and procedures. Furthermore, the results showed that the Pillar 7 Leaders with Moral Authority servant leadership characteristics of being worthy of accepting and delegating responsibility, sharing power and control, and creating a culture of accountability were consistent with empathic care being included in the organizational policies and procedures.

Likewise, the respondents felt that in their medical group practices, the Pillar 4 Compassionate Collaborator servant leadership characteristics of expressing appreciation, building teams and communities, and negotiating conflict were consistent with empathic care being included in the organizational policies and procedures. Finally, correlation results also showed that Pillar 2 Putting People First characteristics of displaying a servant's heart, being mentor minded, and showing care and concern correlated with empathic care being included in the organizational policies and procedures of their medical group practices.

EC Overall Promotion. Five of the seven pillar variables had correlations equal to or greater than .500 with EC Overall Promotion. The three servant leadership pillar variables that most highly correlated with EC Overall Promotion were Pillar 4

Compassionate Collaborator ($r = .549$, $p < .001$), Pillar 5 Has Foresight ($r = .547$, $p < .001$), and Pillar 7 Leads with Moral Authority variable ($r = .531$, $p < .001$).

These results revealed that respondents felt that in their medical group practices, the Pillar 4 Compassionate Collaborator servant leadership characteristics of expressing appreciation, building teams and communities, and negotiating conflict as well as being a visionary, displaying creativity, and taking courageous and decisive action as found in Pillar 5 Has Foresight were consistent with visual promotion of empathic care in their medical group practices. Respondents also indicated that the Pillar 7 Leads with Moral Authority servant leadership characteristics of accepting and delegating responsibility, sharing power and control, and creating a culture of accountability were moderately consistent with visual promotion of empathic care being present in their medical group practices.

EC Visual Promotion. Pillar variable correlations ranged from a weak (.226) to a weak moderate (.432) correlation with EC Visual Promotion. The two servant leadership pillar variables that were moderately correlated with the EC Visual Promotion variable were Pillar 4 Compassionate Collaborators ($r = .409$, $p < .001$) and Pillar 5 Has Foresight ($r = .432$, $p < .001$).

In sum, respondents indicated that in their medical group practices, the Pillar 4 Compassionate Collaborator servant leadership characteristics of expressing appreciation, building teams and communities, and negotiating conflict as well as being a visionary, displaying creativity, and taking courageous and decisive action as found in Pillar 5 Has Foresight were consistent with visual promotion of empathic care in their medical group practices.

EC Training. Correlations between the pillar variables and EC Training were weak (.237) to low moderate (.378). The four pillars of servant leadership that most highly correlated with the EC Training variable were Pillar 4 Compassionate Collaborators ($r = .352$, $p < .001$), Pillar 5 Has Foresight ($r = .378$, $p < .001$), Pillar 2 People First ($r = .358$, $p < .001$), and Pillar 4 Compassionate Collaborators ($r = .345$, $p < .001$).

Servant leadership pillars that most strongly influence measures of empathic care. Exploratory regression analyses were conducted to determine which, if any, of the seven servant leadership pillars influenced the empathic care variables. The five regression models included the seven pillars of servant leadership as the independent variables, and each of the empathic care variables as the dependent variable. The independent variables were entered into the regression model in one block using the step-wise approach to variable retention. Table 4.15 shows the influences of the seven pillars of servant leadership on measures of empathic care in organizational policies and procedures.

Table 4.15

Servant Leadership Pillars That Most Influence Measures of Empathic Care

Empathic Care Dependent Variables	Servant Leadership Independent Variables	F	R^2	t Statistic (p value)	Standardized Beta
EC All	P5 Has Foresight	37.372	31.0%		
	P4 Compassionate Collaborators			2.897 ($p < .001$)	.305
				2.695 ($p < .001$)	.284
EC Policies/ Procedures		42.797	32.1%		
	P5 Has Foresight			3.807 ($p = .000$)	.371
	P7 Leaders with Moral Authority			2.342 ($p < .001$)	.228
EC Training		26.715	13.8%		
	P4 Compassionate Collaborators			5.169 ($p = .000$)	.371
EC Visual Promotion		45.670	20.3%		
	P4 Compassionate Collaborators			6.758 ($p = .000$)	.451
EC Overall Promotion		44.958	33.6%		
	P4 Compassionate Collaborators			3.964 ($p = .000$)	.386
	P7 Leaders with Moral Authority			2.320 ($p = .000$)	.226

Note. In Table 4.15, in the "Servant Leadership Variables" column, the uppercase "P" is an abbreviation of the word "Pillar"

All measures of empathy variables. A multiple linear regression analysis was conducted to examine whether any of the servant leadership pillars explained a significant amount of variance in the Empathic Care All dependent variable. Results indicated that P5 Has Foresight significantly influenced Empathic Care All, with F(167) = 37.372, $p < .001$), $R^2 = 31.0\%$, t(169)=2.897, $p < .001$.). Additionally, P4 Compassionate Collaborators significantly influenced Empathic Care All, with F(167) = 37.372, $p < .001$), $R^2 = 31.0\%$, t(169) = 2.695, $p < .001$)

Empathic care in organizational policies and procedures variables. Regression analyses indicated that P5 Has Foresight significantly influenced Empathic Care Policies and Procedures, with F(179) = 42.797, $p < .001$), $R^2 = 32.1\%$, t(181) = 3.807, $p = .000$). Furthermore, P7 Leads with Moral Authority, with F(167) = 42.797, $p < .001$), $R^2 = 32.1\%$, t(169) = 2.342, $p < .001$) also significantly influenced Empathic Care Policies and Procedures.

Empathic care formal training variables. A regression equation found P4 Compassionate Collaborators significantly influenced Empathic Care Training, with F(167) = 26.715, $p = .000$), $R^2 = 13.8\%$, t(169) = 6.758, $p = .000$)

Empathic care visual marketing and promotion variables. A regression equation found P4 Compassionate Collaborators significantly influenced Empathic Care Visual Promotion, with F(179) = 45.670, $p < .001$), $R^2 = 20.3\%$, t(181) = 6.758, $p = .000$)

Overall promotion of empathic care variables. Finally, a regression equation found P4 Compassionate Collaborators significantly influenced Empathic Care Overall Promotion, with F(179) = 44.958, $p < .001$), $R^2 = 33.6\%$, t(181) = 3.964, $p = .000$). Additionally, regression analysis found P7 Leads with Moral Authority also significantly

influenced Empathic Care Overall Promotion, with F(167) = 44.958, p = .000), R^2 = 33.6%, t(169) = 2.320, p = .000)

Research Question 3: Staff Views and Servant Leadership Characteristics

Research Question 3 asked: "In what ways are the views of the non-clinical and clinical staff of the medical group practices similar or different with respect to servant leadership characteristics in their medical group practices?"

The mean scores for the non-clinical and clinical mid-level practitioners were compared for the aggregate pillar variable scores and the empathic care variables. For the purpose of this study, the non-clinical staff consisted of the practice managers (also referred to as clinic administrators) who are responsible for the operations of the medical group practices. Practice managers provide indirect patient care that can include supervising lower-level staff, ensuring patient scheduling and patient registration operates smoothly and the like. Clinical mid-level practitioners are team members who provide direct patient care. These are the nurse practitioners and physician assistants in the medical group practices.

Comparisons of mean scores using independent samples t-tests showed that a trend exists where the mean scores for each aggregate pillar of servant leadership variable was higher for non-clinical staff than the mean scores for the clinical mid-level practitioners. The comparisons between the non-clinical and clinical mid-level practitioners in descending order of statistical significance are shown in Table 4.16.

Table 4.16

Comparison Mean Scores for Aggregate Pillars of Servant Leadership Variables

Variables	Clinical (Direct Patient Care) Mean, SD	Non-Clinical (Indirect Patient Care) Mean, SD	Statistical Significance t
Pillar 2 - Puts People First	M=4.91 SD=0.83	M=5.54 SD=0.43	- 6.501**
Pillar 4 - Compassionate Collaborators	M=4.47 SD=1.10	M=5.22 SD=0.58	- 5.787**
Pillar 5-Has Foresight	M=4.77 SD=1.17	M=5.27 SD=0.63	- 5.751**
Pillar 7-Leaders with Moral Authority	M=4.71 SD=1.05	M=5.41 SD=0.54	- 5.686**
Pillar 6-Systems Thinkers	M=4.98 SD=0.99	M=5.60 SD=0.42	- 5.456**
Pillar 3-Skilled Communicators	M=4.77 SD=0.93	M=5.25 SD=0.56	- 4.230**
Pillar 1-Persons of Character	M=5.20 SD=0.79	M=5.54 SD=0.54	- 3.511**

** All mean score differences were statistically significant at the .05 level

The pattern of statistically significant differences between responses of the non-clinical and clinical mid-level practitioners indicated that non-clinical leaders agreed more frequently that the seven pillars of servant leadership characteristics were present in their medical group practices more than clinical mid-level practitioners. The statistically significant differences in responses supports the notion that there is a divide between non-clinical and clinical perspectives in servant leadership.

For the servant leadership pillar mean scores, the most notable difference was between non-clinical and clinical mid-level practitioners for Pillar 2 People First; this difference was statistically significant at the $p < .001$ level. The non-clinical staff was more likely than clinical mid-level practitioners to perceive that team members displayed a servant's heart, were mentor minded, and showed care and concern in their medical group practices.

Phase 2: Qualitative Results

The second phase of the sequential explanatory research design for this study was comprised of an interview with two mid-level practitioners. As such, Phase 2 of data collection provided the qualitative results. The narrative data collected through the interviews were stored on a separate transcript. The names of the participants were removed, and any other personal identifying information was also removed. To validate the participant response, member checking was administered before data analysis.

The interview began with verbal expressions of gratitude for agreeing to participate in the interview, review of study goals, restatement of confidentiality, confirmation (receipt and sign-off) of informed consent, and receipt of servant leadership and empathic care outline document.

Next, each interview participant provided her demographic information. Interview Participant A was a nurse practitioner that had been with the organization for 30 years. This Nurse Practitioner identifies as a female, serving in the Greater Charlotte Market, and in the 35–54 years age range. Interview Participant B was a practice manager who had been with the organization for 40 years. The Practice Manager identifies as a female, serving in the Greater Charlotte Market and is in the 55–74 years age range.

The interview continued with a review of the quantitative data results that included the demographic composition of respondents before moving on to the question and answer phase.

Interview Question #1: Ranking Servant Leadership Characteristics

The first interview question was *"What are your thoughts on the data I just shared, particularly the ranking of servant leadership characteristics? What stands out? What surprises you?"* Both participants indicated that they were not surprised by the outcome of the quantitative data results. In fact, the Practice Manager stated the following about Pillar 1 Persons of Character being ranked in the top three servant leadership characteristics: "I definitely tend to agree with that. I definitely think if you don't have a base of integrity, it's very difficult to lead and manage in healthcare."

Related to the survey response rates of 23.8% of nurse practitioners, 27.5% of physician assistants, and 48.7% of practice managers, the Practice Manager suggested that conflict between completing administrative duties versus spending time with patients was at work here. The Practice Manager offered that, "We're very accustomed to responding to surveys and the clinical folks, sometimes I have to prod them to do the things they have to do to keep their job."

The Nurse Practitioner agreed with the Practice Manager's assessment. She outlined how her administrative duties can be significantly delayed because of patient volume and her patient load. Since the introduction of the electronic medical record, clinicians have reported an increase in their workloads. This increase is often attributed to the need for providers to enter their notes into the Electronic Medical Records. The Nurse

Practitioner's comments suggest that the overwhelming nature of duties contributes to burnout.

The Nurse Practitioner also indicated that she did not believe that the administrative duties impacted patient care. She shared the following:

> I would have to agree…. I mean, there are days I don't even look at my emails because I've got to take care of what's directly in front of me, which is the patient and the Electronic Medical Records and that kind of thing. By the time I get to my emails, it's overwhelming and I'm just like "delete," quite honestly. Because it's not going to impact patient care, I know the few things that I have to look for and the rest of it, sometimes I just get rid of it because it's too overwhelming.

Interview Question #2: Empathy in Patient Care Setting

An aligned view of the empathic care and how it is practiced by mid-levels in the medical group environment is important to ensuring that wide variations in patient care are minimized or even eliminated so that there is consistency in the standard of excellence of care. As such, the next interview question, "What does empathy in the patient care setting look like to you?" was asked in an effort to understand if both types of mid-level practitioners view empathic care in the medical group practice similarly.

The Practice Manager responded by stating that her medical group practice is a patient-centered medical home. One of the key measurements of the effectiveness of a patient-centered medical home involves systems thinking in that recognizing that a fundamental benefit of primary care is its adaptability to diverse people, populations, and systems. As such, patient-centered medical homes must adapt to the needs of their patient population. The Practice Manager noted that:

> We are actually a patient-centered medical home and I think, just, you know, bringing that to the forefront in everything we do has made us a more compassionate and caring practice. We talk about it all the time. We try to show empathy to our patients in everything we do daily.

The Practice Manager's view of her medical group as a patient-centered medical home points to the type of processes that support an environment of empathic care.

Also relating to what an environment of empathic care looks like in her medical group practice, the Practice Manager offered a tangible example of how empathy is practiced on a regular basis by showing empathy for patients who are late for their appointment.

> We recognize that each patient is different and has a different background, a different issue, and trying to tailor the clinical and clerical response to that. For example, if a patient shows up late, our policy is that we'll try to work them in, but we may not be able to. However, there are extreme circumstances sometimes and I think we just have to work with the providers or with the clinical staff to make sure that patient does get taken care of, if there's any way that we could possibly do it. So, I think that's a perfect example of going above and beyond.

The Nurse Practitioner also offered insights related to this question. She provided some tangible examples of how her medical group practice has shown empathy to patients. She offered the following thoughts demonstrating concern for patients and their families.

Yes, I would agree…I think we show respect to those families with their concerns. They may come in for a check-up, but we're going to focus on their voiced concern. They sometimes do have to put aside the routine things that doctors are supposed to talk about because something else bubbles up to the surface. It's more relevant to the patient, it's on their minds, it's a concern of theirs and so we'll shift gears; I will talk to them about what that specific concern they have. Also, we usually don't see people when they're late, but again, it's not 'well, you're late, we can't see you,' or 'you have to reschedule.' It's more like 'I'm so sorry; your appointment time is over. Let's see when we can get you in, what's your problem, what do we need to do.' We'll have our triage nurse come out and assess them and see if we need to see them emergently or if

they're safe to leave and schedule at another time. I think a lot of it is the way you present it. Knowing that people have busy lives and things happen. Rather than being more harsh or accusatory, we're going to say we understand life happens and we want to give you the time you need so let's see how we can work this to your advantage as well.

Interview Question #3: Empathetic Care in Organizational Policies and Procedures

The third interview question was *"Is empathic care reflected in the organization's policies and procedures?"* The Nurse Practitioner responded to this question by indicating that she thought that empathic care is reflected in the organization's policies and procedures because the Crestdale Health Care mission statement alludes to providing the best care to patients in every dimension and every time. The Nurse Practitioner made the point that healthcare consumerism is pushing healthcare providers to practice with empathy because of patient demands to be treated as an individual with unique needs. The Nurse Practitioner shared the following:

> I mean, that is part of the mission statement. It's evolved over time, but that's always been kind of the underlying. You know, we want people to receive the best care they can in every setting and in every dimension. It's changed. Now, it's care about me, it's "see me," so again, we're being encouraged to look at our patients as individuals.

The Practice Manager agreed with the Nurse Practitioner's assessment and further commented that even empathic care wasn't officially in the organization's policies and procedures, it is an underlying part of the organization's culture.

Interview Question #4: Including Patients in Empathic Care

The fourth interview question was, ***"****What are some of the ways that patients can be included in maintaining/promoting an environment of empathic care?* The Practice Manager pointed out that some activities relating to patient input were already in process. The Practice Manager shared that surveying is an activity designed to elicit patient input,

but she also points out that surveying can be limited in its granularity or specificity. She stated the following,

> Well, I think one of the things that we do, obviously, we've got our Press-Ganey survey and our patients have the opportunity to comment about our providers. We also have the survey that's out there on the web which comes from Press-Ganey where anyone can access and read comments about our providers. So, I think we review that and take that feedback and try to target and focus on areas that need improvement. So, it's a pretty continuous thing for us. We focus on it every month.

Continuing with interview question 4, the Practice Manager also shared that her medical group practice hosts in-person meetings with some of their patients. These meetings are conducted as focus groups that typically consist of four to six patients for a single session. Medical group practice staff usually host the focus groups, however, occasionally guests such as clinical experts or pharmaceutical representatives also facilitate the meetings. In these focus group sessions, patients are afforded the opportunity to meet the healthcare providers that are involved in giving care. They are also are given the opportunity to share their stories and receive education on health care topics that are relevant to them.

The Nurse Practitioner also discussed that her medical group practice utilized the Press-Ganey surveys. She noted that her medical group practice did not engage in the patient focus groups, but that comments made on the surveys are addressed. Additionally, the Nurse Practitioner stated that her medical group practice has a high Medicaid population. As such, her medical group practice is committed to providing high quality resources and care for that population and that the patients do appreciate it. They continue to frequent her medical group practice because the Medicaid patients do not feel the stigma that is so often attached to uninsured and underinsured patients. The nurse

practitioner felt that the Medicaid patients are treated like the insured patient population that her medical group practice serves and that

> A lot of our patients come to us because they don't feel like going to the clinic. They're coming because they have an appointment, they know who they're going to see, they see them on time, it's not like they're going to a clinic where they just have to sit in a wait room with 50 other people and wait an hour or two for whenever they get called back. I think we certainly hear appreciation from our patients about the care that they get and that no one makes them feel like they're less than or that they're on Medicaid. There's a certain stigma that goes with that and they report they just don't feel when they come here.

The Nurse Practitioner's comments speak to cultural competence in healthcare and highlight the complexities for healthcare systems with the social determinants of health and diversity and inclusion. Diversity is not always a reference to race; it can also include disparities in income and social status that can affect access to healthcare.

Interview Question #5: Other Practices for Creating/Promoting Empathic Care

The fifth interview question asked, "Are there any other characteristics or practices that you think are important to creating/promoting an environment of empathic care?" The Practice Manager provided insight on what she believes it will take to successfully create/promote an environment of empathic care. She pointed out that achieving buy-in for team members is critically important. She also referenced that hiring smartly is important; that is, bringing in new employees that align well with a promoting a culture of empathic care.

> If you don't have buy-in from the team members, the staff, then you'll never get there. So, it does kind of start with the providers, but a lot is contingent on hiring

> the right team member who has that same type of philosophy and integrity to make it all work.

The Nurse Practitioner's assessment was largely consistent with the Practice Manager's statements. The Nurse Practitioner reinforced the notion that creating/promoting an environment of empathic care will require the leadership of the medical group practice to spearhead and model the effort. As such, the rest of the team will feel more at ease in buying into their role in fostering an environment of empathic care. The Nurse Practitioner shared the following:

> I do agree that it definitely comes from the top down. So, the providers need to have that concern for each other and also concerns for the team members. That will foster it and then your team members are going to buy into it. As a result, they won't feel like they're going out on a limb because the practice manager or the clinical providers aren't modeling that behavior to begin with.

The qualitative data collected during Phase 2 was valuable in that the participants were not bound by the limits of responding to survey questions. As such, several areas of agreement and key findings emerged from the interviews. The key findings from the interviews indicated that:

- Practicing cultural competency is important to developing and maintaining an environment of empathic care;
- Achieving buy-in to an environment of empathic care requires hiring "smartly" to bring in employees that will learn and promote an environment of empathic care;
- It is important that leaders practice empathic care;
- Empathic care needs to be included in the organization's policies and procedures; and

- A culture of accountability, diversity and inclusion is a key feature in an environment of empathic care.

Chapter V: Findings and Recommendations

This study of servant leadership behaviors and empathic care at Crestdale Health Care has important implications for the general business of healthcare and the patients that seek to access care. In this chapter, I begin by summarizing the results of the data analysis and present an interpretation of findings. I discuss study limitations, and, then offer proposals for healthcare constituents and stakeholders, and health policymakers based on the study. Implications for future research into servant leadership and empathic care conclude this dissertation.

Summary and Interpretation of Findings

The demographic profile of the research study's participants was that 83.5% identified as female compared to 15.9% who identified as male. Furthermore, the majority (56.0%) of survey respondents reported being in the 35–54 years old age category and an additional 25.3% were 18–34 years old. These data are consistent with the overall health care industry statistics. Diamond (2014) reported that more than 76% of hospital employees are women, more than 77% of people who work in doctors' offices are women, and more than 88% of home health workers are women. These data have important implications for the health care industry. While women far outnumber men by four to one, they still represent a minority of health care's C-suite (Diamond, 2014).

Most frequently exhibited servant leadership behaviors. Analysis of the means, standard deviations, and percentage distributions highlighted that over half of the respondents *strongly agreed* that Pillar 1 Persons of Character (M = 5.37) was exhibited in Crestdale Health Care medical group practices. Other pillars of servant leadership that respondents were most likely to agree were exhibited in their practices included:

- Pillar 6 Systems Thinkers (*M* = 5.28);
- Pillar 2 Puts People First (*M* = 5.22); and
- Pillar 7 Leads with Moral Authority (*M* = 5.05).

Further, respondents moderately agreed that Pillar 3 Skilled Communicators (*M* = 5.00), Pillar 5 Has Foresight (*M* = 4.85), and Pillar 4 Compassionate Collaborators (*M* = 4.83) characteristics, were exhibited in their medical group practices. Respondents strongly agreed that the themes represented by the individual servant leadership pillar items that were most exhibited in their medical group practices were:

- Demonstrating care and concern (under Pillar 2 Puts People First)
- Demonstrating understanding (under Pillar 3 Skilled Communicators
- Demonstrating adaptability (under Pillar 6 Systems Thinkers); and
- Maintaining professional integrity (under Pillar 1 Persons of Character).

Additionally, respondents indicated moderate agreement that the themes represented by the individual servant leadership pillar items that were exhibited in their medical group practices were:

- Inviting feedback from each other (under Pillar 3 Skilled Communicators);
- Building teams, impacting communities (under Pillar 4 Compassionate Collaborators);
- Expressing appreciation for patients (under Pillar 3 Skilled Communicators); and
- Demonstrating appreciation amongst team-members (under Pillar 4 Compassionate Collaborators).

The survey design allowed for the segmentation of the servant leadership pillars into team-member focused and patient-focused categories. Pillar 2 Puts People First, Pillar 3 Skilled Communicators, and Pillar 4 Compassionate Collaborators each included patient and team-focused items. Respondents indicated that the servant leadership characteristics were exhibited more frequently with patients than among team members. The trend of servant leadership pillars being more frequently exhibited with patients than amongst team-members was consistent in Pillar 3 Skilled Communicators, and Pillar 4 Compassionate Collaborators. In particular, respondents indicated that team-members were demonstrating understanding with patients more frequently than amongst each other.

Correlations among servant leadership pillars. Bivariate correlations for the individual servant leadership pillars revealed that the seven pillars of servant leadership correlated well with each other. For example, there was a strong positive correlation between Pillar 3 Skilled Communicators and Pillar 4 Compassionate Collaborators. Respondents indicated that team members who were skilled communicators, demonstrated understanding, invited feedback, and communicated persuasively (Pillar 3) were likely to be compassionate collaborators (Pillar 4) who express appreciation of team members and patients, build teams and communities, and negotiate conflict.

Servant leadership characteristics among team members and patients. The results showed that team members agreed that they practiced the servant leadership pillars more often with patients than among the team members. Showing care and concern, demonstrating understanding, inviting feedback, and expressing appreciation were practiced more often with patients than among team members. This finding may

indicate that there are opportunities for team members to develop team-oriented skills that can be expressed amongst each other.

Servant leadership perspectives relating to clinical and non-clinical team members.

The research further showed that team members who functioned in a clinical role (nurse practitioner and physician assistant) tended to respond differently from non-clinical team-members (practice managers/clinic administrators). The findings support the notion that there is a divide between non-clinical and clinical perspectives in servant leadership. Clinicians were more likely to be more patient focused than non-clinicians by exhibiting the servant leadership characteristics found in Pillar 2 Putting People First. Those characteristics include displaying a servant's heart, being mentor-minded, and showing care and concern.

Enhancing empathic care through servant leadership behaviors. Regression analysis showed that the P4 Compassionate Collaborators variable strongly influenced each of the Empathic Care variables except for the Empathic Care in Organizational Policies and Procedures variable. Additionally, the P5 Has Foresight and P7 Leaders with Moral Authority variables strongly influenced the Empathic Care in Organizational Policies and Procedures variable.

Furthermore, the P4 Compassionate Collaborators variable strongly influenced the Empathic Care Formal Training and Empathic Care Visual Promotion variables. Also, the P4 Compassionate Collaborators variable and the P7 Leaders with Moral Authority variable strongly influenced the Empathic Care Overall Promotion variable. Respondents indicated that the P5 Has Foresight variable and the P4 Compassionate

Collaborators variable strongly influenced all of the Empathic Care variables. Overall, respondents indicated that their medical group practices did promote an environment of empathic care.

In essence, Crestdale Health Care can promote an environment of empathic care through strengthening relationships, supporting diversity, and creating a sense of belonging through expressing appreciation, building teams and communities, and negotiating conflict. Team members at Crestdale Health Care can influence Empathic Care in Organizational Policies and Procedures through imagining possibilities, anticipating the future, and proceeding with clarity of purpose through being a visionary, displaying creativity, and taking courageous and decisive action. Furthermore, team members at Crestdale Health Care can influence Empathic Care in Organizational Policies and Procedures by exhibiting servant leadership characteristics that result in their being worthy of respect, inspiring trust and confidence, and establishing quality standards for performance by accepting and delegating responsibility, sharing power and control, and creating a culture of accountability.

Participant interviews. The participant interviews shed light on a number of issues inherent in empathic care in the medical group practice. Interviews surfaced potential unintended consequences of the Electronic Medical Record system that included increasing time spent by clinical mid-level practitioners (nurse practitioners and physician assistants) spent on record-keeping rather than providing direct patient care.

Interviewees pointed out that promoting an environment of empathic care in the medical group practice can be as simple as fitting into the schedule with a patient who is late for an appointment. Both the Practice Manager (non-clinical) and Nurse Practitioner

(clinical) agreed that this patient satisfaction strategy engages empathic care. The Nurse Practitioner further asserted that team members recognized that each patient is different and has a unique background and that makes them special. Interviewees also noted that feedback from patients is typically asked for in the form of surveys. There have been some face-to-face engagements with patients in the form of focus groups, however, the opportunity exists for medical group practice leaders and team members to develop strategies to further engage and solicit patient feedback.

Interviewees also noted the importance of cultural competency. Both the Practice Manager (non-clinical) and the Nurse Practitioner (clinical) discussed that their medical group practices provide care to a high volume of Medicaid patients. As such, empathic care is practiced by team members through understanding the stigma that is so often associated with underinsured and uninsured patients and mitigating these circumstances that can be so humiliating and de-valuing of these patients. Mitigation typically happens through customer service. The Nurse Practitioner (clinical) noted that her medical group practice has been able to build loyalty with these patients through a high level of customer service and that many of them return for their healthcare needs.

The Nurse Practitioner and the Practice Manager both agreed that maintaining and promoting an environment of empathic care through team member buy-in was essential. They agreed that Medical group practices should hire team members “smartly”—that is, hiring future team members who will not be averse to buying into the notion of maintaining and promoting an environment of empathic care in their medical group practices.

The Practice Manager (non-clinical) and Nurse Practitioner (clinical) also both agreed that promoting and maintaining an environment of empathic care requires leadership from the top down. They suggested that maintaining and promoting an environment of empathic care requires senior leaders in the medical group practices to drive and model the effort.

Overall, the participant interviews provided deeper insights into some of the granular, real-life situations and circumstances that are evident with maintaining and promoting an environment of empathic care in the medical group practices.

Contributions to Theory

A link between servant leadership and empathic care has been established through the literature reviewed in Chapter II. The findings in this study support this link and contribute data on the frequency of servant leadership behaviors exhibited in the medical group practices, as well as on the specific servant leadership behaviors and that influence measures of empathic care. The findings also distinguish and analyze the differences in perspectives between clinicians and non-clinicians in the medical group practice.

Consumerism and empathic care. Merisalo (2018) pointed out that healthcare consumerism is disrupting the healthcare industry and as patients become more discriminating in choosing healthcare providers, providing an exceptional patient experience becomes a very important factor in the decision-making of savvy consumer-conscious patients.

This study informs the research on healthcare consumerism and empathic care in that it provides insights into how healthcare providers can address the issue of improving the patient experience that is a by-product of consumerism in healthcare. By identifying

and understanding the servant leadership characteristics that most influence measures of empathic care, healthcare providers can strategically train and develop staff to exhibit those servant leadership characteristics to enhance empathic care. For Crestdale Health Care, this study identified Pillar 4 Compassionate Collaborators with the characteristics of expressing appreciation, building teams and communities, and negotiating conflict strongly influenced almost all of the empathic care variables. As such, at Crestdale Health Care, servant leadership training and development of staff could include instruction on strengthen relationships, support diversity, and create a sense of belonging through these characteristics.

Additionally, identifying the frequency of the individual servant leadership characteristics that are currently being exhibited in the healthcare provider's facilities can serve as a baseline or indicator of current status for healthcare providers. Merisalo (2018) suggested that along with high-quality care, personalization, convenience, follow-up, compassion, and courtesy are expectations for consumer-centric patients. For example, for Crestdale Health Care the most frequently exhibited servant leadership characteristics of maintaining integrity, demonstrating humility, and serving a higher purpose as found in Pillar 1 Persons of Character were the most frequently exhibited practices.

The design of this research study identified the frequency of servant leadership characteristics that were exhibited by team members among each other, and by team members with patients. Developing a culture of empathy can be challenging and requires ongoing attention. However, the effort is valuable because empathy improves the patient experience, staff satisfaction, and enhances the bottom line (Care Transformation Center, 2016).

Chong, Lim, and Matchar (2017) asserted that in the context of healthcare data, the advantages patient population segmentation analysis for the provision of patient-centred care include the facilitation of healthcare needs evaluation, outcomes tracking and care integration. While the individual patient data were not segmented in this research study, the team member data versus patient data revealed insight that indicated that team members exhibited servant leadership characteristics with patients more than with each other.

The interviewees pointed out that engaging dissatisfied patients by being flexible with the appointment schedule to assist patients that missed their appointments is a way to demonstrate empathic care. Heath (2017) suggested treating patient consumerism like a retail experience. Heath contended that patients will be more selective of their health care about their choice for a health care provider as they continue to shoulder more of the out-of-pocket expenses for the cost of their care. The healthcare provider that offers the consumer-centric patient experience will likely satisfy patients and also keep them returning for their future healthcare needs. Furthermore, Peter Fine, President and CEO of Banner Healthcare, a large non-profit health care organization, stated: "Healthcare organizations will need to live up to a new service expectation if they want to continue to win the business of their service savvy customers" (as cited in Heath, 2017, para.16).

Servant leadership. This study adds to the research on servant leadership in that it provides information on servant leadership as a leadership style that supports an organizational culture focused on the patient care and quality clinical outcomes that are important to developing an environment of empathic care. Just as servant leadership is

suitable for the healthcare industry as a whole (Schwartz & Tumblin, 2002), it is also a leadership style that can be used to develop an environment of empathic care.

The findings from this research study indicated that Sipe and Frick's (2009) seven pillars of servant leadership are correlated well with each other. Team members who exhibit the characteristics of a certain leadership pillar are likely to exhibit other characteristics of other pillars. Environments that feature collaborative partnerships require strong leadership (Boswell & Cannon, 2005). Study results show that healthcare providers can strengthen the leadership skills of employees by building servant leadership characteristics.

Clinical and non-clinical team member perspectives. The findings from this study were congruent with the notion of the cultural divide between clinical (nurse practitioners and physician assistants) and non-clinical team members (practice managers). Ferlie and Shortell (2001) discussed the idea that there can be rifts in the working relationships among clinical and non-clinical team members. For this study, both clinical (nurse practitioners and physician assistants) and non-clinical mid-level practitioners responded to survey questions that sought insight into the differences and similarities in the views of these two employee groups. Analysis of the mean score differences showed that non-clinical staff (practice managers) were significantly more likely than clinical (nurse practitioners and physician assistants) mid-level practitioners to exhibit each of the seven pillars of servant leadership.

The divide between these two groups can result in negative effects. Ferlie and Shortell (2001) identified a cultural divide in the working relationship between clinical and non-clinical managerial cultures in healthcare that is a "deterrent to quality-

improvement work" (p. 293). Specific examples of this divide between non-clinical and clinical staff have been identified in the literature. Ramirez and Bartunek (1989) pointed out that clinicians do not always trust healthcare administrators to understand the role of the clinician or appreciate their needs. Additionally, Elder et al. (2008) argued that clinicians are sometimes fearful of reporting errors because of possible negative responses from healthcare administrators. Furthermore, Tucker and Edmondson (2003) reported that when clinicians do solve the problems that they encounter, they might not communicate the solution to the non-clinicians who need to know. Moreover, it is entirely plausible that non-clinicians, by the nature of their professional roles, are emotionally removed from the daily emotional investment often required in providing direct patient care. As such, in general, non-clinicians may be less prone to exhibiting servant leadership behaviors in their medical group practices.

Interviewees point to an example of the divide between clinical (nurse practitioners and physician assistants) and non-clinical (practice managers) mid-level practitioners. In discussion about challenges clinical practitioners face that reduce the amount of time that they are able to spend with patients, the nurse practitioner team member pointed out that maintaining the Electronic Medical Record was time-consuming and had little impact on patient care. The non-clinical team member (practice manager) shared her opposing view that Electronic Medical Record maintenance was important. She asserted that it was important enough that accountability, including disciplinary action, should be—and is—a real possibility for clinicians who are derelict in their Electronic Medical Record duties. She thought that the Electronic Medical Record was an important part of providing patient care and the functioning of the medical group practice

Segmentation of servant leadership pillars. The effectiveness of segmentation of research data consistent with the literature, was found also by Khanjani et al. (2015) who asserted that hospitals and health systems can work toward enhancing the patient experience through promoting an environment of empathic care by conducting research that segments the populations that they serve. Infusing creativity into research data can often lead to innovation generation and effective strategy development. Vermeulen et al., 2010) asserted that the complexities of work and organizational life have increased significantly because of technological advancements, globalization, and other forces. Furthermore, because of the complexities of human interactions, the organizational internal environment is also in flux to the point where organizational leaders must find solutions to deal with these seismic shifts (Vermeulen et al., 2010). This research study segmented patient and team-member responses that highlighted team-members practicing servant leadership behaviors more frequently with patients than amongst each other as well as differently from each other.

Cultural competency and empathic care. Participant interviews identified effective methods of promoting empathic care in the medical group practices. One method was employing the principles of cultural competency to serve underinsured and uninsured patients in the medical group practices. Understanding cultural, ethnic, gender and economic differences is an important part of enhancing an environment of empathic care. Participant interviews highlighted how some of the medical group practices are intentional about treating each patient with the same level of care, dignity, and respect, regardless of their cultural, ethnic, gender, and economic status. This was particularly evident when providing care to underinsured and uninsured patients. Feedback

ascertained through surveys indicated that this focus on culture positively impacted patient experiences, and therefore, patients positively viewed the leveraging cultural competency.

The findings in this study are consistent with Amador et al. (2015) who discussed understanding the impact of empathy on different cultures and its importance to health systems and hospitals that intend to provide care to patients from diverse cultural backgrounds in their patient population. Amador et al. (2015) found that following a negative patient experience, when women perceived that the healthcare provider was being empathic during the follow up encounter, they perceived that they experienced better care.

This study found that the servant leadership pillars, such as being a visionary, displaying creativity, and taking courageous and decisive action, as found in Pillar 5 Has Foresight, and expressing appreciation of patients, building teams and communities and negotiating conflicts, as found in Pillar 4 Compassionate Collaborators had the most influence on empathic care. These servant leadership characteristics with team members could serve as a component of an overall strategy to align with implementing and leveraging cultural competency in the medical group practices.

Hiring the right talent. Participant interviewees pointed out that hiring the right talent is important to enhancing an environment of empathic care. Integrating new hires integrate into the culture of empathic care is essential and can have an impact on how well new hires will work with their team members. This finding aligns with Costa and McCrae (1998) along with Goldberg (1990) who assert that individuals who possess certain character traits are more likely to practice certain servant leadership behaviors.

Furthermore, findings from Jaramillo et al. (2009) showed that servant leadership influences staff turnover through a chain of effects that include person-organizational fit and organizational commitment. Opportunities may exist in medical group practices where Pillar 4 Compassionate Collaborators characteristics are frequently exhibited to exercise the characteristics of building teams and communities to attract, develop, and maintain the right talent.

Gaps in the literature. In general, the findings from this study add to the research on servant leadership in that they measure how frequently the characteristics of Sipe and Frick (2009)'s seven pillars of servant leadership are being exhibited. A review of the literature indicated that there was no published scale assessing the seven pillars of servant leadership and measures of empathic care. In addition, this study provides a methodology to assess how the seven pillars of servant leadership influence measures of empathic care. Furthermore, the findings from this study identified the correlations between the servant leadership pillars. This is important because this study informs healthcare leaders in medical group practices about which of the servant leadership pillars has the most influence on measures of empathic care. Therefore, certain servant leadership pillars can be strategically implemented by healthcare leaders in medical group practices to enhance individual elements of empathic care.

Implications for Practice

The data from this research study indicates that there are correlations among the servant leadership pillars, servant leadership characteristics influence measures of empathic care, and the divide in perspectives among clinical and non-clinical team members. These findings have implications for professionals and their practices. Health

policy makers, health care innovators, hospital and health system leaders and staff, medical schools, and healthcare consultants may be interested in using these findings in their respective professional practices.

Health policy makers. The trend of moving from volume-based care to value based care has introduced an expanded level of requirements designed to improve quality outcomes and the overall patient experience. The findings of this study can assist with formulating policy that includes more of a focus on promoting servant leadership behaviors to influence empathic care in the healthcare work environment that is congruent with the goals improving healthcare through value-based care. The implications of this study can be used to inform healthcare policy maker's decision-making as they continue to explore ways to improve quality outcomes and the patient experience for the nation.

Hospital and health system leaders. The nation's hospital and health system leaders continue to wrestle with the myriad of challenges to the profitability of their enterprises, the findings of this study can be used to help improve the patient experience. Patients are, more than ever, consumers of healthcare; that is, they are becoming more and more selective in determining when and how they receive healthcare services and how much they're willing to spend. As a result of the findings from this study, hospital and healthcare leaders can develop and implement training programs for leaders and staff that are targeted at understanding and applying the servant leadership behaviors that most influence the development, promotion, and maintenance of an environment of empathic care. Future research might also consider the influences of gender and age on servant

leadership and empathic care. Women comprise the majority of healthcare professionals but are in the minority when it comes to being key decision-makers.

Medical schools. Medical schools, and other institutions of higher learning that are focused on teaching healthcare, can benefit from the findings of this study. The servant leadership behaviors that were identified to have the most influence on empathic care can be incorporated into existing curriculum. Medical schools could add streamlined training for medical students on those specific servant leadership behaviors that most influence an environment of empathic care. The training could specifically inform students about those specific servant leadership behaviors that most positively influence an environment of empathic care. Training could also include role-playing as well as authentic conversations about students' passion for helping people through providing healthcare. Students could be encouraged to embrace and incorporate these servant leadership behaviors as a part of their overall leadership style. Additionally, medical schools could develop training content that focuses on clinician burnout and how practicing empathic care can lower the levels of clinician burnout.

Healthcare consultants. As a result of the findings of this research, healthcare consultants could play an important role in promoting empathic care through servant leadership behaviors by providing training and development to health care systems and hospitals on the servant leadership behaviors that most contribute to developing an environment of empathic care. Furthermore, financial models could be developed and presented by healthcare consultants to health systems and hospital leadership teams, which show how an environment of empathic care can impact market share and

profitability. This data can be used to contribute to the development of organization's strategic plans.

Chronic substance abuse. The current opioid epidemic that that is sweeping the United States has garnered the attention of many healthcare providers. Reports indicate that more than 115 people overdose daily on opioids (National Institute on Drug Abuse, 2018). Furthermore, the economic costs associated with opioid addiction are astronomical. This epidemic, even by 2013, was costing the United States $78.5 billion per year in treatment, lost productivity, and the costs associated with the justice system (Florence, Zhou, Luo, & Xu, 2016).

Caregivers are often on the front lines of this crisis. As such, they have worked to develop patient engagement strategies to treat addicted patients. One such strategy involves empathic care. Fertel (2018) advocates that healthcare providers should focus conversations with patients on functionality rather than their pain. Fertel believes that this shifts the patient's focus from their pain—for which they desire opiates—to the next activity that the patient would like to do. In essence, caregivers should focus on getting the patient in a position to where they can be prepared to tackle their next task rather than just focusing on their pain management. Maté (2015) supports this notion in the context of when a patient presents for care that "The first question is never why the addiction, but why the pain?" (para. 18). This form of empathic care requires the caregiver to invest the time in getting to know the patient, understanding their needs, and building trust.

Overall Research Study Critique

I found that Sipe and Frick (2009) was structured as a useful way to think about servant leadership characteristics and facilitate continuous improvement as a servant

leader. This study deconstructed the seven overall pillars to specific actionable, measurable competencies organized around these seven pillars. Individuals can measure their progress to evolving as servant leaders by focusing on the specific actions related to the pillars. Furthermore, the measurable competencies of the seven pillars enabled the assessment of the influence of servant leadership characteristics on empathic care variables. Conversely, analyses indicated that the Seven Pillars of Servant Leadership were highly correlated with each other and, therefore, not as completely distinct concepts as Sipe and Frick (2009) indicate.

I found that Sipe and Frick (2009) could have maximized the impact of the Seven Pillars of Servant Leadership through the development of a servant leadership assessment instrument as a part of the book. An assessment tool would have been very beneficial to individuals who are interested in assessing their competencies as a servant leader and also being able to measure their progress toward evolving as an advanced servant leader.

Because this research study involved inquiring into empathic care, I employed a strategy in developing the key empathic care variables that would engage departments across the organization. These departments do not provide direct patient care can be characterized as internal shared services. Policies and procedures, marketing and promotion, legal, finance, and training and development are activities that are typically consistent across an organization. These departments do not provide direct patient care and, because of the research design, there would be no need to develop special empathic care variable to assess these non-clinical departments.

Overall, I believe that this research study added value to the literature on servant leadership and empathic care. Identifying ways to measure servant leadership

characteristics and empathy, understanding which servant leadership characteristics influence measures of empathy, and understanding the differences in opinions of clinical and non-clinical professionals regarding servant leadership characteristics and measures of empathy added to the body of research literature. Furthermore, the development of a survey designed to measure servant leadership and empathy added to the body of literature.

The research study was also unique in its potential to assist organizations with their patient satisfaction improvement efforts, by lending insight into which individual servant leadership characteristics influence key measures of empathic care. In essence, the research study enables health systems and hospitals to avoid employing a "one size fits all" approach to their patient satisfaction improvement efforts. Rather, they can now employ a more customizable "one size fits one" approach to promoting empathic care through servant leadership characteristics in their organizations.

Limitations of this Study

This research study yielded numerous findings related to the implementation of servant leadership characteristics and empathic care in developing a culture of empathy in the healthcare setting. However, there were certain items that restricted the scope of this study and, as a result, limited the research study.

Access to employees. Like any large and sophisticated enterprise, Crestdale Health Care has its fair share of politics. Intra-organizational politics negatively impacted this study in that my access to physicians was denied. Because of the status and stature that physicians maintain in healthcare organizations, providing the opportunity for them to participate in this study would have added additional value. Physicians play an

important leadership role and carry much more influence than physician assistants, nurse practitioners, and practice managers in and beyond the medical group practice setting. Physicians are often leaders in the communities that they serve and very often encounter and engage patient populations while serving in the community. This gives the physicians additional insight into daily issues, circumstances, and needs that patients face. Physician insight could be used to provide better understanding about making empathic care in the medical group practice more holistic. Additionally, having the opportunity to assess the humanistic attitudes and behaviors of medical group physicians and comparing and contrasting them with physician assistants, nurse practitioners, and practice managers to see how they impact environment of empathic care, could have added more significance to this study.

Access to stratified patient satisfaction data. During the data collection phase of this study, I formally requested access to stratified patient satisfaction data for Crestdale Health Care. After a two-week waiting period in which the appropriate senior leaders at Crestdale Health Care were reviewing the request, it was denied. These data had been sought because I believed that having access to stratified patient data would add value to the study allowing for comparison to aggregated data for Crestdale Health Care. If this request had been granted, I would have been able to benchmark and track annual trends for patient satisfaction scores by medical group practice for Crestdale Health Care. The results of this type of comparative analysis could make the study more valuable because the data could be used for strategy development, targeted training and development, and best practice sharing among Crestdale Health Care medical group practices.

Staff reductions during data collection. Prior to the data collection phase, informal discussions were underway at Crestdale regarding large-scale staff reductions. This may have influenced the candor of responses, as I was a mid-level executive with Crestdale Health Care. Thus, n this atmosphere of cutbacks it is possible that, during part of the data collection phase some participants may have tried to be "politically correct" in their responses to survey and interview questions. During the data collection phase, in fact, I was laid off and no longer had access to Crestdale Health Care access and resources from an internal perspective. This may also have impacted the survey response rates of the target population.

Future Directions of Research

This study leads to some significant ideas for future innovations Healthcare regulations and healthcare consumerism are placing requirements on healthcare providers that often require investment of resources while improving patient outcomes and patient satisfaction. Innovations in the healthcare industry will help healthcare providers to meet some of these current and future challenges. The implementation of servant leadership behaviors to develop and promote an environment of empathic care in medical group practices contributes to improved patient satisfaction. Other innovations such as patient medication reminders that are essentially text messages that are sent to a patient's mobile phone to remind them to take their medication. These types of innovations, when implemented in concert with medical group practices promoting an environment of empathic care, have the potential to significantly reduce readmission rates, which, in turn, will reduce the cost of healthcare.

Innovations in healthcare continue to move at a very rapid pace. Healthcare innovations today are generally based upon advancements in technology. Technologies such “Fitbits” and other types of portable consumer heart rate monitors that are commonly worn on the wrist by the user (often referred to as “wearables”) have become popular with healthcare consumers (Piwek, Ellis, Andrews, & Joinson, 2016). While these innovations have become popular, *precision medicine* is also emerging as a more comprehensive approach to holistic healthcare. According to precision medicine described as “an emerging approach for disease treatment and prevention that takes into account individual variability in genes, environment, and lifestyle for each person" (Garrido, et al., 2018, p. 443). Precision medicine allows doctors and healthcare researchers to predict more accurately if the correct course of treatment and prevention strategies for a particular disease in certain groups of people will work. It is opposite to a one-size-fits-all approach, where disease treatment and prevention strategies are developed for the average person; Precision medicine takes into account the finer differences between individuals. As a result of this approach, healthcare innovators could add value to new innovations by humanizing new technologies thereby adding an empathic care component. This could be in the form of promoting empathic care with patients involved in a precision medicine related course of treatment. For example, this could mean matching the cognitive genetic makeup of a patient with the set of servant leadership behaviors that the patient would be most responsive to. In doing so, patients working with care providers trained in servant leadership would probably become more observant with their medications and compliant with specific treatment instructions.

Another innovation, congruent with the findings of this study, and that could benefit healthcare providers is the addition of voice technology to the Electronic Medical Record. This approach uses voice recognition technology to record notes from patient encounters. The data is automatically uploaded to the Electronic Medical Record where a medical office assistant can assist the physician with reviewing and modifying the notes for accuracy. This innovation has the potential to significantly reduce the time that physicians spend on the computer maintaining the Electronic Medical Record and, as such, possibly free up time to spend with patients. This time could be spent engaging in behaviors found in the servant leadership pillars such as displaying a servant's heart, demonstrating empathy, and expressing appreciation.

As a result of this study, ideas for areas of future research were developed. This study identified the servant leadership characteristics that most strongly influence measures of empathic care. Future research on developing and implementing specific strategies to leverage the servant leadership pillars and its associated characteristics that most strongly influences the variables of empathic care to create or enhance environments of empathic care in hospitals and health systems. Focusing on the associated characteristics of Pillar 5—Has Foresight, and how these can be customized for other health system medical group practices could be the initial platform for a more comprehensive effort to promote an environment of empathic care.

Another area for future research as a result of this research study would be to analyze and determine the variances in patient care where empathy can be the constant. Medical group practice team members could benefit from developing strategies to streamline medical group practice protocols for quality improvement while keeping

empathy as the primary constant. In doing so, strategies could be developed where empathic care serves as a main driver of improved patient satisfaction.

Research that focuses on the implications of healthcare providers that demonstrate more empathy with patients than with each other could be very helpful to health systems, hospitals, and medical group practices in understanding what type of team building activities could be most effective. This approach is counter to the "one-size fits all" approach that is so often implemented by large organizations. A more customized approach could see more effective team building strategies developed for team members.

Researching the potential root causes of the divide in thinking and perspectives between clinicians and non-clinicians could also be another future search study. Clinicians and non-clinicians could benefit from this type of understanding in that it would facilitate authentic communication and build trust among team members. Furthermore, medical schools and universities could benefit from this data in that it could help shape their planned curriculum offered to students.

Lastly, overall research focused on how to keep the humanity in healthcare in the face of new technologies could help hospitals and health systems to maintain their efforts toward patient satisfaction and empathic care with an authentic, personal, human touch that can be found with servant leadership behaviors and empathic care. The value of this type of research is that the findings could positively impact clinical outcomes and quality scores, as well as increased market share through enhancing brand loyalty with patients. Additionally, it could help hospitals and health systems with planning and design of new facilities.

Conclusion

As a result of this study, new knowledge has been added to the body of literature. Relating to servant leadership, the research revealed that Pillar 1—Persons of Character was the servant leadership pillar most frequently exhibited in the medical group practices. The study also found that team members practice the characteristics associated with the seven pillars of servant leadership more with patients than amongst each other. The study also revealed that mid-level practitioners agreed that their medical group practices promote an overall environment of empathic care. Furthermore, team members indicated that empathic care is reflected in the organizations' policies and procedures. The research also indicated team members level of agreement was varied regarding formal empathic care training being offered in the medical group practices, and marketing and promotion is displayed in the medical group practice facilities. The research identified Pillar 5 Has Foresight and Pillar 4 Skilled Communicators and their associated characteristics as the servant leadership pillars that most strongly influence all measures of empathic care.

The research revealed that differences in perceptions of healthcare between non-clinical and clinical mid-level practitioners exist. As a result of this research, team building, and training opportunities can be leveraged to further explore these differences and create space for authentic conversations designed to reduce this variation in team engagement. The findings from this study provide options for healthcare leaders, healthcare practitioners, consultants, and training and development specialists to develop innovative training for healthcare organizations to develop, maintain, and enhance environments of empathic care. As technology innovations in healthcare continue their rapid advancement, it will be important for healthcare leaders to be mindful that the

business of healthcare is about providing care for people. Keeping empathic care as a core process of the healthcare system will contribute to mitigating the potential dehumanization of providing healthcare due to implementation of new healthcare technologies. Developing environments of empathic care can help healthcare organizations maintain a competitive advantage in a healthcare landscape that is becoming more dynamic and more challenging to successfully operate in.

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Appendices

Appendix A: Boolean Search Codes Strategy

Search ID#	Search Terms	Search Options	Last Run Via	Results
S27	S25 and (S26 or S24)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	10
S26	patient w1 satisfaction	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	12,050
S25	S22 not S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	561
S24	TI (empath* or compassion*) OR SU (empath* or compassion*) OR KW (empath* or compassion*)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	16,642
S23	S22 and S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	16
S22	S1 and s2	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	577
S21	S10 and S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	8
S20	S18 OR S19	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	123,952
S19	MR "Literature Review"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	123,200
S18	DE "Literature Review"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	22,287
S17	S10 and patient w1 satisfaction	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	16

Search ID#	Search Terms	Search Options	Last Run Via	Results
S16	S10 and compassion*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	2
S15	S10 and ethic w1 care		Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	1,087
S14	S10 and ethic w1 care	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	0
S13	S10 and S12	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	9
S12	TI empath* OR SU empath* OR KW empath*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	14,928
S11	S10 and S1	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	6
S10	physician* w2 assistant* or nurse w1 practitioner*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	692
S9	SU (nursing and S6) NOT S5	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	1
S8	(S7 and S1 and S3) NOT S5	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	3
S7	DE "Hospitals" OR DE "Hospital Administration" OR DE "Hospital Environment" OR DE "Intensive Care"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	18,782
S6	s1 and servant w1 leader*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	487
S5	S3 and S4	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	33

Search ID#	Search Terms	Search Options	Last Run Via	Results
S4	DE "Medical Personnel" OR DE "Nurses" OR DE "Psychiatric Nurses" OR DE "Public Health Service Nurses" OR DE "School Nurses" OR DE "Physical Therapists" OR DE "Physicians" OR DE "Family Physicians" OR DE "General Practitioners" OR DE "Gynecologists" OR DE "Internists" OR DE "Neurologists" OR DE "Obstetricians" OR DE "Pathologists" OR DE "Pediatricians" OR DE "Psychiatrists" OR DE "Surgeons"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	70,812
S3	servant or greenleaf*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	2,219
S2	servant or greenleaf*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	2,219
S1	DE "Leadership" OR DE "Leader Member Exchange Theory" OR DE "Leadership Qualities" OR DE "Leadership Style" OR DE "Transactional Leadership" OR DE "Transformational Leadership"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	36,372
S23	S22 and S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	16
S22	S1 and s2	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	577

Search ID#	Search Terms	Search Options	Last Run Via	Results
S21	S10 and S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	8
S20	S18 OR S19	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	123,952
S19	MR "Literature Review"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	123,200
S18	DE "Literature Review"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	22,287
S17	S10 and patient w1 satisfaction	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	16
S16	S10 and compassion*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	2
S15	S10 and ethic w1 care		Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	1,087
S14	S10 and ethic w1 care	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	0
S13	S10 and S12	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	9
S12	TI empath* OR SU empath* OR KW empath*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	14,928
S11	S10 and S1	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	6
S10	physician* w2 assistant* or nurse w1 practitioner*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	692

Search ID#	Search Terms	Search Options	Last Run Via	Results
S9	SU (nursing and S6) NOT S5	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	1
S8	(S7 and S1 and S3) NOT S5	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	3
S7	DE "Hospitals" OR DE "Hospital Administration" OR DE "Hospital Environment" OR DE "Intensive Care"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	18,782
S6	s1 and servant w1 leader*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	487
S5	S3 and S4	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	33
S4	DE "Medical Personnel" OR DE "Nurses" OR DE "Psychiatric Nurses" OR DE "Public Health Service Nurses" OR DE "School Nurses" OR DE "Physical Therapists" OR DE "Physicians" OR DE "Family Physicians" OR DE "General Practitioners" OR DE "Gynecologists" OR DE "Internists" OR DE "Neurologists" OR DE "Obstetricians" OR DE "Pathologists" OR DE "Pediatricians" OR DE "Psychiatrists" OR DE "Surgeons"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	70,812
S3	servant or greenleaf*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	2,219

Search ID#	Search Terms	Search Options	Last Run Via	Results
S2	servant or greenleaf*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	2,219
S1	DE "Leadership" OR DE "Leader Member Exchange Theory" OR DE "Leadership Qualities" OR DE "Leadership Style" OR DE "Transactional Leadership" OR DE "Transformational Leadership"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - PsycINFO	36,372
S34	S29 AND S30	Limiters - Publication Year: 2013-2014 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	92
S33	S29 AND S30	Limiters - Publication Year: 2012-2013 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	50
S32	S29 AND S30	Limiters - Publication Year: 2014-2016 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	134
S31	S29 AND S30	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	325
S30	TI servant OR KW servant OR SU servant	Limiters - Publication Year: 2000-2016 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	584
S29	S25 not (S26 or S24)	Limiters - Publication Year: 2000-2016 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	521

Search ID#	Search Terms	Search Options	Last Run Via	Results
S28	S25 not (S26 or S24)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	551
S27	S25 and (S26 or S24)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	10
S26	patient w1 satisfaction	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	12,050
S25	S22 not S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	561
S24	TI (empath* or compassion*) OR SU (empath* or compassion*) OR KW (empath* or compassion*)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	16,642
S23	S22 and S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	16
S22	S1 and s2	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	577
S21	S10 and S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	8
S20	S18 OR S19	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	123,952
S19	MR "Literature Review"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	123,200
S18	DE "Literature Review"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	22,287
S17	S10 and patient w1 satisfaction	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	16

Search ID#	Search Terms	Search Options	Last Run Via	Results
S16	S10 and compassion*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	2
S15	S10 and ethic w1 care	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	1,087
S14	S10 and ethic w1 care	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	0
S13	S10 and S12	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	9
S12	TI empath* OR SU empath* OR KW empath*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	14,928
S11	S10 and S1	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	6
S10	physician* w2 assistant* or nurse w1 practitioner*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	692
S9	SU (nursing and S6) NOT S5	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	1
S8	(S7 and S1 and S3) NOT S5	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	3
S7	DE "Hospitals" OR DE "Hospital Administration" OR DE "Hospital Environment" OR DE "Intensive Care"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	18,782
S6	s1 and servant w1 leader*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	487
S5	S3 and S4	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	33

Search ID#	Search Terms	Search Options	Last Run Via	Results
S4	DE "Medical Personnel" OR DE "Nurses" OR DE "Psychiatric Nurses" OR DE "Public Health Service Nurses" OR DE "School Nurses" OR DE "Physical Therapists" OR DE "Physicians" OR DE "Family Physicians" OR DE "General Practitioners" OR DE "Gynecologists" OR DE "Internists" OR DE "Neurologists" OR DE "Obstetricians" OR DE "Pathologists" OR DE "Pediatricians" OR DE "Psychiatrists" OR DE "Surgeons"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	70,812
S3	servant or greenleaf*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	2,219
S2	servant or greenleaf*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	2,219
S1	DE "Leadership" OR DE "Leader Member Exchange Theory" OR DE "Leadership Qualities" OR DE "Leadership Style" OR DE "Transactional Leadership" OR DE "Transformational Leadership"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database – PsycINFO	36,372

Appendix B: Supplementary References for Empathic Interpersonal Engagement in Clinical Environments

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Appendix C: Work Environments Survey for Servant Leadership and Empathic Care

Work Environments Research Survey

Introduction / Consent Form

Greetings and welcome!

Work environments are important to all of us and this survey explores how mid-levels in medical group practices perceive their work environments. My name is Mark Martin and I'm currently pursuing my PhD in Leadership and Change from Antioch University. I'm in the midst of completing my research for my dissertation and I'd sincerely appreciate your participation in my survey.

You are being invited to participate in this survey because you are a Nurse Practitioner, a Physician Assistant, or Practice Manager serving in a Crestdale Health Care Medical Group practice. With thoughtful reflection, I estimate that this survey will take between 10 – 15 minutes to complete.

Crestdale Health Care has approved the survey, as well as the Institutional Review Board at Antioch University. All individual responses will be anonymous and confidential. Only aggregate data will be reported and no individual identifying information will be included in any oral or written reports of study data. Your participation is voluntary and you may elect to discontinue your participation and stop responding to the survey at any time. Although no study is completely risk free, I do not anticipate that you will be harmed or distressed by responding to the survey questions.

I do hope that participating in this survey will be a good experience for you. If you have any ethical concerns about this survey, contact Lisa Kreeger, PhD, Chair, Institutional Review Board, Antioch University Ph.D. in Leadership and Change.

I look forward to listening and learning about your experiences through this survey.
Thanks so much for your participation!

Mark A. Martin, PhD Candidate
Antioch University PhD Program in Leadership & Change

By clicking "NEXT" below, you are indicating that you are 18 years of age or older and that you have read and understand this consent form and agree to participate in this project. Please print a copy of this page for your records.

Work Environments Research Survey

I. Job Function

* 1. Are you a Nurse Practitioner, Physician Assistant, Practice Manager?

- ◯ Yes
- ◯ No

Other (please specify)

* 2. Do you work in a Crestdale Health Care Medical Group practice?

- ◯ Yes
- ◯ No

* 3. Please indicate your role within the organization:

- ◯ Nurse Practitioner
- ◯ Physician Assistant
- ◯ Practice Manager
- ◯ Other (Please describe)

Other (please specify)

Work Environments Research Survey

II. Leadership Characteristics

* 4. Thinking about your role in your medical group practice, please indicate how strongly you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
(a) Maintaining professional integrity is important to our team norms in my medical group practice.	○	○	○	○	○	○
(b) In my medical group practice, our team members are expected to demonstrate humility.	○	○	○	○	○	○
(c) In my medical group practice, our team members seek to serve a higher purpose.	○	○	○	○	○	○
(d) Team members displaying a servants heart is important in my medical group practice.	○	○	○	○	○	○
(e) Being mentor-minded is an expectation of team members in my medical group practice.	○	○	○	○	○	○
(f) In my medical group practice, our team members seek to show care and concern with each other.	○	○	○	○	○	○
(g) In my medical group practice, our team members seek to show care and concern with patients.	○	○	○	○	○	○
(h) Demonstrating understanding with each other as team members is important in my medical group practice.	○	○	○	○	○	○
(i) Team members demonstrating understanding with patients is important in my medical group practice.	○	○	○	○	○	○

Work Environments Research Survey

I. Leadership (continued)

5. Thinking about your role in the medical group practice, please indicate how strongly you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
(j) Our team members are intentional about inviting feedback from from each other in my medical group practice.	○	○	○	○	○	○
(k) Our team members are intentional about inviting feedback from patients in my medical group practice.	○	○	○	○	○	○
(l) In my medical group practice, our team members seek to communicate with each other in a persuasive way without intimidation, bullying, or manipulation.	○	○	○	○	○	○
(m) Expressing appreciation of each other is a team norm in my medical group practice.	○	○	○	○	○	○
(n) Expressing appreciation of patients is an expectation of team members in my medical group practice.	○	○	○	○	○	○
(o) In my medical group practice, our team members seek to build teams and impact communities.	○	○	○	○	○	○
(p) In my medical group practice, visionary thinking by physicians and mid-levels is essential.	○	○	○	○	○	○
(q) Team members valuing creativity is important in my medical group practice.	○	○	○	○	○	○
(r) Negotiating conflict is an important activity in my medical group practice.	○	○	○	○	○	○

Work Environments Research Survey

II. Leadership (continued)

* 6. Thinking about your role in the medical group practice that you work in, please indicate how strongly you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
(s) In my medical group practice, our team members are expected to take courageous and decisive action.	○	○	○	○	○	○
(t) In my medical group practice, it is important that our team members be comfortable with complexity and change.	○	○	○	○	○	○
(u) Our team members are expected to demonstrate adaptability in my medical group practice.	○	○	○	○	○	○
(v) In my medical group practice, our team members seek to consider the "greater good" when making decisions.	○	○	○	○	○	○
(w) In my medical group practice, our team members are expected to accept as well as delegate responsibility.	○	○	○	○	○	○
(x) It is important that our team members share power and control in my medical group practice.	○	○	○	○	○	○
(y) In my medical group practice, our team members are expected to create a culture of accountability.	○	○	○	○	○	○

Work Environments Research Survey

III. Empathic Care

An environment of empathic care is one that emphasizes empathy and deep compassion for others (including patients) in the medical group practice.

Thinking about your role in your medical group practice, on a scale on 1 to 10, please indicate how strongly you disagree or agree with each of the following statements:

* 7. In my medical group practice, empathic care is reflected in the organizational policies and procedures.

1 - Strongly Disagree 10 - Strongly Agree

8. In my primary care practice, leaders and staff receive monthly formal training (i.e. corporate education, continuing education units, etc.) on empathic care.

1 -- Strongly Disagree 10 -- Strongly Agree

* 9. In my medical group practice, I see visual evidence of promotional items related empathic care displayed in the patient waiting areas, exam rooms, and general office area.

1 10

* 10. Overall, my medical group practice promotes an environment of empathic care.

1 10

Work Environments Research Survey

IV. Demographics

11. Please indicate your gender identification:

- ○ Male
- ○ Female
- ○ Other

12. Please indicate your age range:

- ○ 18 - 34 years old
- ○ 35 - 54 years old
- ○ 55 - 74 years old
- ○ 75 years or older

13. Please indicate your Crestdale Health Care market:

- ○ Greater Charlotte
- ○ Greater Winston-Salem
- ○ Coastal (Brunswick Area)
- ○ Northern Virginia
- ○ Triangle
- ○ Other (please specify)

Appendix D: Participant Confirmation Email

Interview Session Confirmation Email

Thank you again for agreeing to participate in the interview session group. I sincerely appreciate your assistance!!

As you know, my dissertation is entitled "Servant Leadership Behaviors & Empathic Care: Developing A Culture of Empathy in the Healthcare Setting." The goal of the interview session will be to share some of the results from the survey that explored how mid-level professionals in primary care practices perceive their work environments, and to hear your thoughts about the survey results and about your experiences with servant leadership and empathy in your primary care practice.

The interview session will be conducted by conference call and will last for one hour. This facilitated discussion will audiotaped and **all discussions and responses will be kept strictly confidential.** Your participation in the interview session presents the opportunity for you to participate in the creation of new and original research that is related to how work environments contribute to patient care. Crestdale Health Care has approved this research study as well as the Institutional Review Board at Antioch University. I've also attached a letter of informed consent; please sign and email to me at [redacted]@[redacted].

This document provides some context for our discussion. Please review in preparation for the virtual focus group session. If you have any questions or need additional information, please don't hesitate to contact me by email at [redacted]@[redacted] I look forward to your feedback and thanks so much for your participation!

Mark A. Martin, PhD Candidate
Antioch University PhD Program in Leadership & Change

Appendix E: Synopsis of Servant Leadership Characteristics and Empathic Care

Synopsis of Servant Leadership Characteristics and Empathic Care

The Seven Pillars of Servant Leadership are characteristics or behaviors of the servant leader. Within each of the Seven Pillars, is a set of key leadership traits or core competencies.

PILLAR I (PERSON OF CHARACTER)
Defined: A servant leader makes insightful, ethical, and principle-centered decisions. A Person of Character is honest, trustworthy, authentic, and humble. They lead by conscience, not by ego. They are filled with a depth of spirit and enthusiasm and are committed to the desire to serve something beyond oneself.

The key leadership traits/core competencies that comprise Pillar I (Person of Character):

- Maintaining Integrity
- Demonstrates Humility
- Serves a Higher Purpose

PILLAR II (PUTS PEOPLE FIRST)
Defined: A person who puts people first seeks first to serve then aspires to lead. Their self-interest is deeply connected to the needs and interests of others. They serve in a manner that allows those served to grow as person, and express genuine care and concern for others.

The key leadership traits/core competencies that comprise Pillar II (Puts People First):

- Displays a Servant's Heart
- Is Mentor Minded
- Shows Care and Concern

PILLAR III (SKILLED COMMUNICATOR)
Defined: A person who is a skilled communicator listens earnestly and speaks effectively. They seek first to understand, then to be understood. They listen receptively to others, demonstrating genuine interest, warmth, and respect. They listen honestly and deeply to oneself and invites feedback from others, and they influence others with assertiveness and persuasion rather than power.

The key leadership traits/core competencies that comprise Pillar III (Skilled Communicator):

- Demonstrates Empathy
- Invites Feedback
- Communicates Persuasively

PILLAR IV (COMPASSIONATE COLLABORATOR)
Defined: A person who is a compassionate collaborator invites and rewards the contributions of others. They pay attention to the quality of work-life and strive to build caring, collaborative teams and communities. They relate well to people of diverse backgrounds and interest and value individual difference. They manage disagreements respectfully, fairly, and constructively.

The key leadership traits/core competencies that comprise Pillar IV (Compassionate Collaborator):

- Expresses Appreciation
- Builds Teams and Communities
- Negotiates Conflict

PILLAR V (HAS FORESIGHT)

Defined: A person who has foresight views foresight as the central ethic of leadership and knows how to access intuition. They can articulate and inspire a shared vision, and they use creativity as a strategic tool. They are discerning, decisive, and courageous decision-makers.

The key leadership traits/core competencies that comprise Pillar V (Has Foresight):

- Visionary
- Displays Creativity
- Takes Courageous and Decisive Action

PILLAR VI (SYSTEMS THINKER)

Defined: A person who is a systems thinker connects systems thinking with ethical issues. They apply the principles of servant leadership to systems analysis and decision-making. They integrate input from all parties in a system to arrive at holistic solutions, and demonstrate an awareness of how to lead and manage change.

The core competencies that comprise Pillar VI (Systems Thinker):

- Comfortable with Complexity
- Demonstrates Adaptability
- Considers the "Greater Good"

PILLAR VII (LEADS WITH MORAL AUTHORITY)

Defined: A person who leads with moral authority values moral authority over positional authority. They empower the others with responsibility and authority. They set clear, firm yet flexible boundaries, and establish, model, and enforce quality standards for conduct and performance.

The core competencies that comprise Pillar VII (Leads with Moral Authority):

- Accepts and Delegates Responsibility
- Shares Power and Control
- Creates a Culture of Accountability

EMPATHIC CARE ENVIRONMENT

Defined: An environment of empathic care is one that emphasizes empathy and deep compassion for others in the primary care practice.

Measures of Empathic Care

- Empathic Care Reflected in Organizational Policies and Procedures (i.e. a component of the organizations' governance)
- Empathic Care Formal Training Offered to Leaders and Staff (i.e. Continuing Medical Education units)
- Empathic Care Visually Marketed and Promoted in Medical Group Practice Facilities (i.e. posters, flyers, media, etc.)
- Empathic Care Environment (Overall) Promoted (i.e. team members in promote a general environment of empathic care)

Appendix F: Informed Consent Form

Servant Leadership & Empathic Care Dissertation Research Consent Form

This informed consent form is for mid-level managers who are being inviting to participate in a research project titled "Servant Leadership & Empathic Care: Developing A Culture of Empathy in the Healthcare Setting."

- Name of Principle Investigator: Mark A. Martin
- Name of Organization: Antioch University, PhD in Leadership and Change Program
- Name of Project: Virtual Focus Group Research

You will be given a copy of the full Informed Consent Form

A. Introduction

I am Mark A. Martin, a student in Antioch University, PhD in Leadership and Change Program. As part of this degree, I am completing a project to fulfill the requirements of the PhD that includes dissertation research. This research project examines servant leadership characteristics and empathic care. I am going to share with you information about the study and invite you to be part of this research. You may talk to anyone you feel comfortable talking with about the research, and take time to reflect on whether you want to participate or not. You may ask questions at any time.

B. Purpose of the research

The purpose of this project is to investigate the relationship between servant leadership and empathic care. This information may help us to better understand how hospitals and health systems can improve their patient satisfaction scores.

C. Type of Research Intervention

This research will involve your participation in a virtual focus group, where your input will contribute to a more granular discussion of servant leadership and empathic care. The virtual focus group session be tape recorded solely for research purposes, but all of the participants' contributions will be de-identified prior to publication or the sharing of the research results. The recording, and any other information that may connect you to the study, will be kept in a locked, secure location. The virtual focus group session will be one hour in length and conducted by conference call.

D. Participant Selection

You are being invited to take part in this research because you are a mid-level manager in the Crestdale Health Care Medical Group. You should not consider participation in this research if you are **not** a nurse practitioner, physician assistant, or practice manager.

E. Voluntary Participation

Your participation in this study is completely voluntary. You may choose not to participate. You will not be penalized for your decision not to participate or for anything of your contributions during the study. Your position in Crestdale Health Care will not be affected by this decision or your participation. You may withdraw from this study at any time. If an interview has already taken place, the information you provided will not be used in the research study.

F. Risks

No study is completely risk free. However, I do not anticipate that you will be harmed or distressed during this study. You may stop participating in the study at any time and for any reason.

G. Benefits

There will be no direct benefit to you, but your participation may help others in the future.

H. Reimbursements

You will not be provided any monetary incentive to take part in this research project.

I. Confidentiality

All information will be de-identified, so that it cannot be connected back to you. Your real name will be replaced with a pseudonym in the write-up of this project, and only the primary researcher will have access to the list connecting your name to the pseudonym. This list, along with tape recordings of the discussion sessions, will be kept in a secure, locked location.

J. Limits of Privacy

Confidentiality: Generally speaking, I can assure you that I will keep everything you tell me or do for the study private. Yet there are times where I cannot keep things private (confidential). The researcher cannot keep things private (confidential) when:

- The researcher finds out that a child or vulnerable adult has been abused
- The researcher finds out that that a person plans to hurt him or herself, such as commit suicide,
- The researcher finds out that a person plans to hurt someone else, There are laws that require many professionals to take action if they think a person is at risk for self-harm or are self-harming, harming another or if a child or adult is being abused. In addition, there are guidelines that researchers must follow to make sure all people are treated with respect and kept safe. In most states, there is a government agency that must be told if someone is being abused or plans to self-harm or harm another person. Please ask any questions you may have about this issue before agreeing to be in the study. It is important that you do not feel betrayed if it turns out that the researcher cannot keep some things private.

K. Future Publication

The primary researcher, Mark A. Martin, reserves the right to include any results of this study in future scholarly presentations and/or publications. All information will be de-identified prior to publication.

L. Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and you may withdraw from the study at any time without your job being affected.

M. Who to Contact

If you have any questions, you may ask them now or later. If you have questions later, you may contact Mark A. Martin at [redacted]. If you have any questions about your rights as a research participant, you may contact Dr. Lisa Kreeger, Chair, Institutional Review Board, Antioch University Ph.D. in Leadership and Change at [redacted]. This proposal has been reviewed and approved by the Antioch International Review Board (IRB), which is a committee whose task it is to make sure

that research participants are protected. If you wish to find out more about the IRB, contact Dr. Lisa Kreeger.

DO YOU WISH TO BE IN THIS STUDY? I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Name of Participant (PRINT) _____

Signature of Participant _____

Date _____ Day/month/year

DO YOU WISH TO BE AUDIOTAPED IN THIS STUDY? I voluntarily agree to let the researcher audiotape me for this study. I agree to allow the use of my recordings as described in this form.

Name of Participant (PRINT) _____

Signature of Participant _____

Date _____ Day/month/year

To be filled out by the researcher or the person taking consent: I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this Informed Consent Form has been provided to the participant.

Name of Researcher/person taking the consent (PRINT):

_____

Signature of Research/person taking the consent

_____

Date _____ Day/month/year