Servant-Leadership as Loving-Leadership

Explorations for Catholic Health Ministry

— Michael D. Cox

Leading within Catholic health care is a growing struggle as the health care environment undergoes monumental change. The Institute for Healthcare Improvement (IHI), a significant force in shaping health care policy, lists its five primary focus areas on its website: "Improvement Capability; Patient and Family Experience; Patient Safety; Quality, Cost and Value; and Triple Aim for Populations" (IHI, n.d.). Successfully addressing each area provides unique challenges to leaders because each area demands significant changes to individual behavior and organizational structure. Added to this is the reality that any improvement in one area likely adds complexity to another area. For example, patient safety advocates, most notably the Institute of Medicine, have championed the utilization of electronic medical or health records as mechanisms to eliminate variation and share real time patient information that is supposedly helpful to clinicians (Jarrett, 2016). Yet as more nurses and physicians use computers in the daily course of their work treating and healing their patients, over time, it may become easier to communicate with the device in their hands than with the patient and family

physically present in their midst, thus possibly defeating efforts to improve another focus area: the patient and family experience. This is but one example of the inherent tension that exists between competing priorities. In health care, these tensions highlight the fact that the provider and patient relationship is fundamentally transforming. Effective leaders confronting the monumental changes affecting the Catholic health ministry are tasked with not simply installing computers and electronic systems and a host of other seemingly more important ways but rather, assisting in the integration of such nouveau technology into the primal substance animating the Catholic health ministry: Love. The purpose of this paper is to explore how living into the art and practice of servant-leadership transforms and sustains loving relationships within the Catholic health ministry through its leaders' relationships with themselves, with those who follow them, and with the broader community they profess to love.

One Catholic health ministry Chief Executive I worked with compared leading Catholic health ministries to changing the tires on a bus hurtling down the freeway. In my view, the therapeutic relationships providers, nurses, and other health care professionals have with their patients and on a macro scale, hospitals, have with their community are rooted in self-less loving relationships. Most importantly, yet often lacking emphasis and attention, mutual loving relationships inhabit servant-leader and follower relationships. Gratefully for Catholic health ministry leaders, Robert Greenleaf (1977) pioneered the term servant-leadership. Frick (2004) suggests

that, “true servants operate out of love” (p. 15). Love is a virtue well integrated into Greenleaf’s servant-leadership philosophy, which, when adopted as both personal ethic and professional obligation, provides Catholic health ministry leaders with the language and experience to retain love as a foundational and contemporary directive towards further health ministry viability, enabling a thriving and discerning response to the increasing complexity of a centuries old ministry.

To be clear, love is the operative virtue hidden within many Catholic health care systems’ mission statements that read, “Furthering the healing ministry of Jesus” (Dignity Health, n.d.), and “Rooted in the loving ministry of Jesus as healer” (Ascension Health, n.d.). Love, or to put it in a different way, serving one another, is the foundational ingredient in the Catholic health ministry. Practically, love empowers Catholic health organizations to recognize patients, family members, employees, and providers as whole persons. Catholic health organizations demonstrate this love by investing in formal and informal responses to these individuals’ physical, emotional, and spiritual needs with spiritual care departments, No One Dies Alone programs, and educational offerings on physician burnout. Love is also at the heart of servant-leadership as a virtue that compels us to serve others. Greenleaf (1977) defines love as a, “subtle and infinite…unlimited liability” for others (p. 52). His experience as a child and young man cemented this understanding through watching and experiencing life with his father (Frick, 2004). Frick (2004) suggests that Greenleaf learned about self-less service and a deep and abiding

unconditional concern for others from his father, George. George Greenleaf was animated through service to others. It did not matter what role he assumed. His spin on each distinct role bent towards loving service (Frick, 2004). Clearly, Robert Greenleaf (1977) bore out of his experience and formation in those early years an ethic of loving service he articulated in "The Servant as Leader." Greenleaf's legacy was not his own, nor simply his father's, but a legacy of love that each person can embrace and build upon. Catholic health ministry leaders hear similar stories of profound impact in improving patients' experience of health care and hospitals. Stories are present that exemplify how each and every person, regardless of their position or role, impacts patients' and their families' experiences. Impacting others is, in my view, serving others. Servant-leadership begins with the notion that every person can serve, they simply need to choose to do so.

Servant-leadership invites leaders to primarily love and serve others first, then choose to lead through loving service. This formal invitation begins with an important metaphorical save-the-date card inviting the servant first, leader second, to reflect upon how the leader loves himself or herself. Servant-leader, such as James Autry (2015), notes that "we cannot renew ourselves without love" (p. 20). Autry found that love is not just simply about oneself, but about, "love of what we do together, love of ourselves, love of our customers, love of our products" (p. 20). Autry's insights on love coupled with Greenleaf's philosophy of meaningful service for others provides a powerful recipe for Catholic health ministry leaders

seeking to sustain healing relationships within their organizations.

Not everyone can author a book, or determine how a particular hospital is performing, but becoming a servant is attainable by those who care enough about their fellow human beings to make a difference in their lives. Nevertheless, Catholic health ministry leaders are faced with increasing pressures to drive performance, increase revenues, and decrease costs. For Catholic health ministry leaders, leadership is both a "job" and "meddling in other people's lives" (De Pree, 1992, p. 5). This is daunting work that transforms people's lives. With increasing stressors, leaders are not the only individuals affected, but are at the source of what may constitute healing. Often what leaders fail at, in my experience, is embracing opportunities to reconnect with those personal reasons for why they chose to be a leader and how being a servant first shapes that decision. Health ministry leaders who are unable to disconnect from their work may succumb to the tangible objectivity of key performance indicators and operational metrics. Doing so prevents them from engaging in more personal and subjective reflection required for those leaders who strive to lead during personal difficulties and organizational challenges. Servant-leadership may provide some helpful clarity.

Servant-leadership calls Catholic health ministry leaders to deepen their love for themselves and in doing so, take the necessary time to reflect upon the legacies that have been entrusted to them. Legacies akin to Greenleaf's experience

with his father, where stories abound of how religious women and men transformed communities within the western frontier throughout the nineteenth and twentieth centuries by simply meeting unmet needs of those marginalized by society: the ill, dying, poor, and outcast. These women, like George Greenleaf, simply approached those in need with loving service. They rarely sought notoriety or fame, but humbly led the tremendous growth and success of their healing ministries. They too integrated love, often understood as mercy, into their day to day efforts and like Autry's (2015) experience, it "just worked" (p. 20).

These legacies of loving compassion coupled with fierce determination and creativity marked the first modern foundations of the Catholic health ministry. These stories are important reflecting points for Catholic health ministry leaders who seek to first grant themselves their own loving service. This is a gift that does not inflate egos, but grounds the servant-leader within the integration of his or her own story and that of the organization he or she leads. Finding synergy within these individual and communal stories empowers the servant-leader to embed oneself within the organization, encountering the meaningful impact of loving others.

Effectively loving oneself leads one towards loving others. Yet loving others is no simple endeavor. It demands a deep desire to listen to the other (Gunnarsson & Blohm, 2008). Gunnarsson and Blohm suggest dialogue seeks, "understanding and agreement. We listen not only to words, but also to the entire person" (p. 123). How does one listen to an entire

person? Perhaps listening to an entire person involves careful reading of body language along with hearing what was said as well as what was not said. Yet this understanding seems lacking. Servant-leadership invites us into an attitude of listening first to other people's stories, where they come from, and what they find valuable because, ultimately, listening strengthens others (Greenleaf, 1977).

Listening and servant-leadership bode well for Catholic health ministry leaders who are intent on sustaining healing relationships within their organizations. Often, health care workers embrace their calling to serve and heal others through reflecting on stories that shaped and changed them. When facilitating new employee orientation recently at a hospital I serve, I asked why people chose to be in the healing professions. Most participants shared a story of how they were impacted by someone who had either cared for them or a family member. Intentional story telling within the context of servant-leadership offers leaders an alternative method in addressing change by listening first to the stories of those served. These leaders, I argue, are serving by eliciting others' stories for the community to hear. In doing so, they serve the individual and community. It strikes me as important for servant-leaders to spend ample time investing in learning and participating in the stories of those they profess to serve.

Leaders may encounter these meaningful learning experiences in unexpected ways if they are attuned to the stories of those they lead. Exemplifying this was Kenneth Branagh's stellar performance in the movie, *Shackleton*.

Branagh's character, Lord Shackleton, embraces the story of a young sailor who, during a community celebration, retreats to be painfully reminded of how far he is from those he loves (Barra & Fine, 2002). Shackleton deepens his role as a servant-leader through observing the sailor leave the gathering, following him, and then demonstrating his intense interest in this man's story. In this sacred moment, Shackleton and the young man are not simply leader and follower but are connected much more deeply. This scene is one of many in the movie that demonstrate Shackleton's love for his men. Other examples include the opening scene where Shackleton declares how important his men were to him on his previous failed voyage and the movie's ending where a brief interchange between Shackleton and his stranded first mate. "Are you all well? Yes, we are all well!" (Barra and Fine, 2002). Shackleton, in my view, was concerned with not just their survival but with their experience. Throughout the voyage, he consistently was concerned about his men not simply as sailors, but as human beings. He fully participated in their stories and was devoted to the entire community's experience.

Shackleton's legend is another example of how devoted leaders who see themselves as servants before they are leaders remind us of how powerful love can be within relationships. Perhaps in no other industry or business are relationships so prized as in health care. The physician-patient relationship is held to a high standard similar to attorney-client and confessor-penitent relationships. Within the Catholic health ministry, organizational mission and values statements place equal

weight upon the relationships leaders have with followers. Loving relationships are predicated on an intentional choice we make to "accept the authenticity of every person in an organization" (De Pree, 1992, p. 72). Doing so allows everyone to reach his or her potential rather than simply meet metrics (De Pree, 1992). Furthermore, true servant-leaders within the Catholic health ministry are better able to avoid causing suffering and instead, bear the suffering of those they lead (De Pree, 1992). Empathy forged in this intentional acceptance of another's suffering allows leaders the ability to be compassionate and merciful when implementing decisions that affect those they serve (their employees). Doing so on a macro scale proves more difficult but just as worthy when a servant organization serves its community.

Over time, the legacy stories of the Catholic health ministry have become legends within the communities they served. I had the opportunity to serve in one particular health system embarking on a new way of conducting community needs assessments. Previously, this hospital's community needs assessments were conducted through research done primarily through data mining demographics and other external, seemingly objective sources. These methods were reasonable at the time and saved on the costs of exhaustive focus groups and interviews. But they were missing an organic and life-giving sense to them.

One day, a senior level leader chose to have lunch with some of the maintenance staff and learned that one of their buddies in the shop had lost his home and was sleeping in his car in the

hospital parking lot. During a conversation with the larger leadership team when we were sharing the initial findings of the external data review for the needs assessment, this leader spoke up, naming the pain he felt in learning that one of his own was suffering. His empathic response sparked conversation and change and as such, needs assessments began to integrate personal interviews rather than simply reliance on external data collections; focus groups versus computer files; and real human subjective stories in addition to historical objective data. Hearing people's and community organization's stories helped the organization shift its approach to assessing not simply the needs of our communities, but the strengths as well. This change transformed the relationships the hospital had with its community primarily through recognizing the strengths and assets in the community as fertile soil in which to plant the seeds of partnerships, collaborations, and mutual service in hope of further transforming individuals' and communities' lives. Epiphanies such as these were the initial life-blood of deepening loving relationships through dialogue and relationship.

Within the tremendous chaos that is health care today, the Catholic health ministry commonality with servant-leadership is a lit beacon of hope. However, it takes intention for leaders to first embrace a servant's heart and then choose to lead, avoiding thinking that by leading others one is serving. With intentional work, leaders may find listening and engaging in the informal culture of their organizations, invigorating and infusing experiential wisdom to shape policy and one's leadership style. Certainly, followers see leaders' authenticity

and engagement as strengths, especially when coupled with competence and accountability. Modeling authentic concern for those at the margins is not simply embedded in Catholic health ministry mission and values statements, it is an outward sign of love for the innate goodness and humanity of each person the leader serves. Service is, gratefully, an ego-less pursuit, as a true servant-leader knows when to lead, and when to follow. Loving relationships animate this style of leadership as leaders seek to love themselves, those they serve, and empower their organizations to serve the communities in which they live. Doing so gives honor to the legacies they have grown from and allows these servant-leaders to thrive and enable those they serve to become servants themselves.

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