ASPIRATIONS of a SERVANT LEADER

BY THOMAS C. DOLAN, PHD, FACHE, FASAE
LIKE MANY OF YOU, I HAVE ALWAYS ASPIRED TO BE A SERVANT LEADER.

Robert K. Greenleaf developed the concept of servant leadership in the 1970s. An executive for 40 years with AT&T, Greenleaf felt the power-centered authoritarian leadership style that was so prominent in U.S. institutions was not working. The concept of servant leadership was his solution.

Greenleaf defined a servant leader as “a leader who is a servant first.” He wrote that “servant leadership begins with the natural feeling that one wants to serve—to serve first. Then, conscious choice brings one to aspire to lead.” I am sure we can all identify with this statement.

How do you know servant leadership when you see it? Greenleaf pondered: “Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants?”

Many of us entered the healthcare field because we wanted to serve. Initially we did a specific clinical or nonclinical job. It was only after that experience that we became managers with the responsibility of leading others. That is why I feel servant leadership is so relevant to our profession. It is the kind of leader I have tried to be throughout my career. In this article, I will describe some of the many challenges I have faced in striving for this goal.
OVERCOME OVERCONFIDENCE
One of the greatest challenges for any leader is overconfidence. I often say hubris can destroy your career. So why, then, are so many executives overconfident? There are a number of reasons.

First, we have difficult jobs that require self-confidence, whether it is leading a unit, department or whole organization. Second, we seldom, if ever, get universal agreement on our decisions. No matter what we decide, there will always be naysayers. Finally, people often criticize our decisions and may even ask that we be terminated. More than once during my tenure as president and CEO of ACHE, its Board of Governors received a letter expressing that ACHE would be a better organization if someone else were CEO.

As a defense mechanism, we become overconfident and begin thinking we are right more often than we actually are. This reminds me of an urban legend-turned-TV commercial and now popular YouTube video in which we see a U.S. Navy captain sternly requesting that an unknown vessel at sea divert its course to avoid collision. When the other vessel replies that it will not change course and instead requests that the Navy ship divert its course, the Navy ship makes the request again, this time more sternly. Finally, the other vessel replies that it is the Navy ship’s call about what it wants to do—because the mystery vessel, it turns out, is actually a lighthouse. I have to confess that I have often expected lighthouses to move for me.

TALK LESS, LISTEN OFTEN
Another big problem with overconfidence is that you do not listen to others enough, or others do not tell you what they really think. This can have disastrous consequences; we are all familiar with what happens if a surgeon ignores comments from her or his surgical team.

There are a number of things I try to do to address this problem. Even though I love the sound of my own voice, I continually try to talk less. My mother identified my tendency to talk early on in my life when she told me there was a reason God gave me two ears but only one mouth. When this did not work, she often said, “Better to remain silent and be thought a fool than to speak out and remove all doubt.” I was in my 20s when I realized my mother was quoting Abraham Lincoln.

Even the noted management theorist Will Rogers once said, “Never miss a good chance to shut up.” And Robert Greenleaf said, “In saying what I have in mind will I really improve on the silence?”

This article is based in part on the Parker B. Francis Distinguished Lecture given by Thomas C. Dolan, PhD, FACHE, FASAE, president emeritus, ACHE (above), during the Opening Session at the 2013 Congress on Healthcare Leadership in Chicago. The lecture can be viewed at ache.org/Congress.
While I enjoy sharing my thoughts, I have learned that while I am talking others cannot. As leaders, we must pay attention when people speak. How many of us are checking email when we are on the phone or in a meeting? One cannot really pay full attention to a speaker while doing this.

Also, try to really understand what others are saying. Early on in my marriage I realized when my wife, Georgia, said “we’ll see” to me or our children she really meant “no.” After working a few years with your new ACHE President/CEO Deborah Bowen, FACHE, CAE, I realized that when I said something to her and her reply began with the phrase “help me understand …” it was not because what I said was so profound. It was because she could not believe somebody my age could be so wrong.

Leaders must encourage others to speak. Rather than giving answers, ask questions. And when you receive answers, withhold immediate judgment. If you do disagree with the response, use comments like “have you considered?” and “have you thought about?” rather than immediately discounting the answer.

Finally, I think it is very important to apologize when wrong, an opportunity I get to do often. Followers need to hear you take responsibility for your mistakes, so apologize, whether it is to an individual, a group or a total organization. We talk a lot about the importance of medical apologies. Equally important are our management apologies.

LIKE THE PEOPLE YOU SERVE ... AND BE LIKED BY THEM
I try to like the people I serve—and be liked by them. How many of you have heard, “Leaders do not have to be liked, they just have to be respected?” It was a philosophy I was taught and that I employed for many years. As James Kouzes and Barry Posner say in A Leader’s Legacy, “Like and respect are not mutually exclusive.”

But liking people and wanting to be liked by them makes us vulnerable. It makes it harder to hold people accountable, reprimand them and maybe even fire them. Leaders sometimes hurt others and get hurt themselves. So how do I address this challenge?

First, I try to like the people I serve. This is not always easy when you hire people who are different from yourself. The older I have gotten, however, the more comfortable I have become hiring people who are different than myself. One of the best compliments I have ever received was when someone said to me, “How do you work with some of these people? They are so different than you.” People who are different than me may have been more difficult to work with, but they complemented my skills and made ACHE a better organization. An organization of all Tom Dolans would have been a disaster.

I did have to learn that no one came to work to make me miserable. I tried to put myself in their shoes and get to know them. It enriched my life, and I believe it made me a better leader. I also hope my co-workers at ACHE learned that I did not come to work to make them miserable.

Second, I try to be liked by the people I serve. We all have heard the golden rule—treat others as you wish to be treated. Unfortunately, it often does not work. People really want us to abide by the platinum rule—treat others as they wish to be treated. This does work. While it may not always be possible, it is something I strive to do.
TELL THE TRUTH AS YOU SEE IT
While you should try to be liked by the people you serve, it is equally important to tell the truth as you see it and then act on it. Let me highlight the term “as you see it.” Often in my career I would see a situation one way, and others would see it a different way. Neither of us was totally right nor wrong, which underscores the importance of always listening to and trying to understand others’ perspectives.

Another leadership edict I live by is that we should not accept for others what we would not accept for ourselves. How many of us have or have had supervisors in our organizations whom we would not want to be supervised by? How many clinicians are there in your organization from whom you would not want to receive care? I am not referring to individuals who are not the absolute best in the organization, but, rather, those whose performance falls below an acceptable level.

While no one likes to do performance reviews, that is a way to address these poor performers. Too often we highlight individuals’ strengths and ignore their weaknesses. I know I have done that when I have given performance reviews.

Sugarcoated performance reviews, however, often lead to a situation in which the employee must be discharged. And then how often do we delay doing that?

Not discharging a poorly performing employee after counseling and training is unfair to our patients, their co-workers and even the employee.

These challenges, of course, are magnified at the organizational level. Organizational decisions and their ramifications are a far greater challenge. I remember vividly when ACHE’s Board of Governors and I felt it was necessary to streamline ACHE’s credentialing process. Even under the very capable leadership of our Chairman at the time, William Schoenhard, FACHE, the former deputy under secretary for health for operations and management, Department of Veterans Affairs, a vocal minority disagreed with the decision. They were the catalyst for the *Modern Healthcare* cartoon, at left.

Of course, this cartoon is tame compared to the ones that will be drawn of you when you close and merge facilities. I hope you will remain steadfast in doing what you think is right.

You face similar challenges within your organizations. For example, why are we still hiring smokers in healthcare? In my opinion, only nonsmokers should be hired in the future. And existing smokers should be given a reasonable amount of time—with support—to quit smoking or face termination. While a more difficult problem, it is not unreasonable to expect overweight employees to reduce their BMIs if they are too high. Again, we should provide support and assistance.

I also wonder why we are retaining clinicians who will not get flu shots or wear masks when they are with patients. Do we really question the efficacy of the flu vaccine? Do we not believe we are putting patients at risk by exposing them to individuals who may have an easily preventable disease? Healthcare organizations need to model healthy practices.

These types of challenges become even greater at the community level. Society today must demand that
individuals take more responsibility for their health. As we all know, a large proportion of illness in this country is self-inflicted by poor lifestyle choices: poor diet, lack of exercise and smoking, to name just a few. One-third of our population is overweight and another third is obese, creating an epidemic of diabetes and other weight-related diseases. Especially frightening is the increase in these diseases among our nation’s youth.

I used to think it was wrong to charge different rates for health insurance based on an individual’s health; I no longer do when it is self-inflicted. I believe we should use both the carrot and the stick. I think employers, especially healthcare employers, should financially reward employees who meet certain health standards such as BMI, blood pressure, cholesterol and not smoking. We do so at ACHE. Unfortunately, I think we also have to take the next step by charging individuals with poor health habits, like smoking, more for their health insurance. This seems to be the only way to get some individuals to take more responsibility for their health.

Some will say these standards will be more difficult to meet for certain populations like low-income individuals. While I know there is some truth to this, I believe the solution is to provide these groups with additional assistance in meeting these standards rather than ignoring them.

DIVERSITY AND INCLUSION: EASIER SAID THAN DONE

Borrowing from the terminology used by the American Society of Association Executives when discussing diversity and inclusion: “Diversity” refers to the composition of a group of people from any number of demographic backgrounds and identities (innate and selected) and the collective strength of their experiences, beliefs, values, skills and perspectives. “Inclusion” is the act of establishing philosophies, policies, practices and procedures to ensure equal access to opportunities and resources to support individuals in contributing in the organization’s success.

WE ALL HAVE HEARD THE GOLDEN RULE—TREAT OTHERS AS YOU WISH TO BE TREATED. UNFORTUNATELY, IT OFTEN DOES NOT WORK. PEOPLE REALLY WANT US TO ABIDE BY THE PLATINUM RULE—TREAT OTHERS AS THEY WISH TO BE TREATED. THIS DOES WORK.

I am sure we would all agree that diversity and inclusion are the right things to do. Society’s challenges are so great—why would we exclude anyone from assisting us in addressing them?

I also hope you agree that a multicultural society requires multicultural leaders. Unfortunately, as reported by the American Hospital Association’s Institute for Diversity in Health Management and Health Research and Educational Trust, while minorities represent a reported 29 percent of patients nationally, they comprise only 14 percent of hospital board members, 14 percent of executive leadership, and 15 percent of first- and mid-level management positions. This situation must change.

Why is diversity and inclusion a challenge for society? Because most people are most comfortable being with individuals who are like themselves. We need to recognize our conscious and unconscious biases and how they affect our behavior. The problem is denying our biases or acting on them inappropriately.

How do I address my biases? Many years ago I decided to spend more time with people who are different than me. For example, I periodically went to the annual meeting of the National Association of Health Services Executives, the nonprofit association of black healthcare
executives in the U.S. Not only did I find it difficult to be the only white person in the room, but I also found it somewhat intimidating. In fact, I actually felt lonely and sorry for myself until I reminded myself that this was an everyday occurrence for most black professionals in our field. More importantly, exposure like this to people who I felt were different from me actually taught me we are more alike than different.

Another way I tried to address my biases throughout my career was to actively recruit for diversity and train for inclusion. An organization with a homogenous workforce will not find diverse individuals where they have recruited in the past. They must use new and different mechanisms to attract diverse employees. They must then create inclusion by establishing philosophies, policies, practices and procedures to ensure equal access to opportunities and resources to support individuals in contributing to the organization’s success.

While a diverse and inclusive society will be difficult to achieve, we must continually strive to do so.

**FINAL THOUGHTS**

The national high school debate topic in 1964 was “Resolved: That Social Security benefits should be extended to include complete medical care.” I debated both sides, but I really believed senior citizens should receive complete medical care. On July 30, 1965, Medicare was signed into law. I thought to myself, “That was pretty easy.”

When I entered healthcare management graduate school in 1969, many of my professors said a national healthcare program was “right around the corner.” It took 41 years for the Accountable Care Act to become law. My generation wanted to provide healthcare for all; I believe in the next 10 years we will.

As servant leaders, we need to provide our patients and communities with effective and efficient healthcare services. While we will continue to make scientific breakthroughs in medicine, we need to more effectively disseminate the scientific advances we have already made.

We may have a shortage of healthcare professionals in selected areas, but a lot of this could be remedied by allowing everyone to work at their maximum capacity and delegate lesser tasks to others. We also do not need more money. In fact, healthcare costs are consuming dollars that cannot be spent on education, housing and other services that have as much, if not more, impact on health status.

What we do need is more leadership for our patients, communities and society, and I believe you are the leaders who will provide it.

*Thomas C. Dolan, PhD, FACHE, FASAE, is president emeritus of ACHE. He retired in May 2013 after 22 years of service as the organization’s president and CEO. He can be reached at tdolan@ache.org.*