14

Improving Health Care Organizations Through Servant Leadership

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Improving Health Care Organizations

Public health care is faced with growing challenges as the government and public demand more health care but the government does not increase funding proportionally. Health care systems respond to these challenges by rationalizing work and implementing new and more cost-effective procedures. Rationalization has been implemented often using the principles of lean manufacturing, which has become a dominating approach (Hasle et al. 2016) with some hospitals developing their own

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approach to lean (Winkel et al. 2015). Rationalization is often initiated by hospital management and pushed to the wards. New procedures are driven by the desire of occupational groups for keeping up to date within their fields. Health care is also faced with changes imposed from outside such as political changes, structural reforms and changes in governance linked to a relentless pace of change.

The practical reality of change is played out in the day-to-day health care work. Here doctors, nurses, therapists and patients converge to carry out treatment. Treatment is an interaction between the immediate idiosyncratic needs of the patient as well as predefined care processes and structures. Health care professionals use predefined processes to leverage efficiency but at the same time bypass the processes and rely on professional discretion should the patient's condition require so. While processes exist they are difficult to maintain due to changing staff and patient requirements. Health care work is a fluid and constantly developing practice where health care professionals navigate and adapt. Such adaptability is admirable and flexible but also a source of variation in treatment, frustration among staff and lack of efficiency.

This self-development of practice reflects that health care adapts and it also highlights what we believe to be a potential problem: development is based on individual professional discretion negotiated by solving concrete patient problems. A blunter statement is that the system relies on trial and error to develop practice. Health care managers and leaders are absent from this development, not because they choose to but because they have no role.

However, literature indicates that the quality of first line management is foundational to organizational empowerment and social capital in health care and facilitates ongoing changes (Strömgren et al. 2016, 2017). In this regard, there are reasons to believe that servant leadership of first line managers can be useful for successful change management. Servant leadership is characterized by intrinsic interest in other people's ideas and interests as well as self-knowledge and a clear vision and foresight (Greenleaf 1970/2010).

The purpose of this chapter is to present a model for developing care processes and well-being at work in hospital wards. We argue that the ward manager/nurse plays a central role for leading change in a hospital ward and develop practice. The ward manager must become a servant leader (Greenleaf 1972/2009) who creates organizational social capital (OSC) (Olesen et al. 2008) and balances a top-down approach where changes are instructed with a bottom-up approach where changes are suggested by staff. We argue that social capital among professionals and employees also has a crucial role and is intertwined with ward managers practicing servant leadership. Servant leadership is practiced by the ward nurse in both the development and implementation of care processes. Social capital grows as processes are developed through collaboration facilitated by the servant leader ward nurse.

The chapter begins with a brief introduction to servant leadership as a practice model and OSC. This is followed by a study that underpins our model which is then presented and discussed in relation to how servant leadership at more organizational levels contributes to improvement work through strengthened OSC.

Core Elements of Servant Leadership

In his foundational writings, Robert Greenleaf emphasizes that a good leader must first be a good servant (1970/2010). To be a good servant, in this regard, relates to the ability to be a good listener, to develop self-awareness and to have a clear foresight. These characteristics are then related to community of equals, sharing of ideas and demonstrating courage to create and develop new ideas and approaches to solve problems. A servant leader fosters accountability among his coworkers. His daily work is characterized by being tough on the problem and gentle on the person; he is at the same time a servant and a leader. These elements are important for the development of mutual trust and in particular for the creation of trust toward the leader and his or her ideas (Hayes and Comer 2010). A servant leader is known to be a person of principles who decides to use different management and leadership styles depending on circumstances and current tasks (Prosser 2010).

According to Greenleaf's writings servant leadership can be modeled by three interdependent core elements, that is, sincere interest in others, self-knowledge and foresight, see Fig. 14.1. These elements are based on Greenleaf's foundational ideas (1970/2010) and the three elements are related to various sub-elements of servant leadership. The core elements can each be placed on three corners of a triangle. The triangle can be drawn as an opposite hierarchical triangle to emphasize the difference between the two approaches. The elements can also be linked by a circle in line with Greenleaf's emphasis on a circle of equals and friends. Related concepts can be placed on the sides between the triangle's corners to demonstrate how the core elements are interrelated (Gunnarsdóttir 2011).

The first core element of the model is *sincere interest in other people* and is based on Greenleaf's foundational emphasis about the servant leader being a servant first. This is demonstrated by an ability to build strength in other people by true listening, to facilitate dialogue and the ability to empower.

The second core element is *self-knowledge* which is foundational to the ability of the servant leader to know one's strengths and weaknesses. Self-knowledge is developed by reflection and the ability to withdraw to listen to oneself, to develop *awareness* and humility and to open the door of perception of inner voice and intuition.

These two core elements can be considered as building blocks of the servant part of servant leadership—the ability to meet other people's needs, to enjoy inner strength and the ability to be humble.

The third core element is *foresight and clear vision*. This element can be considered as the leader part of servant leadership placed at the bottom corner of the triangle. The leader part is characterized by the ability to provide focus and direction and to create important goals, a common great dream, and shared purpose and accountability. The leader's strength is having overview, and the ability to have foresight is according to Greenleaf a prerequisite and foundational to the leader being able to be a true leader. According to this threefold model servant leadership is practiced through the core elements which are interwoven and linked by related concepts such as the will to serve, community of equals, and humility (see Fig. 14.1).

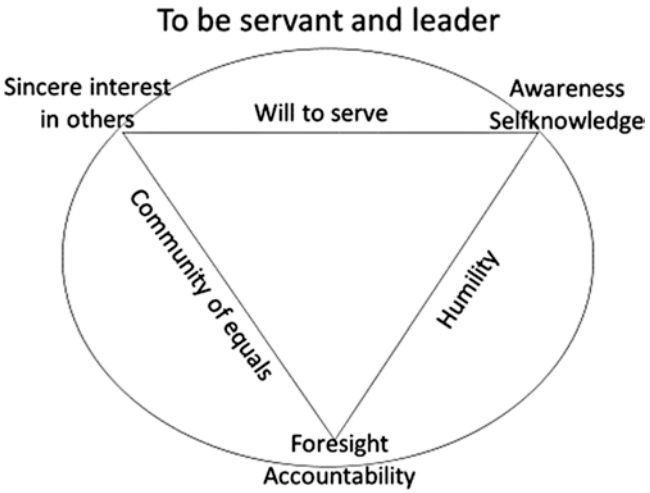

Fig. 14.1 Threefold model on core elements of servant leadership based on Robert K. Greenleaf's original ideas (Gunnarsdóttir 2011)

This threefold model underpins the goal of servant leadership according to Greenleaf, which is to contribute to the development of many servant leaders such that there are leaders in every chair of the organization (Greenleaf 1970/2010). For this purpose, Hayes and Comer (2010) state that the servant leader is an empowering role model who facilitates dialogue, helps other people to shine and has a particular ability to create and sustain trust. Recent health care research provides evidence to what Greenleaf called the best test of servant leadership, that is, "that those being served become more autonomous, healthier and wiser and are willing to become servants themselves" (Greenleaf 1970/2010, p. 15). An example of these studies regards a link between servant leadership of first line nurse managers and nursing job satisfaction, nurse freedom to control own work and opportunities for professional development (Rafnsdóttir et al. 2011). Also, a significant link has been identified between higher levels of servant leadership of next superior and higher levels of engagement (e.g. Hakanen and Dierendonck 2012) and commitment to change (Kool and Van Dierendonck 2012).

Core Elements of Organizational Social Capital

While servant leadership describes a certain way of practicing leadership, a role, OSC characterizes certain kinds of relationship in a group. OSC is a term that can trace its lineage back to the early 1970s where Granovetter (1973) analyzed the strength of weak ties. Bourdieu (1986) extended the concept of capital to a person's ability to mobilize his/her network. Coleman (1988) builds on Bourdieus' notion of OSC as a product of a social network and further added human capital, for example, education, to the concept. OSC became a functional resource tied to the strength of a group's relations resulting in relative higher productivity due to higher levels of trust. Putnam (1995) further developed the concept by characterizing the relations between and within social groups, that is, bridging and bonding social capital. Woolcock (1998) reiterates the importance of the social network and argues that trust, norms and mutual dependency are central to forming OSC. Olesen et al. (2008) focus on the concept of OSC further and point to the group and its *key task*.

We use the definition by Olesen et al. (2008): OSC is the ability of the members of the organization to collaborate when solving the key tasks of the organization based on trust and justice. This definition is extensively used in the Nordic countries and part of the COPSOQ (Copenhagen Psychosocial Questionnaire) (Pejtersen et al. 2009).

Where servant leadership is a behavior, OSC is the resulting group effect and a tangible resource that translates into job satisfaction and high organizational performance. Servant leadership develops relationships based on trust and justice between followers thereby creating social capital. A servant leader has foresight and clear vision of the work, which result in a focus on defining the key tasks. This is instrumental for collaborating in a group, and a common understanding of the key task allows the group to discuss and organize work.

OSC has distinct temporal properties as trust and justice are formed over time and not given. Leadership can influence OSC by working with the elements in the context of the key tasks. Trust is increased if our perceptions are reinforced—a promise made and kept builds trust. Accountability results in trust not only in the leader but also between

workers because the servant leader makes workers accountable for their key tasks. Over time workers learn to trust each other because they are made accountable by and to the leader.

A servant leader's desire to create a community of equals results in perceived justice among followers. Perceived justice is a powerful personal trigger of negative behavior toward the organization if imbalance is perceived. Justice may be broken into several dimensions such as procedural, interpersonal, informational, and so on, which are determined by the leader. In a community of equals there is a high degree of perceived justice.

Developing a Model of Practice Servant Leadership in Health Care

The recent scientific findings connected to servant leadership highlight the need to better understand how servant leadership actually works in practice in various settings and contexts. In health care service, leaders often operate on a day-to-day basis and often face many difficulties in translating, interpreting, integrating and implementing regulations, improvements and health objectives (Tengblad 2012, 2017; Dellve and Eriksson 2017). Therefore, in further development of successful leadership during organizational changes in health care we applied more practical perspectives of managerial work practices to explore and further understand the complex social practices of managerial work that create sustainable changes (Andreasson et al. 2016; Eriksson et al. 2016).

This perspective shifting is supported by, for example, Barley and Kunda (2001), who argued for focusing more on the work itself than on more abstract ideas of how organizations should look, and Lawrence et al. (2011), who argued for bringing individuals back into organizational studies and institutional theory. They highlighted the importance of individual managers who actively interact with others (their social roles) in institutions allowing for a substantial degree of freedom and choice in the interest of organizational capacity. Results from such studies using shadowing and interviews in the Nordic countries have described

managerial work in public human service organizations in ways that include fragmentation, uncertainties, conflicts of values and loyalties, high-performance pressures, and often a hectic work pace and long working hours (Tengblad 2017; Dellve and Eriksson 2017; Arman et al. 2012; Gunnarsdóttir 2006). The present study contributes to further understanding of managerial practices, and the findings highlight the importance of practice servant leadership in health care.

Inductive, constructivist perspectives that are sensitive to context and defined by managers' handling and organizing in practice were used. Thus, the study was not theoretically driven by the concept of servant leadership but driven by characterizing the practice of leadership that emerged as successful for implementing and sustaining improvements. This successful practice was studied in connection to a research program of sustainable organizational improvements and redesigns of care processes (Dellve et al. 2016).

Study Context and Method

In Sweden, health care is tax-funded and politically governed by 21 county councils, each responsible for providing health care to citizens within their geographic area. In Swedish health care service, the hospital management group is accountable for the overall strategies in improvement work and the clinical and ward management is responsible for operative day-to-day clinical activities. Governance of public health care service during the last decades has been strongly influenced by ideas connected to New Public Management (NPM). In short, NPM aims to mimic efficiency and clearer control in the private industry through, for example, focus on management responsibility, use of standardized methods and transparency (Berlin and Kastberg 2011). However, the criticism against NPM has been hard from operative managers and professionals due to, for example, reduced influence over their work. This has implied, for example, that they chose not to participate or engage in organizational development work (Choi 2011).

Five middle-sized hospitals in three county councils were observed during a five-year period. We used a combination of qualitative and quantitative research methods and focused on leadership at both operational

and strategic levels. The data collection started with interviews with strategic key persons for the management of development work at the hospitals (n = 48). These interviews focused on identifying strategy, planning changes and clinics that were to implement change. Based on this, 22 units were selected and followed. All managers in the first and second line levels in the 22 selected units were interviewed (n = 40). These focused on conditions, goals, vision, approaches and approaches to development and took about one hour each. Follow-up interviews with observations of the work were conducted throughout the years or at least yearly, with line managers (n = 57), development managers and support functions in the development work (n = 51). Focus groups were also held with care professionals at all participating emergency units in the hospitals, at baseline and after two years. In addition, all health care professionals (nurses and physicians) working at the 22 selected units and all managers at the hospitals answered annual surveys.

The 22 units were sorted into two groups: (1) successful implementation of change and (2) failure to implement change. The analysis compared leadership of success and failure in line with the grounded theory approach (Charmaz 2006). This allows us to identify characteristics of practice servant leadership.

The Practice Servant Leadership Approaches Supported the Crafting of Improvements

The results showed that most improvements at the hospitals' operative units happened slowly. Despite great efforts from the management group and change agents, there were on average small changes in the redesign of care processes and their outcomes with regard to efficiency and quality of care, during the three-year follow-up (Dellve et al. 2016).

There were some units that were more successful with improvement of care processes and increased engagement among professionals. These were characterized by a more practice servant leadership approach focusing on the care processes and work context at the unit. The ward managers' leadership approach played key roles in improving care processes through their crafting and optimizing of resources and engagement

among employees. These managers had good experience as managers and had knowledge of the health care context. They had also arranged more shared or distributed leadership through their servant leadership approach which, in turn, also served their success. However, a practice servant leadership approach at first line was supported by a similar leadership approach at the second level and hospital management levels. Their governance and implementation by balancing the need for cost reductions and improvements with trust and focus on professionals' knowledge were associated with more engagement and less frustration and exhaustion among employees. Thus, change management approaches from all organizational levels, which adjusted the implementation strategies to each units' specific conditions and core business, had importance for changes in practice.

How can we explain the success in sustainable improvements found at wards where there were practice servant leadership approaches among the ward managers? We believe that the practice servant leadership could bridge over and compensate for the many gaps seen in hospital organizations in management and communication (between politics—hospital management—clinical management—ward management—professionals/employees). These gaps imply challenges for implementation strategies to have impact in practice, and on the other side unrealistic planning of implementation strategies that have poor possibilities to make relevant impact on operative levels. Earlier studies have highlighted this through other concepts such as "hybrid leadership", that is, managers who are actively bridging and communicating across hospital organizational levels and between professional groups have more success in sustainable organizational developments (Wikström and Dellve 2009; Choi 2010).

However, these could not explain the core aspects of when and how bridging the gaps was conducted. Instead, servant leadership provided best explanations for successful leadership during improvements in health care. The managers in the successful units all showed qualities associated with servant leadership, such as sincere interest in other people expressed by empowering and developing people; self-knowledge expressed by humility, authenticity and interpersonal acceptance; and foresight expressed by stewardship and by providing direction (Van Dierendonck 2011;

Gunnarsdóttir 2011). Further, they were engaged in the actual practice of the units and approached central patterns of handling strategies in their servant leadership to practical and tangible improvements in the units. Therefore, the approach was labeled "Practice servant leadership" (Dellve 2015).

In the following the core elements of a practice servant leadership in health care contexts are described in terms of anchoring including continuous dialogue, learning through visualizing, and follower- and practice focus. To illustrate the practice servant leadership, as a further contribution to theory of servant leadership, we describe practice servant leadership in relation to traditional leadership in Nordic health care organizations, which has strongly been influenced by the dominating governance through NPM, see Fig. 14.2.

Loci of Anchoring

Loci (Lat: places) of anchoring highlight that anchoring happens at a particular place as a part of practice. Such loci of anchoring are often actual physical places where staff meet and either work or discuss work. Loci interconnect management and practice between various organizational surfaces, that is, levels—positions—functions—professionals. Anchoring practices are to support learning and understanding over levels, to involve in solving continuously arising and complex challenges in practice.

Active and continuous dialogue is one locus to anchor change and refers to how to solve urgent and relevant issues that continuously emerge in different phases of the implementation. The practice servant leader engages in the dialogue when and where it arises—this is the locus of anchoring. In contrast, the opposite approaches could be characterized by distancing and detaching from other positions—levels—functions or professionals with clear assignments, delegated responsibilities and respect for the separated functions. This non-anchoring approach was defended through the argumentation of being more professional, having separate responsibilities, and that one's function had provided the other with decent preconditions.

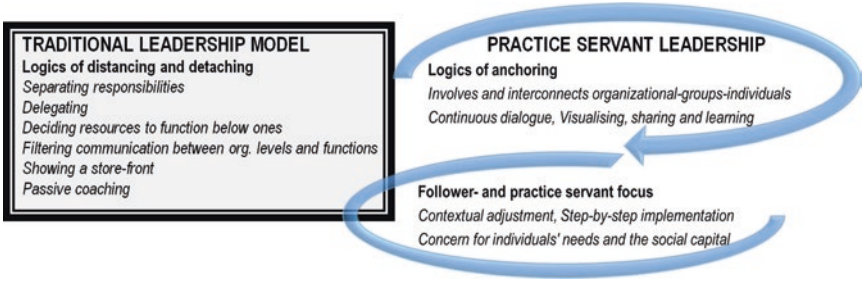

Fig. 14.2 The model describing central approaches in practice servant leadership that support crafting improvements in health care and the traditional leadership model influenced by New Public Management (Dellve 2015)

To support the anchoring, ward managers also used *visualization* of processes, developments, suggestions and follow-up data to support the broader learning and understanding of the development process. Thus, the visualization was a locus and important tool for anchoring leading, communicating and learning. It was important to have a simple, understandable and structured method for the development work, to select a couple of care processes, to illustrate the development process and outcomes, and use the visualizing tool in everyday work. Our studies showed that the daily use of visualization supported employees' cognitive overview, understanding of complex processes, perceived influence and also more active engagement in suggestions to improve care processes (Williamsson et al. 2015). Visualization from strategic management was also used to act as role model, to increase goal clarity and to support employees' understanding of prioritizing and desired outputs of increased quality and efficiency. The more the servant leadership approaches were characterized by two-way communication flow the better the adjustment between operative and strategic levels.

In contrast, the non-anchoring approaches used internal one-way communication (top-down) and store-fronting communication, that is, to show up results to media and county council without connection to real conditions, circumstances and outputs at operative levels. Common for the non-anchoring approaches was their lack of connection to practice and loci.

Follower- and Practice Servant Focus: Developing Organizational Social Capital

Central among practice servant leaders was also having a *follower- and practice servant focus* to build capacity for improvement work through social capital, engagement and trust among employees as well as more patient-centered improvements of care processes. Such a servant leadership approach asked actively and continuously how to support employees and the functions below their positions in their work to adjust implementation and develop care processes in practice. For example, in their monitoring work through key performance indicators (KPIs), the

practice servant leaders increasingly asked the level below about what KPIs to follow that had relevance for their work and best supported a constructive meeting between operative and strategic management and local visualization. The created trust and spurred social capital between leaders and followers ensured that KPIs would support the key task. The KPIs became a reference point to discuss and focus collaboration toward and thus a locus of anchoring.

The choice of KPI was based on the actual needs that exist in practice as well as opportunities and competence to work with developments. The advantages are that the person being checked ensures that the control is effective and fits the reality. This check instills justice in both the KPI and the relation and creates social capital. In addition, the dialogue provides the ability to understand what works and what does not work. It can improve the ability to negotiate and act as well as spread knowledge about opportunities and experience within the organization. Thus, this made the follow-up more effective and created less irritation among professionals over non-relevant administration and control. Governance by these principles also created a focus on KPI related to more patient-centered issues. This form of governance can be compared with more trust-building management and so-called horizontal control (Noteboom 2002). In contrast, traditional control through, for example, NPM governance often takes place with vertical control. Such a "top-down" control can be counterproductive and create illusion of control, despite long distances to the clinical business and inadequate competence about conditions of importance.

The practice servant leaders were characterized by having a *broader awareness of the various aspects and perspectives that influence progress in development work*. Contextual knowledge and experience as manager were important conditions for creating meaningfulness, engagement, trust and a sense of fairness among employees during development work. By managers' contextual knowledge of the clinical work, they could better adapt the development model to the conditions at the clinic in terms of care, staffing and competences. Thus, organizational improvements through implementation strategies could be meaningful and functional and anchored at the clinic through necessary adjustments and applied communication. In addition, the successful practice servant leaders also

had a good knowledge of the strengths and challenges of individual employees as well as professions, teams and other groups that are linked to the core processes in different ways. More experience as managers was also important to handle the complex challenges that are connected to development work. This broader awareness is often implied in a step-by-step implementation to adjust according to contexts and employees. The adjustments were related to awareness of the following:

(a) Social capital as a decisive resource for development work and careful supporting of the social capital and equality through leadership, especially relationship oriented
(b) Individual employees' needs and supporting them by taking into account individuals, listening and ensuring the individual's needs for support and development opportunities
(c) Importance of clinical significance of development work, that is, awareness of the frustration that may arise among professionals through the top-down implemented rationalizations; that these are sometimes perceived meaningless, administratively burdensome and creating time conflicts

Discussion

In this chapter we have proposed contributions to the servant leadership theory from a managerial practice perspective exemplified by health care in the Nordic countries. Our findings are derived from close studies of managerial work that, despite great challenges during organizational improvements, was exceptionally successful in achieving results through mobilizing high engagement among professionals.

The key elements in their servant leadership approach were anchoring in practice and loci and having a sincere follower- and servant focus. This was conducted through their continuous work involving and interconnecting values, goals and challenges from organizational-, group- and individuals' perspectives; through continuous dialogue, visualizing complex processes as well as through extensive sharing and learning across boundaries. Through a broader awareness of the importance of the social

capital among the professionals for crafting changes, they implemented changes step by step to allow important adjustments according to the context.

In the following paragraphs, we will discuss the findings in relation to the core elements of servant leadership and to OSC. Last, we integrate the practice servant leadership, the core elements and the OSC suggesting a development of organizational servant leadership. The integrated aspects may have additional importance for creating organizational improvements in organizations such as those offering health care service.

Practice servant leadership relates to the three core elements proposed in the background. The first core element is the *sincere interest in other people*, such as the followers/professionals and serving them in their improvement work to increase efficiency and quality of care for patients.

Improvements in quality of care during times of necessary cost savings are very complex and demand collaborations and smooth processes of care. Thus, the managers need to build strength in other people from shared understanding of the complexity and goals (through visualization, listening, role modeling) and through true listening and the ability to empower. The studied servant managers also had arranged more shared or distributed leadership to support the engagement and development of others (Gittell 2009). The second core element is the *self-knowledge* and awareness of own strengths and weaknesses as well as of others and within context. The studied managers had extensive experience as managers and had knowledge of the health care context. This certainly supported them in having more balanced communication (Losada and Heaphy 2004), which also supported engagement among professionals. The third core element is *foresight and clear vision*, which essentially should focus on a deep concern for real improvements of core processes in practice, based on their knowledge of impotencies in the context—and not on ideas that are too strategic. These core elements are based on ideas of communities of equals and serving through humility and trust, discussed below in relation to serving OSC and illustrated in Fig. 14.3.

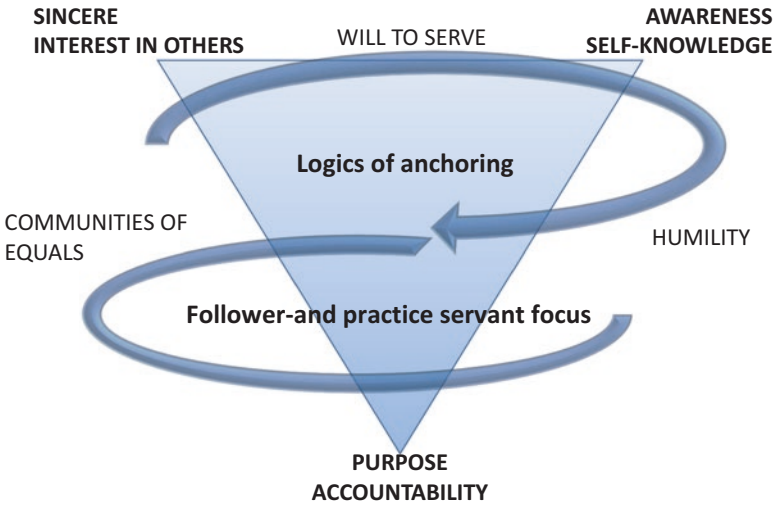

Fig. 14.3 A proposed model of developing practice servant leadership and social capital through integration of servant leadership (the triangle) and loci of anchoring, follower- and practice servant focus, and developing social capital (the spiral)

Mobilizing Organizational Social Capital

We argue that the mobilization of social capital among professionals is the core for crafting sustainable improvements, especially in health care organizations, where success relies on professionals' competence and engagement. OSC is the ability of the professionals in the organization to collaborate when solving key tasks of the organization. This ability is based on their trust and perceived justice. Thus the managerial work and leadership qualities have central importance in building the social capital that is needed to craft improvements in health care.

In line with the described findings, a leader must be close to his/her group to do so as promises between colleagues are as important as between leader and employee. A leader must find loci where trust, justice and collaboration may be practiced and ensure anchoring. Coordination meetings are one such locus; however, a leader must engage actively in

coordination and not simply distribute responsibility. Tasks and responsibilities must be assigned and most importantly followed up on. Thus, as described in connection to the practice servant leadership approach, managers need to operate from a broader awareness related to the social capital as a decisive resource for development work, individuals' needs and the importance of clinical significance to mobilize OSC among the professionals. This is an important extension of servant leadership—to be mindful of and take responsibility for the psychosocial dynamics of the group and reflects Greenleaf's original idea about servant leadership as presented by organizations as communities with focus on listening and empathy (Greenleaf 1970/2010). However, this is a tightrope as the practice servant leader must balance between humility, promoting a community of equals and developing the right group dynamics.

Servant Organizations

Servant leadership has provided understanding of successful leadership qualities. However, servant leadership on its own may fail to acknowledge the crafting aspects of leadership and the importance of crossing system boundaries for gaining positive effect in complex organizations. Here system theory approaches and practice perspective on managerial work and organizing may support the development of a theory of crafting sustainable work conditions that serves to adapt and adjust across organizational boundaries. Further, we argue that health care organizations that manage to improve their service in a sustainable manner need to account for and serve a number of perspectives and values—and integrate these in the overall management. Thus and in line with Laub (2010) we argue that organizations may also exhibit servant properties, that is, that organizations can be servant and non-servant. A servant organization is an organization where the culture values promote servant leadership. As such the values of servant leadership permeate the practice and employees' understanding and expectations of leadership.

Nordic hospitals are predominantly publicly financed and have been subject to NPM (Berlin and Kastberg 2011) with performance and financial goals and demand for increasing productivity. The strict performance

goals foster an instrumental approach to leadership, which is essentially transformed to management of increasing productivity. At the same time hospitals are organizations based on highly motivated and knowledgeable staff who will navigate the system to provide the best possible treatment. Each occupational group, for example, doctors, nurses, has its own professional development but is not directed together toward work processes in the wards. As such wards develop idiosyncratic practices which are adjusted to patients and treatments.

The performance focus and professional discretion generally make hospitals and subsequently wards non-servant organizations. However, as this study has shown, servant leadership can develop under these adverse conditions and be more effective than normal wards in implementing change. We propose that development of care processes constitutes an opportunity, a positive spiral, where servant leadership and social capital may develop and be sustained. This requires putting the needs of the led first and to treat workers as partners within the organization. Laub (2003) presents a model for servant organization which promotes valuing and developing of people, building of community, practice of authenticity, providing of leadership for the good of those led, and sharing of power and status (Laub 2003). Studies across different fields and professional groups have shown associations between servant leadership and positive workplace outcomes, such as team effectiveness, job satisfaction, leader trust, employee safety and employee attrition (Laub 2010). Also the findings in the presented empirical study showed increased work engagement and clinical engagement where there was a practice servant leadership approach from the managerial group to first line manager (Dellve et al. 2016).

An Integrated Model: Developing Practice Servant Leadership and Social Capital Through Processes

Based on our findings we propose an integrated model of developing practice servant leadership and social capital. This model is demonstrated in Fig. 14.3 and shows how practice of servant leadership is developed through integration of servant leadership based on three core elements of a triangle and loci of anchoring, follower- and practice servant focus, and developing social capital linked together as a spiral.

Further our findings show that the key to develop practice servant leadership and social capital is the development of care processes in the wards. This is a radical departure from professional discretion and not an easy change. Public health care experiences high variation among patients and wards must handle this. Consequently there are many different care processes in a ward where practice and skilled employees ensure that patients are well cared for. New processes mean that health care professionals must align practice with the new care processes. This presents an opportunity to develop both social capital and servant leadership. Developing new care processes by visualizing the activities and roles in the ward creates a common understanding of what from a social capital perspective can be understood as key tasks. Such visualizations are loci that allow anchoring of practice. Developing the care process also functions to develop collaboration between roles. A participatory approach allows staff to engage in the new processes thereby developing a common understanding. Mutual trust as a core element of social capital enhances communication and discussion about common goals. Clear foresight and a good sense for the meaning of work enhance motivation at work, in particular intrinsic motivation and willingness to meet the goals and standards of the organization, and thus strengthen accountability among staff.

Trust and justice are developed through the first line manager transforming into a servant leader. The servant leader turns abstract trust and justice into concrete action by taking the newly developed process seriously and insisting that the process must be followed: accountability is strengthened. While it is often difficult to break from existing behavior and follow a new process the servant leaders instill trust by enforcing the new process, and trust is learned over time. Justice is developed by confronting staff not following the new process in the same way. Whether a colleague who is not following the new process is a friend or a stranger the response must be the same.

A servant leader aims at balancing care for the individual and focus on accountability. This is a delicate balance of being gentle with the person and tough on the problem at the same time (Hayes and Comer 2010), being a servant and being a leader at the same time (Greenleaf 1970/2010).

This may be considered as practice of paradoxes or practice of balance. This is characterized by showing sincere interest in other people, knowing oneself, and focusing on goals and procedures. The servant leader is humble while being self-aware and fosters a community of equals (van Dierendonck 2011). This enables the servant leader to encourage people to do the same, that is, practice accountability and true care for fellow staff members and the patients. These core elements of servant leadership are linked together and can be presented as forming a triangle (Fig. 14.1) or a spiral (Fig. 14.2)—or integrated (Fig. 14.3).

Conclusion

The pace of change in hospitals is relentless and while care processes exist health care professionals use their knowledge and professional discretion to constantly develop practice. This is an admirable adaptability which, however, comes at the risk of variation in treatment, staff frustration and efficiency. We argue that hospital wards must develop stable care processes that support staff and allow for some professional discretion. The ward manager/nurse plays a central role in developing care processes. This role must be based on practice servant leadership, that is, servant leadership embedded in the practice of the ward. This is hands-on leading of the work and developing care processes in a ward. Such leading and developing cannot happen in the midst of treatment and must happen at loci of anchoring. A locus is a place where work processes are discussed, for instance, a wall visualizing care processes. The loci are the physical embodiment of the key task that is the foundation of social capital. The loci are the place to anchor a common understanding of the key tasks. Maintaining and discussing the care processes allow the practice servant leader a locus to develop trust and justice in the group. The practice servant leader is attentive to the psychosocial dynamics of the group and must balance between humility, promoting a community of equals and developing the right group dynamics and accountability.

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