

A CORRELATIONAL STUDY OF SERVANT LEADERSHIP AND REGISTERED  
NURSE JOB SATISFACTION IN ACUTE HEALTH-CARE SETTINGS

by

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## ABSTRACT

Health-care leaders must address registered nurse job dissatisfaction in acute health-care settings to mitigate the critical nursing shortage. The quantitative research study with a correlational design determined (a) the extent that RNs perceive servant leadership behaviors in nonprofit, acute health-care settings, and (b) the relationship between perceptions of servant leadership behaviors and individual job satisfaction. A stratified sample of 313 RNs from two nonprofit acute care hospitals in the northwestern U.S. completed the Organizational Leadership Assessment (OLA) instrument. Results indicate a strong correlation between perceptions of servant leader behaviors and RN job satisfaction in acute health-care settings. Implications for leadership include recruiting and developing servant-minded nurse leaders who can create a caring and satisfying servant-minded nursing practice culture.

## DEDICATION

I dedicate this dissertation to my family for their unwavering love, encouragement, and support. I am especially thankful for my beloved husband Dominick, who not only made the realization of this lifelong dream possible, but made the journey a dream in itself; my cherished son Nicholas, who encouraged me and studied along side me; and my loving parents Christian and Bernadine Hazen, who instilled in me a love for learning and provided endless support.

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## CHAPTER 1: INTRODUCTION

A primary determinant of job satisfaction for nurses is the relationship with the manager (Tourangeau & Cranley, 2006). Cline, Reilly, and Moore (2004) identified management practices, including “lack of support, ineffective measures, and failure to listen or respond to concerns” (p. 40), as the most common reasons cited for nurse dissatisfaction and turnover. Wagner and Seymour (2007) contended a humanistic leadership approach incorporating human factors leads to increased staff satisfaction in health-care settings.

Servant leadership (Greenleaf, 1977), which provides the theoretical framework for the current study, is a leadership model that may be related to job satisfaction among nurses. Although servant leadership was first recommended for the health-care setting by Greenleaf in the 1970s, empirical studies on servant leadership in health care were not conducted until the 21st century. Research studies established a relationship between servant leadership and job satisfaction (K. P. Anderson, 2005; Laub, 1999; Miears, 2004; R. S. Thompson, 2002), although in organizational settings other than health care. Only one study involved an examination of the relationship between servant leadership and job satisfaction among nurses (Swearingen, 2004). Although the findings revealed a positive relationship, the study was limited to the southeast region of the United States.

The current doctoral dissertation study extends the investigation of the relationship between servant leadership and job satisfaction to a different population and setting than previously examined. Upenieks (2003) reported the impact of the nursing shortage is greatest in acute inpatient settings compared to other health-care practice settings. Many nurses employed in hospitals are dissatisfied with their jobs and the

working environment (Sparacio, 2005). The levels of patient acuity in hospitals are increasing while patient length of stay is decreasing (A. R. Smith, 2006). The nursing shortage in acute health-care settings affects both the quality and the availability of care for patients (Donley, 2005). The issue of the nursing shortage is heightened in the northwest region of the United States by fewer registered nurses per capita than other regions (Roman, 2006).

Dracup and Bryan-Brown (2006) asserted that many health-care leaders are creating changes to build healthy, collaborative environments in acute care facilities. Collaborative practice environments that are humane, respectful, and rewarding increase staff satisfaction in health-care settings (A. R. Smith, 2006). The current quantitative correlational study reveals if servant leadership behaviors exist in the hospital setting and discovers if servant leadership behaviors are associated with nurse job satisfaction.

The study is significant because it generates new knowledge about servant leadership behaviors in the nursing profession. Findings from the study reveal which leadership characteristics affect job satisfaction from the perspectives of nurses, nurse managers, and nurse leaders. Improving leadership effectiveness can increase job satisfaction and mitigate factors contributing to the nursing shortage. Chapter 1 presents an explanation of the problem statement, background information, purpose, significance of the study, nature of the study, research questions and hypotheses, theoretical framework, definitions, assumptions, scope and limitations, and delimitations.

### Background of the Problem

Nursing shortages in the United States are cyclic. The current shortage, originating in 1998, differs from earlier shortages in persistence, increasing attrition

among nurses, expanding job roles, and unpredictability of full-time employment (Cohen et al., 2005). Fleming, Evans, and Chutka (2003) recognized the shrinking workforce, financial pressures, and increasing consumer demands as reasons for the expected continuation of the nurse shortage. The nursing shortage is predicted to worsen progressively over the next two decades (Chaguturu & Vallabhaneni, 2005). The Health Resources and Services Administration predicted a need for 1 million more nurses by 2020 and 3 million more nurses by 2030 to meet the health care needs of 30 million older Americans (Habel, 2006). An aging population, a doubling of chronic health-care illnesses among the aged, and an aging nurse force aggravate the predicted severity and continuation of the shortage (Chaguturu & Vallabhaneni; Woods & Craig, 2005).

Upenieks (2003) reported the shortage is particularly severe in acute inpatient care settings. The American Nurses Association reported a 13% vacancy rate for registered nurses, equating to 126,000 openings (Sparacio, 2005). Nurses leaving the profession severely affect the nursing shortage (Sochalski, 2002). Turnover among nurses with less than 1 year of employment ranges from 35 to 60%, costing hospital organizations \$40,000 per nurse (Halfer & Graf, 2006; Woods & Craig, 2005). Chaguturu and Vallabhaneni (2005) noted the contributing problem of early retirements, as up to 20% of experienced nurses retire early. The number of nurses graduating from nursing programs is inadequate to resolve the gap between supply and demand (Buerhaus, 2005).

Turnover among registered nurses has an inverse relationship with job satisfaction (Halfer & Graf, 2006), with turnover decreasing as job satisfaction increases. Studies showed a predictive link between job satisfaction and retention (Buerhaus et al., 2005; Garrett & McDaniel, 2001; Larabee et al., 2003; Lynn & Redman, 2005). Sparacio



(2005) also reported a link between nurses leaving the profession and job dissatisfaction. Sparacio described job dissatisfaction among hospital nurses as four times greater than job dissatisfaction among other U.S. workers.

In the hospital setting, health-care cost cutting and hospital restructuring compromise the work environment (Donley, 2005; Weaver & Ellison, 2004). Strategies such as reengineering, decreasing registered nurse positions, and increasing spans of supervisory control contribute to a dissatisfying work environment (Williams, 2006). Many acute and critical care nurses in the United States perceive health-care work environments to be in severe deterioration (“American Association of Critical Care Nurses,” 2005). Poor and ineffective relationships among health-care professionals are major contributors to unhealthy work environments (“American Association of Critical Care Nurses”).

Nurses confront difficult working conditions and receive little recognition or respect (Alspach, 2005). Manojlovich (2005) contended the work environment strongly affects nurses’ job satisfaction. Robinson and Mee (2003), who noted nurses identify their work environment as the primary cause of job dissatisfaction, confirmed Manojlovich’s assertion. Ulrich et al. (2006) identified the work environment as an essential contributor to job satisfaction among nurses and a factor affecting quality of patient care. Dissatisfaction among nurses contributes to nurses leaving the workforce and negatively impacts the number of individuals who pursue nursing as a vocation (“AACN Standards,” 2005; Cangelosi, 2005). Sparacio (2005) reported 20% of nurses expected to leave their job within the year. The issue is aggravated for younger nurses, as Stechmiller (2002) noted one of three nurses under the age of 30 planned to leave the

profession within a year. Zucker et al. (2006) noted within a 3-year period, 42 to 70% of nurses planned to leave their jobs.

The influence of leadership is crucial in sustaining an adequate nursing workforce (Shirey, 2006; Zucker et al., 2006). The American Organization of Nurse Executives identified leadership as a critical component in developing excellent work environments (Ulrich et al., 2006). Nursing leaders play a significant role in staff nurse retention and affect the job satisfaction of nurses (Ribelin, 2003; Shader, Broome, Broome, West, & Nash, 2001). Kleinman (2004) reported a positive relationship between nurses' perceptions of leadership behaviors and staff nurse turnover. Ulrich et al. contended nurses reported improved leadership as the number one reason that would lead them to reconsider their decision to leave. Nurse leaders' responsibilities include maximizing recruitment and retention because of an increasing nursing shortage (Cox, 2003; O'Connor, 2003) while simultaneously reducing costs and improving performance (Williams, 2006). According to Williams, leading an organization with economic constraints requires competent leaders who can create a culture change through promoting organizational values, positively influencing relationships and behaviors among stakeholders, and making effective decisions based on collaboration.

Shirey (2006) described the need to advance leadership studies to determine optimal practices that will improve hospital environments, mitigating the nursing shortage and positively affecting patient care outcomes. The future of health-care organizations rests on the ability of organizational leaders who are "establishing the culture; creating the capacity for members to implement the changes and integrate it in their practice, and [implementing] strategies that sustain the shift" (Williams, 2006, p.

245). Schwartz, Tumblin, and Peskin (2002) contended servant leadership is one of the most successful leadership styles in energizing human resources within a service industry (p. 1419).

### Statement of the Problem

The demand for nurses in the United States exceeds the supply (Cohen et al., 2005; Upenicks, 2003). The U.S. Department of Health and Human Services projects the nursing shortage to worsen, with more than 1 million unfilled positions by 2020 (Chaguturu & Vallabhaneni, 2005). The 2004 vacancy rate for registered nurses was 13%, which equates to 126,000 unfilled nursing positions (Sparacio, 2005). The general problem is job dissatisfaction among nurses contributes to high turnover (Fleming et al., 2003), with up to 20% of nurses retiring early (Chaguturu & Vallabhaneni) and new graduates leaving the profession earlier than ever (Sparacio). The dissatisfaction experienced by hospital nurses and the resulting vacancies impact the quality of patient care and availability of health care (Ullman, Martin, Kelly, & Homer, 2006).

The specific problem is nursing leadership in the acute health-care setting is contributing to the dissatisfaction among registered nurses (Cline et al., 2004). Leadership is responsible for creating a healthy environment for nursing practice, which is necessary to continue an adequate workforce (Shirey, 2006). Greenleaf (1970) proposed servant leadership as a suitable leadership approach for health-care organizations. R. S. Thompson (2002) noted employees who work in an organization that supports and promotes the principles of servant leadership experience higher levels of job satisfaction. Servant leadership may be an instrumental approach for increasing job satisfaction among nurses.

The quantitative research study involved an examination into the existence of servant leadership behaviors in an acute health-care organization as perceived by registered nurses. A correlational research design helped determine the relationship between perceived servant leadership behaviors and job satisfaction based on data from three employment levels of nurses. The acute health-care organization included two community not-for-profit hospitals in the northwestern United States.

### Purpose of the Study

The quantitative method research study with a correlational design included an examination of the perceptions of registered nurses pertaining to the existence of servant leadership behaviors in the hospital environment to discover if any relationship exists between evidence of servant leadership and job satisfaction among registered nurses, nurse managers, and nurse leaders. The setting for the study was a nonprofit health-care organization encompassing two acute care facilities in the northwestern United States. The independent variable, perceptions of servant leadership characteristics in the hospital environment, and the dependent variable, job satisfaction among registered nurses, were measured through one validated tool, Laub's (1999) Organizational Leadership Assessment (OLA) survey. The OLA survey uses a 5-point Likert-type format and is designed to assess the level of servant leadership perceived within an organization in conjunction with employee job satisfaction. The OLA survey was developed to ascertain six constructs of servant leadership: values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership (Laub, 1999, p. 25). Through a randomly selected sample of registered nurses, nurse managers, and nurse leaders, the degree of correlation between perceptions of servant leadership

characteristics and job satisfaction was statistically analyzed. The quantitative correlational research design was appropriate for the study because it addressed the research question regarding the correlation between the two variables.

### Significance of the Study

The challenges associated with addressing the persistent nursing shortage, including nursing recruitment and retention issues related to job satisfaction, require innovative ideas and changes in organizational culture. The study contributes to the body of knowledge about effective nursing leadership in health-care organizations, specifically nonprofit acute care hospitals. Findings from the study establish the degree of relationship between perceptions of servant leadership behaviors and job satisfaction among registered nurses and increase understanding on how to develop healthy work environments in health care.

A thorough examination of peer-reviewed literature revealed scant research on the topic of servant leadership in the acute health-care setting and negligible research about the effect of servant leadership on job satisfaction among nurses. Previous empirical research addressed the role of servant leadership in organizational settings, notably public education (Miears, 2004), religious education (K. P. Anderson, 2005; R. S. Thompson, 2002), law enforcement (Ledbetter, 2003), business (Braye, 2000), for-profit organizations (Arfsten, 2006), and organizations in the public and private sector (Hebert, 2003). Only two research studies included an examination of the applicability of servant leadership to the health-care setting (Cunningham, 2003; Swearingen, 2004). Cunningham discovered evidence of servant leadership in nonprofit, Catholic-affiliated hospitals. Swearingen examined and reported a positive relationship between servant

leadership and job satisfaction among nurses of different generational cohorts from two central Florida health-care facilities. Recommendations for future research included discovering specific leadership characteristics that have the largest impact on nursing job satisfaction and retention, increasing the sample size, and expanding the scope through regional samples (Swearingen).

The current correlational study provides empirical data on the perceptions of servant leadership behaviors among registered nurses in a nonprofit, community-based hospital organization in the northwestern United States. The OLA instrument was administered to a sample population of registered nurses distinguished by position in the organization consisting of top leadership, management, or clinical staff. Researchers in several previous studies used the OLA survey in part because of its established reliability (Irving, 2005; Laub, 1999; Ledbetter, 2003; R. S. Thompson, 2002). The results of the study provide information on the degree to which the level of servant leadership in a hospital relates to job satisfaction among registered nurses. The relationship of each of the six characteristics of servant leadership to job satisfaction was also determined. The information may be useful to nursing leadership for promoting an organizational culture that fosters job satisfaction among nurses. The knowledge gained may be helpful in relieving the nursing shortage to some degree through increased retention of registered nurses with an accompanying positive effect on quality of patient care.

#### Significance of the Study to Leadership

The study generated empirical data and implications for the academic fields of leadership and management. Although many empirical studies on leadership exist in the literature and references to servant leadership are growing, few studies have included an

examination of servant leadership in health care (Cunningham, 2003). The significance of the study lies in its contributions of empirical data to the emerging theory of servant leadership. As particular servant leadership characteristics are positively associated with job satisfaction among registered nurses, health-care leaders and practitioners may consider servant leadership as an advisable leadership model for nurse leaders.

Developing leadership behaviors consistent with servant leadership in the health-care organization may become a means to influence positively the organizational culture and work environment and empower nurses to develop leadership skills. Although the study was correlative, the results have implications for leadership development and training in nursing and health care. Human resources personnel may also incorporate the results into recruiting and hiring practices, by seeking applicants for leadership positions that include particular leadership behaviors congruent with promoting registered nurse job satisfaction.

#### Nature of the Study

A goal of the study was to determine the existence and extent of servant leadership behaviors in the acute care settings of a nonprofit, community-based health-care organization. A secondary goal was to examine the relationship between registered nurses' perceptions of specific leadership characteristics in the hospital environment and the measured level of job satisfaction as self-reported by the same participants. The study encompassed responses among three categories of registered nurses—top leadership, management, and clinical staff. All participants worked at either of two affiliated, nonprofit, community-based hospitals located in the northwestern United States.

A survey-based, quantitative, nonexperimental correlational design yielded data that provided answers to the research questions. Gall, Gall, and Borg (2003) indicated correlational research involves discovering both the direction and the degree of the associations among variables without manipulating the variables. Although a correlational research design does not establish cause and effect as an experimental design would, a correlational design approach can ascertain potential causal factors for relationships among variables (Gall et al.). Creswell (2002) affirmed a correlational design is well suited for “identifying the type of association, explaining complex relationships of multiple factors that explain an outcome, and predicting an outcome from one or more predictors” (p. 379). Multiple correlations between the independent and dependent variables were examined to discover the presence and degree of relationships.

Correlational research design is quantitative research (Creswell, 2002). The quantitative research method was appropriate for the study because the method is suitable for producing numerical data indicative of the social environment (Gall et al., 2003). The data collected from the Likert-type scale responses on the survey were mathematically analyzed to assess the magnitude of a relationship and association between variables.

The survey instrument employed in the study was Laub’s (1999) OLA, which uses six component variables to encompass the concept of servant leadership. The OLA includes statements using a Likert-type scale to determine relative degrees of concordance with the responses. Data were collected on both the perceived evidence of select leadership characteristics in the workplace and the level of job satisfaction reported by the registered nurses. Registered nurses were randomly selected to participate in the



survey. The data collected from nurses who consented to participate in the study were aggregated and anonymity was guaranteed.

### Research Questions

The study determined the extent that servant leadership is implemented in the hospital setting as perceived by registered nurses. Six distinct characteristics of servant leadership were measured: (a) values people, (b) develops people, (c) builds community, (d) displays authenticity, (e) provides leadership, and (f) shares leadership (Laub, 1999, p. 25). Job satisfaction among registered nurses was also assessed. The following research questions guided the study:

1. To what degree do nursing leaders and managers implement servant leadership as perceived by registered nurses in two nonprofit, community-based hospitals owned by one health-care organization in the northwestern United States?
2. To what degree does the perceived implementation of servant leadership in two nonprofit, community-based hospitals owned by one health-care organization in the northwestern United States correlate with the level of job satisfaction among registered nurses?
3. Are there differences in the perceptions of servant leadership based on the level of position in the organization (e.g., top nursing leadership, nursing management, or clinical nursing staff)? Do demographic factors, including employment level in the organization, have an effect on the relationship between perceptions of servant leadership and job satisfaction?

Demographic factors included the type of nursing educational preparation, length of time employed as a registered nurse, length of time employed at the particular acute care facility, age, and gender.

### Hypotheses

The results of the study support two of three hypotheses. Each hypothesis was based on a corresponding research question. The first hypothesis addresses the first research question, which pertains to perceptions of servant leadership in the hospital organization. The OLA instrument measures the extent of servant leadership behaviors in an organization (Laub, 1999).

H1<sub>0</sub>: Servant leadership behaviors are not perceived at a nonprofit, community-based acute health-care organization by registered nurses.

H1<sub>A</sub>: Servant leadership behaviors are perceived at a nonprofit, community-based acute health-care organization by registered nurses.

The second hypothesis corresponds to the second research question and addresses whether a relationship exists between perceptions of servant leadership behaviors and job satisfaction among registered nurses. Although previous studies established a correlation exists between servant leadership and job satisfaction (K. P. Anderson, 2005; Laub, 1999; Miears, 2004; R. S. Thompson, 2002), only two studies established a link between servant leadership and job satisfaction among nurses (Frietas, 2003; Swearingen, 2004). The current research study expands the investigation of servant leadership and job satisfaction to a different population and setting.

H2<sub>0</sub>: No significant correlation exists between perceived implementation of servant leadership and level of job satisfaction among nurses and administrative leaders

at two community-based nonprofit hospitals owned by one health-care organization in the northwestern United States.

H2A: A significant correlation exists between perceived implementation of servant leadership and level of job satisfaction among nurses and administrative leaders at two community-based nonprofit hospitals owned by one health-care organization in the northwestern United States.

The third hypothesis relates to the third research question, which introduces the variable of employment level and the possible effect on opinions of servant leadership. Kamencik (2003) reported perceptions of leadership vary among nurses depending on level of employment, with chief nurse executives reporting a higher level of transformational leadership behaviors than mid-level nurse managers. The current study changed the focus from transformational to servant leadership and adds a level of employment—clinical workforce.

H3o: No significant differences exist in perceptions of servant leadership behaviors based on level of nursing position, including top leadership, management, and clinical workforce.

H3A: Significant differences exist in perceptions of servant leadership behaviors based on level of nursing position, including top leadership, management, and clinical workforce.

### Theoretical Framework

The use of relevant theoretical frameworks in research studies increases the capacity for meaningful construction of data interpretation (George, 2002). In quantitative studies, a theory offers a prediction and explication of relationships between

the independent and dependent variables (Creswell, 2002). The primary variables in the study include servant leadership and registered nurse job satisfaction. The three main areas of literature that guided the study were servant leadership, integration of spirituality in nursing, and job satisfaction.

### *Servant Leadership*

An integral theoretical component of the study was servant leadership. Originally conceptualized and articulated by Robert Greenleaf in the 1970s, the concept and emerging theory of servant leadership has a religious basis. Greenleaf (1977) proposed servant leadership as an ideal conduit for “value-shaping influence” (p. 81) in a widespread range of organizations, including organizations of an academic, business, government, health, or social service nature.

Leaders in health-care organizations have the capability to transform organizational culture. Servant leadership is described as a model to create an ethical and caring organizational culture. The servant leadership model, in contrast with traditional power models, incorporates interdependence. The basis of servant leadership is service, authenticity, mutual trust, and empowerment (Howatson-Jones, 2004).

The four fundamental characteristics of servant leadership noted by Howatson-Jones are applicable to the nursing environment through congruence with the relational nature of nursing practice centered on caring (Benner, 2004). Benner (2004) asserted that nurses display moral and ethical behaviors based on caring. Blake (2005) recognized authenticity in leadership as fundamental to nursing leadership practice.

*Integration of Spirituality in Nursing and Nursing Leadership*

In the origins of health care, spiritual care was an integral part of health and healing practices (Droege, 1979; Koenig, 2002). Health care was grounded in humanistic values with a focus on the holistic well-being of the patient (Donley, 2005). Beginning in the 4th century, religious groups built the first hospitals (Phillips, 2003). In the early days, religious beliefs, faith, and prayer were considered integral to healing and to health care. Professional nursing evolved from the traditions and incorporated both physical and spiritual elements into nursing practice. In the 1800s, Florence Nightingale, often referred to as the founder of the nursing profession, described nursing as a holistic, integrated endeavor (Koloroutis, 2004). Nightingale vigorously supported the role of spirituality in the provision of care and the therapeutic relationship between nurse and patient (Dossey, 2002).

In the mid-1900s, advancing scientific knowledge and technology strongly impacted health care. Leaders in medicine and nursing emphasized science and overlooked perspectives of humanism, including aspects of spirituality (Wilt & Smucker, 2001). Business models that emphasized profit, shareholder satisfaction, risk sharing, and return on investment (Donley, 2005) often replaced traditional health-care practices. Rising health-care costs and serious issues of hospital sustainability, access to care, disparities in the delivery of care, and the nursing shortage are contemporary challenges.

During the 1970s and 1980s, nursing leaders and theorists recognized the integral and valuable construct of spirituality in nursing practice. One prominent theory or conceptual framework for nursing practice that evolved during the period was Watson's theory of interpersonal caring. Watson's theory advocated "blending the sciences and the

humanities to provide an existential, phenomenological, and spiritual theory of transpersonal caring” (Kilby, 1997, para. 3). The theory articulated the nature of caring as reaching the core of a person’s humanity based upon a trusting relationship (Wilt & Smucker, 2001). Although the construct of caring in nursing often relates to the delivery of nursing care and the interpersonal reciprocity of the nurse–patient relationship, the application of caring is expanding to other stakeholders in the hospital environment through the leadership domain (Swearingen, 2004). Koloroutis (2004) confirmed the essential need for hospital leaders to be caring leaders who maintain belief in others, strive to understand the other person’s perspective, are emotionally present, provide services and help as appropriate, and facilitate another’s development (p. 57). The caring leader as described by Koloroutis is synonymous with the servant leader. Servant leadership, which integrates a spiritual and moral basis, may be an optimal leadership model for the nursing environment.

### *Job Satisfaction*

The third major focus for the literature review is job satisfaction. Many nurses working in acute care facilities report dissatisfaction with their work (Pearson, 2003). Some reasons reported for job dissatisfaction include job-related stress, patient acuity, inadequate levels of staffing, perceptions of little respect, lack of autonomy, and lack of ability to make changes (Sumner & Townsend-Rocchiccioli, 2003). Kovner, Brewer, Wu, Cheng, and Suzuki (2006) determined more than 40% of variance in work satisfaction among registered nurses derived from attitudes toward supervisor support, autonomy, organizational constraint, variety of work, promotional opportunities, work and family conflict, and distributive justice (p. 71). Although other factors influenced job

satisfaction, servant leadership positively correlated with job satisfaction among registered nurses (Swearingen, 2004) and among employees in other fields (K. P. Anderson, 2005; Miers, 2004; R. S. Thompson, 2002). Relevant studies about job satisfaction among registered nurses and the role of leadership behaviors, including servant leadership behaviors, were examined and reported in the literature review.

### Definition of Terms

Operational definitions specify how variables are defined, measured, or assessed in a study (Creswell, 2002, p. 647). Definitions provide a common knowledge of terms used in the study. The following terms had operational use in the study.

Characteristics of servant leadership: Laub (1999) cataloged the characteristics of servant leadership into the following 6 groupings: (a) values people, (b) develops people, (c) builds community, (d) displays authenticity, (e) provides leadership, and (f) shares leadership. Spears (1995) identified 10 distinct characteristics of servant leadership through an examination of Greenleaf's writings: (a) listening, (b) empathy, (c) healing, (d) awareness, (e) persuasion, (f) conceptualization, (g) foresight, (h) stewardship, (i) commitment to the growth of people, and (j) building community (pp. 4-7).

Leadership: A process in which a person influences other people to accomplish a common objective (Northouse, 2004). Leadership incorporates four key components: (a) process, (b) influence, (c) occurs in a group context, and (d) involves goal attainment (Northouse, p. 3).

Management: The term refers to registered nurses in the organization whom directly manage or supervise clinical staff nurses and other first-line employees but are

not at the executive level. Job titles of nurse manager and assistant nurse manager represent the management level of leadership.

Organizational Leadership Assessment (OLA): The OLA is a validated survey instrument developed by Laub (1999).

Servant leadership: A leadership approach that involves

Increased service to others, taking a more holistic approach to work, promoting a sense of community within an organization and between an organization and the greater community, sharing of power and decision-making, and a group-oriented approach to work in contrast to the hierarchical model. (Spears, 1995, p. 196)

Spears described servant leadership as “a long-term, transformational approach to life and work, in essence, a way of being that has the potential for creating positive change throughout our society” (p. 4).

Top leadership: The term refers to registered nurses who are top management in an organization and are at the executive level of leadership. Job titles include chief nurse administrator, administrative director, and directors.

Workforce: The term refers to registered nurses in the organization not employed in supervisory or management positions.

### Assumptions

According to Locke (2003), a research study should be approached with the least amount of assumptions as possible. The assumption in the present study was participants who voluntarily completed the survey were truthful as they responded to the Likert-type statements. To complete the OLA instrument, self-assessment and self-reporting were required. Accuracy of self-reporting may be linked to the participant’s confidence that



confidentiality would be preserved (Laub, 1999). The direct mailing of the completed questionnaire from the participant without any further involvement of personnel from the organization may have augmented the assurances of confidentiality.

### Scope and Limitations

The quantitative correlational research study was designed to determine the extent of servant leadership behaviors in a health-care organization. A second intention was to investigate the relationship between the perceived existence of servant leadership characteristics in the hospital environment and job satisfaction among registered nurses. The methodological approach of the study was to collect survey data from randomly selected nurses employed at two nonprofit, affiliated community hospitals in the northwestern United States. The study involved an examination of characteristics considered representative of servant leadership that are not necessarily associated with other leadership theories outside the scope of the study. Factors outside servant leadership characteristics that may be related to job satisfaction among registered nurses were not considered in the study. The data collected from the sample were generalized to the registered nurse population at the two hospitals and the findings may be applicable to other populations of nurses with similar characteristics employed in similar settings.

The sample surveyed in the research study was registered nurses employed in one of two nonprofit, community-based hospitals in the northwest region of the United States. The size of the sample, setting, and population were limitations of the study. Because the sample included registered nurses, projecting the findings to other populations of health-care workers was not appropriate. Generalizing the findings to nurses employed in nonhospital settings, hospitals other than nonprofit institutions, or different regions of the

country might not be appropriate because of cultural issues. The study was also limited by the gender distribution of the sample, of which a majority was female, which is consistent with the demographics in the nursing workforce, of which 94% is female (Fenkl, 2006).

The nonexperimental, correlational study was subject to the limitations associated with survey and correlational research. Limitations included the number of participants who agreed to participate voluntarily in the study, the number of participants who completed the survey in its entirety, and the accuracy of responses provided by the participants in the study. The method of survey distribution, in which nursing directors randomly selected registered nurses based on employee lists, was a potential limitation in the study. Reliability of the OLA survey tool was a potential limitation, although studies by Laub (1999), Miears (2004), R. S. Thompson (2002), and others determined a high level of reliability.

#### Delimitations

Limits imposed on the research design, including sample size, affect the ability to generalize research findings to settings and populations that are decidedly different from settings and populations in the research study. The focus of the study was the perceptions of registered nurses regarding characteristics associated with servant leadership in the hospital environment. The organizational outcome of interest was the self-reported job satisfaction of the registered nurses. The participants were randomly selected from two large, nonprofit, community-based hospitals in the northwestern United States.

## Summary

Chapter 1 presented the problem of the nursing shortage in the United States, the contributing factors, and the expected progression of severity. Job dissatisfaction among registered nurses was identified through empirical studies as one of the components contributing to the shortage (“American Association of Critical Care Nurses,” 2005; Cangelosi, 2005; Halfer & Graf, 2006; Sparacio, 2005). Servant leadership was proposed as a leadership model for nursing because particular leadership behaviors, such as values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership (Laub, 1999, p. 25), may positively correlate with increased job satisfaction among nurses. An aim of the study was to determine the direction and degree of the relationship between perceptions of servant leadership in the hospital environment and job satisfaction among registered nurses.

A quantitative, nonexperimental correlational design facilitates correlation analysis between servant leadership and job satisfaction. The goal of the study was to produce valid, empirical data that will generate new knowledge applicable to the field of leadership and specifically to nursing leaders. As correlations exist between specific leadership behaviors and job satisfaction, nurse leaders may incorporate the information into practice, positively influencing the work environment, improving organizational leadership, enhancing employee satisfaction, and improving access and quality of patient care. Chapter 2 provides a comprehensive review of historical and current peer-referenced research literature on servant leadership, spirituality in nursing, and job satisfaction.

## CHAPTER 2: REVIEW OF THE LITERATURE

Chapter 1 provided an overview of the problem of job dissatisfaction among registered nurses in the hospital environment as a contributing factor to the nursing shortage. Servant leadership was proposed as a leadership model in which the integrative dimensions of values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership (Laub, 1999, p. 25) may correlate with job satisfaction among registered nurses. The quantitative, nonexperimental correlational study determines the direction and degree of the relationship between perceptions of servant leadership in the hospital environment and job satisfaction among registered nurses from a nonprofit, community-based health-care organization in the northwestern United States.

Chapter 2 presents an investigation of the relevant literature pertaining to the three major areas of ethical leadership, the nursing profession, and job satisfaction. Leadership is examined initially from a general perspective of ethical leadership and ethical theories, followed by a discussion of the development of servant leadership and its respective dimensions. Leadership in nursing, including the applicability of servant leadership in nursing, follows. The next topic is the nursing profession. The section includes a historical perspective of nursing and its spiritual foundation, the evolution of nursing theories and models, and the present-day mission of the health-care organization particular to the research site. The final topic of job satisfaction is presented in a similar approach to leadership, with a broad introduction followed by a specific examination of job satisfaction in nursing. The discussion includes current findings related to the topic

areas of servant leadership, nursing in the hospital organization, and job satisfaction among registered nurses.

### Documentation

Searches of peer-reviewed journal articles, books, and dissertations on the topics of servant leadership, nursing and spirituality, and job satisfaction were conducted through multiple online databases, including ProQuest, EBSCOhost, OVID, MEDLINE, CINAHL, InfoTrac, and the UMI ProQuest Digital Dissertation database. Other sources for the literature review included a traditional university library and a community college library. Evidence exists of increasing interest in the connection between spirituality and leadership through numerous books, papers, and articles published on the topic during the 1990s and into the 21st century. Although research related to spirituality and leadership is recent, the scholarly, philosophical, and theological body of literature on spirituality, as it relates to life and work, is ancient. A portion of the literature review includes tracing the origins of the concept of spirituality through its philosophical and theological development as it pertains to health care. The literature reviewed incorporated a balance of germinal, historical, and current references. Table 1 lists the sources reviewed, categorized by the topic areas.

### Ethical Leadership

Leadership has a crucial impact on an organization's functioning. Leaders have a duty and responsibility to be catalysts for positive change in their organizations, leading to improved institutional effectiveness. In the postmodern world, an increasing number of scholars contended leadership requires an ethical or values-based component to be effective. Avolio and Gardner (2005) posited the significant challenges facing

organizations in the 21st century require genuine leadership that incorporates an ethical basis. Klenke (2003) contended a values-based spiritually anchored paradigm of leadership is essential for organizational effectiveness and claimed successful leadership is connected to an underlying spiritual dimension (p. 56). Vaill (1996) indicated spiritualism equates to dynamism. Vaill's comprehension of effective leadership entailed continual adherence to a clear mission and purpose, despite obstacles, and the integration of a positive application of spirituality among the members of the organization. Covey (1991) noted leadership has an implicit spiritual component and described effective leaders as service-oriented, positive, and people-focused.

Table 1

*Summary of Literature Reviewed by Topic*

Theoretical concepts and search topics	Peer-reviewed			
	journal articles	Dissertations	Books	Other
Ethical leadership theories	48	32	8	22
Servant leadership	68	87	18	47
Nursing, spirituality, and theories	146	38	16	82
Job satisfaction in nursing	169	156	2	145
Total literature reviewed	431	313	44	296

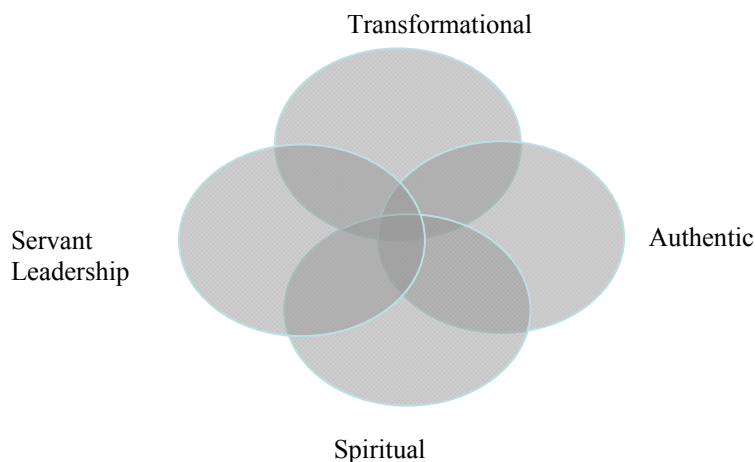
Northouse (2004) characterized ethics as an essential nature of the leadership process. Leaders have an ethical duty to treat people with both dignity and respect, which equates to responding to the particular needs and concerns of followers (Northouse). Bass (1990) described ethics as seeking the highest development of humanism in people and actualizing the human potential. Leadership and ethics are intertwined. Actions,

behaviors, and decision making by leaders are influenced by the leaders' ethics (Mitten, 2007).

According to Northouse (2004), as leaders demonstrate and incorporate organizational values, they are responsible in part for developing the ethical culture of the organization. The influence of leaders has an impact on promoting organizational values. As leaders exert their influence on followers in the aim to achieve organizational goals, organizational values are promoted and established (Northouse). Through the examples set by leaders and the encouragement provided, followers are influenced in their moral reasoning (Pierce & Newstrom, 2006). Koloroutis (2004) asserted, "To give strategic, philosophical, and personal meaning to their employees' endeavors, leaders are making expensive and extensive investments . . . to find sustainability based on a culture of commitment, purpose, and meaning" (p. 79).

Incorporating ethics into leadership is gaining widespread attention in the literature (Ciulla, 2003; Northouse, 2004). Ciulla (1995) determined from a meta-analysis of leadership research that people yearn for highly ethical leaders. However, the literature is fragmented concerning the application of ethics in leadership. Gardner (1990) advocated leaders "keep alive values that are not so easy to embed in laws—our caring for others, about honor and integrity, about tolerance and mutual respect, and about human fulfillment within a framework of values" (p. 77). Rost (1991) considered leadership an ethical endeavor if the employees genuinely agreed planned changes are beneficial to both leaders and followers (p. 161). The followers' beliefs, values, and needs should be considered in developing the organization's goals and purposes (Rost).

Four contemporary leadership theories are spiritual, transformational, authentic, and servant leadership. The four theories are prominent ethics and value-based theories because each incorporates an ethical or spiritual component (Pierce & Newstrom, 2006). All four conceptualizations of leadership incorporate ideals of service and growth in the leader–follower relationship, although variations exist (Pierce & Newstrom, p. 58). Avolio and Gardner (2005) acknowledged the closely related concepts and relationships among the four theories. A brief examination of the ethical theories is presented, incorporating a comparison of spiritual, transformational, and authentic leadership theories with the theoretical construct of servant leadership. Figure 1 illustrates the interrelationships among the theories. An overview of servant leadership theory as espoused by Greenleaf and other scholars follows.



*Figure 1.* Interrelationships among ethical theories.

#### *Spiritual Leadership Theory*

Fry, Vitucci, and Cedillo (2005) described spiritual leadership theory as a broad-based view of ethical leadership that links intrinsic motivation and organizational effectiveness with spiritual components of leadership. Fry et al. depicted spiritual



leadership theory as a new leadership model that embodies aspects of transformational, charismatic, and values-based leadership theories while expanding on the theory constructs (p. 835). In a study of spiritual leadership theory in an army organization, Fry et al. examined the theory's core values and ethical framework and identified authentic concern, caring, and appreciation for organizational members as spiritual constructs (p. 838).

Although described as a new theory in the literature, the focus on humanistic values in the organizational setting espoused by Fry et al. (2005) was introduced decades previously by Taylor (1947). Taylor ascertained scientific management has at its core the concept of justice. During the 1940s, intolerance of employers who focused exclusively on profits and used punitive means to stimulate employee production increased among workers (Taylor, 1947, p. 139). Scientific management involved increasing efficiency through improved processes and improved work environment. Smith (1759, as cited in Covey, 1991) contended success in organizations is connected to the moral foundation. Smith described the moral foundation as how people relate to others with the essence of altruism, service, and compassion (Covey, p. 90). Without a moral foundation, an organization leads to an amoral or immoral system. Fairness, justice, and benevolence are evident in the interactions of humble, servant leaders (Covey, p. 92).

Spiritual leadership theory is similar to servant leadership in the aim of service. In contrast with servant leaders who subjugate their needs in the service of others, the spiritual leader is concerned with oneself and the people in the organization. Fry et al. (2005) noted the spiritual leader “incorporates transcendence of self in pursuit of a vision/ purpose/mission in service to key stakeholders to satisfy one's needs for spiritual survival

through calling and membership” (p. 839). The spiritual aspect of leadership is more explicit in the spiritual leadership theory model than in servant leadership. Servant leadership principles can be employed in the organization from a humanistic perspective without overt religious connotations.

### *Transformational Leadership*

Transformational leadership is another leadership model that integrates ethics (Pierce & Newstrom, 2006). In transformational leadership, ethics is the central feature in the leadership process (Northouse, 2004, p. 308). Burns (1978) believed transformational leaders assist followers in reaching their greater potential, including leadership ability and level of moral reasoning (as cited in Bass, 1990, p. 23). Through engagement with followers, leaders ascribe to helping followers develop moral responsibility. In a comparison of transformational and servant leadership models, B. N. Smith, Montagno, and Kuzmenko (2004) posited the majority of servant leadership can be incorporated in the theory of transformational leadership (p. 84). Beazley and Beggs (2002) described Greenleaf’s (1977) theory of servant leadership as a type of transformational leadership that embodies stewardship, systems thinking, and continual learning.

Both servant leadership and transformational leadership help to develop followers and assist followers in realizing their potential, including their leadership ability (Avolio & Gardner, 2005). B. N. Smith et al. (2004) concluded both servant and transformational leadership theories entail strong moral principles and high regard for the individual, though the rationale for the attributes differs with each theory (p. 87). Although empirical evidence supported the efficacy of both transformational and servant leadership in service

organizations (Schwartz et al., 2002), more evidence exists for the theory of transformational leadership. Servant leadership is a young and unproven theory.

One significant difference between the two theories is transformational leaders do not necessarily seek consensus but instead often use conflict as a tool to help followers reexamine and elevate their values and beliefs (Ciulla, 2003, p. 15). Giampetro-Meyer, Brown, Browne, and Kubasek (1998) portended the transformational approach to leadership is more likely to obvert reflection on ethical reasoning in favor of a simple and confident approach to decision making. A criticism of transformational leadership theory is some transformational leaders exhibit narcissism, which raises the concern that the goals of the leaders may be suspect (Giampetro-Meyer et al., p. 1729). Servant leaders, conversely, are concerned with the priorities of the followers and model empathy in decision making (Greenleaf, 1977), increasing the likelihood of improving organizational culture ethically (Giampetro-Meyer et al.).

#### *Authentic Leadership Theory*

Recent literature on leadership proposed the concept of authentic leadership (Avolio & Gardner, 2005). Terry (1993) identified authentic leadership as a method of leadership that incorporates ethics. Covey (1991) described authenticity as deriving from one's integrity and self-determination (p. 60). According to Terry, leadership is a form of authentic action or an "honorific mode of engagement" (p. 107). The underlying premise of the theory is problems must be communicated authentically.

Avolio and Gardner (2005) described authentic leadership as an emerging leadership theory with conflicting constructs. One perspective of authentic leadership is a process that incorporates "increased self-awareness, self-regulation, and modeling"

(Avolio & Gardner, p. 317), leading to increased authenticity in leaders and followers and contributing to organizational effectiveness. Shirey (2006) identified authentic leadership as a core element in creating healthy work environments for nurses. Of the competing ethics-based theories, Avolio and Gardner considered servant leadership the only theory besides real leadership theory that fully demonstrates authentic behavior (p. 323). Both servant leadership and authentic leadership incorporate values of respect, trust, and positive affect.

Avolio and Gardner (2005) established authentic leadership has a relatively generic conceptualization and is perceived as vague. Some scholars identify an ethical or moral basis to authentic leadership (Driscoll & McKee, 2007; Shirey, 2006), whereas others disagree (Sparrowe, 2005). In contrast with servant leadership, authentic leaders do not display any singular regard for the development of personnel (Avolio & Gardner). Although staff development in followers may be realized through authentic leadership, leadership development is a by-product as opposed to a purposeful endeavor as characterized in transformational leadership and servant leadership (Avolio & Gardner).

### *Servant Leadership*

Greenleaf (1970, 1977) posited one of the leadership theories with a strong ethical basis. Greenleaf introduced a new leadership model, servant leadership, which was inspired by the historical legacy of servant leadership displayed by Jesus (Sendjaya & Sarros, 2002). A normative theory of leadership similar to transformational leadership in many respects (Ciulla, 1995), servant leadership emphasizes service and unequivocally addresses spirituality in leadership (Greenleaf, 1977). Greenleaf (1977) described servant leadership as concerned with the greatest needs of the individuals served, both internal

and external to the organization. To illustrate the concept of servant leadership, Greenleaf (1977) asked the following:

Do those served grow as persons; do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And what is the effect on the least privileged in society; will he benefit, or, at least, will he not be further deprived? (pp. 13-14)

The servant leadership approach helps protect the leader from the “potentially corrupting influence of wielding power” (Vaughan, 1986, p. 134).

Servant leadership epitomizes the type of leadership needed to address the changing organizational mind-set among employees (Avolio, Gardner, Walumbwa, & Luthens, 2004). Employees are increasingly seeking affirmation in their work through empowerment, participation, involvement, and spirituality (Gragnolati & Stupak, 2002). Avolio and Gardner (2005) contended servant leadership addresses the needs of the people through an open, participative leadership style. Servant leaders respect and recognize the skills and talents of the workers and seek to develop the staff through coaching or mentoring (Avolio & Gardner, 2005, p. 101). Veronesi (2001) asserted the servant leader is disposed to share power and to empower the people in the organization.

A servant leader focuses on providing employees with ample support, resources, and nurturing to advance their performance in a progressively more complex, dynamic work environment (Peete, 2005). From the organizational standpoint, the full expression of servant leadership extends itself toward external stakeholders as well (Biberman & Whitty, 2000). Problems encountered in the workforce are addressed through an inward versus an outward perspective (Wagner-Marsh & Conley, 1999). Instead of looking

outwardly for someone to blame, the process for change begins within the individual.

Through service to others, the servant leader aims to make positive changes in the lives of individuals, the organization, and society. Sendjaya and Sarros (2002) contended the spiritual focus of servant leaders leads to benefits of greater stability, a more useful vision, reduced stress, and a balanced life.

Northouse (2004) considered Greenleaf's approach to leadership one with "strong altruistic ethical overtones" (p. 309) in which leaders are "attentive to the concerns of their followers and emphasize with them" (p. 309), which corresponds to taking care of the followers and nurturing them. DePree (1995) asserted the core of servant leadership is the pursuit of ethical intention (p. ix). Bass (1990) described servant leadership as promoting the best interests of the organization, the personnel, and the community over self-interests. Smith et al. (2004) considered Greenleaf's theory of servant leadership unique among leadership theories as the leader's motivation is paramount to the theory. The servant leader is motivated to lead as a way of serving the followers and the followers' interests are considered of greater importance than the leader's self-interest. Giampetro-Meyer et al. (1998) declared servant leadership is an ethically-based leadership model that provides an auspicious approach for organizational improvement, primarily because of the immanent expression of responsible reflective behavior.

### Historical Overview of Servant Leadership

In the 1970s, Robert Greenleaf produced his germinal work, *Servant Leadership: A Journey Into the Nature of Legitimate Power and Greatness* (1977), based on his essay titled *The Servant as Leader* (1970). The book illustrated how Greenleaf formed and

expanded his conception of servant leadership. Greenleaf posited individuals who become leaders as a means to serve others can produce a positive effect in the lives of followers as well as society.

Greenleaf credited the short story *The Journey to the East* by German novelist Herman Hesse (1956) for providing inspiration for the theory of servant leadership. In the story, a fictional group of characters make a spiritual expedition to the East. The main character in the story is Leo, who acts as a servant for the group. The humble guide exerts powerful leadership through his strength, inner spirit, and caring. His spirit affected others and strengthened them, making the journey possible (Greenleaf, 1977, p. 44). When Leo disappears, the group disbands and fails to achieve their purpose or goals. At the end of the story, the characters learn Leo was, in fact, the leader. The parable of Leo contributed to Greenleaf's thesis that leaders serve followers, in which "caring for persons, the more able and less able serving each other, is the rock upon which a good society is built" (Spears, 1995, p. 40). Spears added that optimal leadership transpires when the goal of the leader is to serve others (p. 3).

Greenleaf (1995) described additional influences that led to his creation of the servant leadership model. Two individuals were instrumental in developing the idea, including Greenleaf's father, who provided an example of servant leadership, and Greenleaf's sociology professor, who advised students to work in large institutions to produce positive change from within the organization. Other inspirations came from E. B. White and Elmer Davis. Servant leaders seek to heal or to amend themselves and those they lead (Greenleaf, 1995). Preparation is needed to nurture leadership capability in individuals (Greenleaf, 1995, p. 4). Greenleaf (1995) felt a strong ethical foundation,

which in his experience derived from a Judeo-Christian upbringing and later Quaker affiliation, could mitigate the vulnerability of being corrupted by power. Servant leaders, whether religious or not, demonstrate courage in their development of others and of a climate that is just and loving and fosters ethical behavior. Greenleaf contended the servant leadership model provides a mechanism to foster hope, which is essential for the well-being of individuals.

Greenleaf (1977) acknowledged the terminology servant leadership is likely to be misunderstood or rejected by many scholars due to negative connotations with the terms or the association of the two terms conjoined. Despite criticism of the connection of servant to leadership, Greenleaf purported the two roles can be combined to produce an effective leader. Greenleaf described the servant leader as one who is a natural servant before aspiring to become a leader. One of the benefits of choosing to follow a servant leader is such a leader is concerned with the highest priorities of the individuals he or she serves. The antithesis of a servant leader is a leader who is dominating, authority-ridden, exploitative, and manipulative, which leads to the destruction or diminishing of others (Greenleaf, 1977, p. 43).

Although Greenleaf is credited with the origination of servant leadership theory, the concepts central to servant leadership were in effect for centuries. Greenleaf (1997) accepted his ideas are not new but “rather, a new realization that age-old wisdom of how people best relate as individual human beings must be applied with painstaking care to the vast institutional structures in which all of us are now inextricably involved” (p. 243). In both the Old and the New Testaments of the Bible, accounts of Moses and Jesus illustrated the example of service to others through leadership endeavors. Tan (2006)



described Jesus as the master servant and provided examples of Scripture that support the premise (John 13:14-17, Luke 22:26-27, Matthew 20:28, Philippians 2:5-11). Many authors, both academic and popular, attested Jesus epitomized the servant leader (Blanchard & Hodges, 2005; Dyck & Schroeder, 2005; Harrington, 2006). Biblical citations supported the role of Jesus as a servant “For the Son of Man did not come to be served but to serve” (Mark 10:45) and “I have set you an example that you should do as I have done for you” (John 13:15) when Jesus washed the feet of his disciples. Greenleaf (1977) acknowledged the role of Judeo-Christian theology in developing servant leadership theory.

Taoism, which dates to the 6th century B.C., also incorporated a definitive recognition of the service aspect of leadership. According to Pierce and Newstrom (2006), Taoism purported effective leaders accomplish goals through others while avoiding attention and publicity, which is singularly reminiscent of the humble Leo character in the Hesse novel. The expectation in Taoism is the leader will become unnecessary when individuals who are led become leaders themselves (Vecchio, 1997).

Not all leadership ideals advocated the service element. In Greek literature, the leader in *The Odyssey* was expected to remain socially distant from the individuals led (Vecchio, 1997). An emphasis on a moral foundation or thread through leadership is evident in both Eastern literature and Western literature, from Confucius to Plato and Aristotle. Greenleaf credited Confucius with the concept in which

the servant views any problem in the world as in here, inside oneself, not out there. And if a flaw is to be remedied, to the servant the process of change starts in here, in the servant, not out there. (Rieser, 1995, p. 56)

The relationship between leader and follower is paramount. Hegel noted a leader who serves as a follower can become more effective through a greater understanding of the followers (Vecchio, 1997, p. 5). Taylor (1947) recognized the “close, intimate, personal cooperation between the management and the men is of essence of modern scientific or task management” (p. 26). Deming advanced the conceptuality of management from supervision to leadership (Covey, 1991, p. 263).

#### *Servant Leadership in Health-Care Organizations*

Greenleaf (1977) described functioning institutions in general as mediocre and placed the responsibility for substandard or unsatisfactory performance on poor leadership. The performance is disappointing considering the resources available to achieve at least reasonable performance or better. Describing institutions as mediocre aptly describes health-care institutions (Greenleaf, 1977), in which costs are expanding while consumers do not reap the benefit of the extensive knowledge available to improve their health. Thyer (2003) indicated health-care leadership often uses a transactional style of leadership, which may detrimentally affect the organization and the employees.

Building better institutions that epitomize excellence begins with people from within the institution who have the strength and competence to make positive change (Greenleaf, 1977). Nuttall (2004) described the emphasis on interpersonal relationships as a humanistic approach to leadership in which the superior–subordinate relationship is the key element. The most important ingredient is caring, which extends from the people within the organization to the organization itself (Nuttall). When leaders care enough and use their power to serve, ideas and people grow and the institution benefits (Greenleaf, 1977). The institution must capitalize on all of its resources, including personnel, to

accomplish its goals and objectives and exceed expectations (Greenleaf, 1977, p. 130). If an organization succeeds in becoming a serving institution, serving both individuals who receive products or services and individuals who produce them, then “the work exists for the person as much as the person exists for the work” (Greenleaf, 1977, p. 142). The result may also include the consciousness that “the business exists as much to provide meaningful work to the person as it exists to provide a product or service to the customer” (Greenleaf, 1977, p. 142). Iwata (1995) contended introducing a servant or service-oriented philosophy only recently spread into business corporations.

The servant leadership model is applicable for nonprofit, for-profit, and government institutions (DePree, 1995). Greenleaf (1977) intimated the commonly held assumption that for-profit organizations are self-serving and not-for-profit organizations are necessarily altruistic is belied by experience, and opportunities for servant leadership are the same. The basis of the model is the premise that producing a positive impact through serving others, including the employees, the consumers, and the community, is the main concern (Spears, 1995). Greenleaf (1977) claimed large institutions have an obligation to serve both people and society. Institutions can improve if leadership demonstrates caring for people (Greenleaf, 1977).

Greenleaf (1977) contended caring for individuals must be extended to institutions to elevate morality in a society (p. 53). Greenleaf (1977) described caring as an essential element in servant leadership. Caring applies not only to individuals but also to institutions. Caring encompasses interest, compassion, concern, self-sacrifice, wisdom, tough-mindedness, and discipline (Greenleaf, 1977, p. 243). The degree of caring must be deep enough to foster excellence and render itself as servant (Greenleaf, 1977, p. 244).

*Servant Leadership and Nursing*

During the 19th and early 20th centuries, leadership in health-care settings was patriarchal and hierarchical (Dracup & Bryan-Brown, 2006). Leadership styles and actions evolved in the 20th century to accommodate rising expectations and demands among consumers, notably patients (Williams, 2006). Sanders (2003, as cited in Gershon & Buerstatte, 2003) contended citizens expect behaviors consistent with servant leadership when they are admitted into a hospital. Dracup and Bryan-Brown asserted many hospitals are committed to improving the organizational environment, are implementing strategies to ameliorate the work environment, and are committed to transforming the organizational culture. R. J. Anderson (2003) posited servant leadership is the optimal avenue through which health-care providers can best relate to patients and communities.

The nursing profession is a service industry with a foundation of professional ethics. Nursing practice abides by a professional code of ethics developed and endorsed by the American Nurses Association. Ethical codes serve to ensure a high standard of patient care and to provide guiding principles for nursing practice (Strandell-Lane, Heikkinen, Leino-Kilpi, & van der Arend, 2005). Many individuals who choose nursing as a vocation felt a calling or were compelled to “fulfill the Divine command to tend the sick” (Cook & Webb, 2002, p. 124). Cook and Webb described personal moral characteristics as implicit traditional competencies of a nurse. The commonly held perception by the American public that nurses are highly ethical and honest is confirmed by Gallup polls in which nursing continues to be rated as the most ethical profession (Riley, 2007, p. 6).

Strandell-Laine et al. (2005) explained the ethical codes in nursing practice can be impeded when incongruence with organizational values and principles exists. Hamilton (as cited in Verderber & Fine, 2000) noted, “The realities of contemporary healthcare often conflict with the humanistic ideals of nursing” (p. 265). A predominately female workforce passively accepted practice constraints without dispute for many decades. Hamilton (as cited in Verderber & Fine) described a transforming culture of nurse leaders who are assertive, risk-takers, and collaborators for positive change. Burgeoning nurse leaders believe all nurses must learn to be leaders.

The nursing theory of relationship-based care is formulated on the premise that each employee has the capacity to lead and advocates developing a culture in the organization that fosters leadership development among all employees. Weber (2003) posited each nurse must function as an active leader in the organization. Servant leadership differs from traditional approaches to leadership on the follower role (Pierce & Newstrom, 2006). The leader–follower relationship is supreme; the needs of followers are significant and heard. Leaders should be natural servants, and everyone should both follow and lead (Greenleaf, 1977, p. 240).

Pierce and Newstrom (2006) claimed the basic tenet of servant leadership is human resource development as opposed to an authoritative leadership style. Dyck and Schroeder (2005) described the servant leader’s approach to problem solving as considering the source of the problem from within the organization, such as underlying biases. Actions included respectful dialogue that engages those who are involved or affected, seeking creative responses to address the underlying factors that contribute to the problem, and experimental solutions. Senge (1990) described a leader of a learning

organization as a designer, instructor, and steward (p. 112). Pierce and Newstrom asserted servant leadership is characteristic of an emerging leadership style congruent with the learning organization and leadership in the 21st century.

Leaders in hospital organizations must demonstrate behaviors of caring leaders (Koloroutis, 2004). The caring leader, based on the explanation by Greenleaf, is tantamount to the servant leader. Identified behaviors of caring leaders include maintaining belief in others, striving to understand the other person's perspective, being emotionally present, providing service and help as appropriate, and facilitating another's development (Koloroutis, p. 57).

Northouse (2004) posited the concepts of servant leadership theory are "parallel to and consonant with the *ethic of caring* set forth by Gilligan (1982), who contended that personal relationships should be the beginning point of ethics" (p. 309). Brady (as cited in Northouse) decreed the ethic of caring is the most essential characteristic in building trust and cooperative relationships and thus is critical to organizations (p. 310). Doyle (1997) claimed virtue and character are the essential ingredients for building trust and service in an organization (p. 441). In the servant leadership model, the leader aims to serve the employees, consumers, and community. Giampetro-Meyer et al. (1998) explained servant leaders are likely to participate in conscientious reflection, which leads to consensual goal-setting beneficial to multiple stakeholders, including employees, customers, and the community (p. 1734).

Servant leaders focus on providing employees with ample support, resources, and nurturing to advance the employees' performance in a progressively more complex, dynamic work environment (Peete, 2005). A nurturing leadership style increases job

satisfaction among nurses (Hayhurst, Saylor, & Stuenkel, 2005). From an organizational standpoint, the full expression of servant leadership extends itself toward external stakeholders as well (Biberman & Whitty, 2000). Problems encountered in the workforce are addressed through an inward versus an outward perspective (Wagner-Marsh & Conley, 1999). Instead of looking outwardly for someone to blame, the process for change begins within the individual. Through service to others, servant leaders aim to make positive changes in the lives of individuals, organizations, and society. Sendjaya and Sarros (2002) contended the spiritual focus of servant leaders leads to benefits of greater stability, a more useful vision, reduced stress, and a balanced life. Servant leadership integrates a spiritual and moral basis applicable to the nursing environment.

The servant leadership model, in contrast with traditional power models, incorporates interdependence. Interdependence is characteristic of nursing practice, which is interdisciplinary. The effectiveness of nursing practice relies on the constructs of collaborative practice relationships and communication (Fisher & Riley, 2005). The basis of servant leadership is service, authenticity, mutual trust, and empowerment (Howatson-Jones, 2004; Lee & Zemke, 1995), which are decidedly applicable to the nursing environment. Blake (2005) recognized authenticity in leadership as a core element of nursing leadership practice. A relatively new model, servant leadership integrates spirituality with leadership that is applicable to the nursing environment. Servant leadership may be an optimal leadership model for hospital organizations, specifically the nursing environment. A hypothesis of the study is perceptions of servant leadership characteristics in the nursing environment will positively correlate with job satisfaction of registered nurses.

## Dimensions of Servant Leadership

Greenleaf (1977) acknowledged the assumption that many businesses function with the prime goal of profitability, followed by customer service. In the servant leadership model, Greenleaf (1977) proposed the primary aim should be the development of those who work in the organization, who in turn would ensure customer service in conjunction with profitability (p. 145). To focus on the growth of the individuals in an institution, Laub (1999) identified six distinctive components of servant leadership. The six components are values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership (Laub, 1999, p. 25). The six dimensions of servant leadership promote the development of a servant institution, in which individuals

have a clear focus of purpose, so that they can be supported when they need it and feel a part of a larger purpose without losing their individuality, and so that all the parts can contribute to the total strength of the enterprise. (Laub, 1999, p. 145)

### *Values People*

Greenleaf (1977) provided examples of individuals he considered reflective of servant leadership. When describing the model of servant leadership, Greenleaf (1977) provided explanations rather than practical ideas of how to employ servant leadership. Greenleaf (1977) asserted implementing servant leadership leads to a creative display of leadership based on love for humankind..

A cornerstone of the servant leadership theory is service to others. The servant leader genuinely wants to serve others and thus leads the followers as a service to them. The servant leader values the interests, priorities, and motivations of the followers, which



fosters trust in the leader–follower relationship. Trust is a significant aspect of the leader–follower relationship and is based on both character and competence (Covey, 1991). Dirk (2000) conceptualized trust as “an expectation or belief that [a follower] can rely on the leader’s actions or words and that the leader has good intentions toward the [follower]” (as cited in Pierce & Newstrom, 2006, p. 32). Covey claims the presence of trust leads to transparent communication, understanding, and efficacious interdependency (p. 31). Pierce and Newstrom reported a finding among several studies that linked perceptions of trust and fairness with altruism and cooperation among subordinates. Without trust, communication, problem-solving, and teamwork are impeded, and the success of the organization is compromised (Covey, p. 170).

Covey (1991) contended valuing people equates to treating others as one wishes to be treated. Taylor (1947) identified science, harmony, cooperation, maximum output, and developing each person’s potential for efficiency and prosperity as the essential components of scientific management (p. 140). Covey described the aspect of believing in people as faith in the hidden possibilities of all individuals despite negative behaviors, weaknesses, or other failings. By believing in the unseen potential, leaders create an environment that fosters growth and opportunity (Covey, p. 35).

### *Develops People*

In servant leadership, followers are encouraged to think for themselves. Pierce and Newstrom (2006) posited, “Servant leaders serve their followers best when they model and also encourage others not only to engage in independent moral reasoning, but also to follow it up with constructive participation in organizational governance” (p. 59).

Greenleaf felt the role of the servant leader was to nurture the development of people extending to their ethical actions (Fraker, 1995).

Developing the follower or subordinate was long recognized as a reason for organizational effectiveness. Taylor (1947) affirmed that employee development and training to maximize class of work should be the highest priority of management. Spears (1995) described servant leaders as leaders who are committed to helping individuals reach their full potential. Greenleaf (1977) expressed the essential servant leadership component of developing people: “Anyone could lead perfect people, if there were any. The real challenge is to learn and develop the imperfect people who we all are” (p. 21). According to Greenleaf (1977), the servant leader accepts people and believes in the potential of the individual. When people are supported and encouraged to grow and develop, motivation is generated. The servant leader believes, “I am in the business of growing people—people who are stronger, healthier, more autonomous, more self-reliant, more competent” (Greenleaf, 1977, p. 147).

### *Shares Leadership*

Spears (1995) credited servant leadership theory as a contributing factor in the present-day empowerment movement. Taylor posited the groundwork for the concept of empowerment or shared leadership in the 1920s (Taylor, 1947). Taylor surmised significant individual achievement depends upon the cooperation or assistance of others. To achieve organizational outcomes, collaboration and cooperation among employees are necessary (Taylor, p. 141).

The traditional top-down leadership approach is replaced by consensus building through group analysis and decision making in which individuals participate (DePree,

1995). Vecchio (1997) maintained when individuals are able to participate in decision making, their sense of involvement and dedication to planned actions or goals increases, which likely leads to increased ownership and commitment (p. 121). Servant leadership shares power with the people. A key ingredient in the ability to share leadership is the servant leader's demonstration of listening first before solving problems (Greenleaf, 1977, p. 17). Greenleaf (1977) affirmed conscientious listening augments commitment in other people (p. 17).

#### *Provides Leadership*

Leadership is exemplified in an ethical and caring manner (Spears, 1995). The servant leader displays strength, an openness to knowledge, foresight, and enthusiasm (Greenleaf, 1977, p. 16), which Greenleaf described as a sustaining force that promotes enthusiasm and inspiration (as cited in Fraker, 1995, p. 43). Foresight is a necessary element because the leader has a clear vision and purpose and is willing to take risks to achieve the vision. Such a leader is able to articulate the goal and purpose to the individuals so they develop conviction and intention. A sense of purpose emanates in the culture of an organization led by servant leaders. According to Greenleaf, the desired outcome is "that a much larger than usual number of strong leaders will emerge who are determined to exert a continuous ethics-raising influence wherever they are, and throughout their careers" (as cited in Fraker, p. 45). The servant leader acts through service instead of control (Lee & Zemke, 1995). Instead of coercion, the servant leader uses persuasion, example, and ability to articulate conceptualization (Fraker, p. 51). The leader has a clear vision and has an understanding of what needs to be done to achieve the vision and is willing to take the risks to achieve the vision (Greenleaf, 1977, p. 244).

The servant leader is distinct from individuals who have general goodwill by the willingness to act on what they believe (Greenleaf, 1977, p. 329).

### *Builds Community*

Peck (1995) described community as a group with an explicit partnership with each other (p. 88). Community building is a continuing process that includes authentic communication and consensual decision making. A growing level of trust among the members of the group leads to community. Regarding health care, Greenleaf (1977) indicated community is necessary for individuals to heal (p. 37) and generalized that “human service that requires love cannot be satisfactorily dispensed by specialized institutions that exist apart from community, that take the problem out of sight of the community” (p. 38).

### *Displays Authenticity*

Leaders can demonstrate evidence of authenticity through the expression of responsibility in which the leaders’ thoughts, actions, and words are congruent with accountability in serving others (Fraker, 1995). Fraker identified the characteristics that epitomize authenticity as “awareness, openness, freedom from self-righteousness, sensitivity to others’ needs and aspirations, and acceptance of compromise” (p. 41). Rieser (1995) described the ability of the servant leader to listen and understand as well as empathize and accept a person within a context of accountability as signature characteristics of authenticity. Greenleaf (1977) described listening as openness toward others and a genuine desire to understand what they are trying to convey (p. 300). Listening requires deliberate attention, a genuine desire to understand, and openness to the individual (Greenleaf, 1977, p. 300).

The servant leader advances an ethical and caring organizational culture that integrates the six dimensions of servant leadership, including valuing people, developing people, sharing leadership, providing leadership, building community, and displaying authenticity. B. N. Smith et al. (2004) predicted performing servant leadership behaviors, as described by the six dimensions, is likely to result in employees that communicate more effectively, develop strong collaborative relationships, are more ethical, engage in developing a shared vision, and strive to achieve goals (p. 86). B. N. Smith et al. contended creating a spiritual generative culture produces satisfaction among its members (p. 86).

#### Criticisms of Servant Leadership

Pfeffer (1997) insisted the connection between the general concept of leadership and effective performance is an assumption. Pfeffer explained that empirical studies do not consistently support a relationship between leadership and performance and results of studies examining the effects of leadership are generally ambiguous (p. 56). A specific criticism of servant leadership is the perception of service as a gentle value more commonly associated with women than with men (Hofstede, 1997). B. N. Smith et al. (2004) concluded some authors perceive servant leadership to be a solicitous model for leadership with emphasis on the emotional well-being of the followers. Beyond the view that servant leadership may be a soft style of leadership, Reinke (2004) acknowledged the idealistic nature of the theory. Although the number of research studies on servant leadership is growing, additional empirical evidence is necessary to demonstrate how servant leadership relates to organizational performance.

Dyck and Schroeder (2005) expressed concern that pseudoservant leaders may practice aspects of servant leadership but soon discard them if maximum profits are not readily achieved. Some pseudoservant leaders believe they are acting in the best interests of people but are without a moral compass. Dyck and Schroeder also indicated the perfect servant leader is unlikely to exist. Smith et al. (2004) posited servant leadership is likely to be more effective in static environments compared with high-change environments in which the transformational leadership approach is likely to be more effective. Smith et al. described a limitation of servant leadership theory (as well as transformational theory) as “the underestimation of the impact of contextual factors” (p. 89). Giampetro-Meyer et al. (1998) acknowledged servant leadership is not focused on efficiency and not useful when short-term profits need to be maximized (p. 1733).

Ciulla (1995) asserted, “Normative theories of leadership, such as transforming leadership and servant leadership, are not well-developed in terms of their philosophic implications. They need more analysis as ethical theories and more empirical testing” (p. 17). Such research may lead to a greater comprehension of the phenomenon of leadership, including who is best to lead and what the moral responsibilities of leadership are (Ciulla, 1995). Greenleaf’s model of servant leadership was developed based on his extensive experience and not on empirical studies. Greenleaf’s relatively recent theory espoused in 1977 is considered a nontraditional approach to leadership (Vecchio, 1997) that was only recently examined through empirical tests. Determining the robustness or veracity of the theory requires further rigorous empirical testing.

### Historical Overview: Integration of Spirituality in Nursing

The health-care professions, including nursing, originated from a spiritual foundation. The genesis of nursing can be traced to particular churches or religious orders (Wilt & Smucker, 2001). Spiritual care was an essential component of health care and religious beliefs, faith, and prayer were considered integral to healing (Droege, 1979; Koenig, 2002). Nightingale, considered the founder of the nursing profession (Koloroutis, 2004), envisioned nursing as a holistic, integrated endeavor in which the spirit of the patient was considered fundamental to healing. The domain of nursing extended beyond the patient to the patient's environment and the community. Nurses demonstrated evidence of humanistic values while promoting the patients' well-being (Donley, 2005). Professional nursing evolved from the traditions and continued a holistic approach to nursing care.

Nightingale exhibited many characteristics of a servant leader, including dedication to nurses and patients without expecting remuneration. Romaine-Davis (1997) identified a service orientation without expectation of self-promotion as a characteristic of a profession. Nightingale's motivation to serve derived from her strong faith and a reported calling to save lives through service (McDonald, 2006, p. 12). Dodge (1954) asserted Nightingale hoped to "prove to the world the great value of women nurses in military hospitals . . . [so] no hospital doors would again be closed to them and nursing might become a profession" (p. 29).

The service orientation of the nursing profession is evident in the Florence Nightingale Pledge, adapted in 1893 from the Hippocratic Oath. The pledge, often recited at graduation or pinning ceremonies for nurses, reads as follows:

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care. (*Florence Nightingale pledge*, n.d.)

The pledge is reflective of Nightingale's spiritual foundation and the spiritual component of the nursing profession.

Cook and Webb (2002) credited Nightingale for creating improvements in nursing, including advancing the quality of nursing care and nursing education. Nightingale advocated collaboration with physicians, teamwork, and extensive schooling in the humanities and sciences. Nightingale believed nurses needed to take a leadership role in the hospital and in health-care reform. The changes in nursing practice inspired by Nightingale led to an elevated status of the profession and increased professional satisfaction among nurses. Many of Nightingale's aims for the nursing profession are reflected in the constructs of servant leadership identified by Laub (1999), including support for nurses, valuing people, building community, providing leadership, sharing leadership, and authenticity.



## Nursing Theories and Models

True to the origins of nursing, caring remains a central phenomenon of the nursing profession. Beginning in the 1970s, nursing theorists developed theories or conceptual models for professional nursing practice. Although the construct of caring is implied or consistent in most nursing theories, two theories that incorporate both caring and a spiritual component are Watson's theory of human caring (Watson, 1985) and the relationship-based care model (Koloroutis, 2004). Although spiritual care is widely acknowledged as an integral and valued part of holistic nursing care (Narayanasamy, 2004), few nursing theorists integrate the spiritual dimension into their respective models of care.

Watson's theory of interpersonal caring "advocates blending the sciences and the humanities to provide an existential, phenomenological, and spiritual theory of transpersonal caring" (Kilby, 1997, para. 3). The nature of caring is explained in the theory as a connection with the humanness of an individual based upon a trusting relationship (Wilt & Smucker, 2001, p. 15). Watson (1985) described nursing as an ethically based profession with the goal of accentuating health (p. 15). Watson's theory of human caring contended individuals cannot be separated from self, others, nature, or the larger universe (Knestrick & Lohri-Posey, 2005). Oldnall (1995) affirmed Watson's model as the singular nursing theory to recognize explicitly the spiritual dimension. In Watson's model, spirituality is a dimension of the person whom relates to others through reciprocal interaction in a holistic way (Martsolf & Mickley, 1998).

Although Watson's theory focused on the interpersonal reciprocity of the nurse-patient relationship, the current research study extends the impact of interpersonal

reciprocity from the nurse leader to other stakeholders in the hospital environment, in particular registered nurses. Nursing practice is interdisciplinary and its effectiveness relies on the constructs of collaborative practice relationships and communication (Fisher & Riley, 2005). According to Hannon (2001), interpersonal relationships are the means through which many people experience God (p. 19).

A recent model titled relationship-based care was also pertinent to the study (Koloroutis, 2004). The relationship-based care model substantiates Watson's framework of the interpersonal relationship between nurse and patient and the significance of a caring-healing consciousness (Koloroutis). The power of relationships is the driving force behind the delivery of care. The model, based on care and service, extends the interpersonal reciprocity identified by Watson (1985) to patients' families, coworkers, and other colleagues. A premise of the model is the morale in the unit directly affects quality of patient care (Kerfoot, 2006). In the model, every person in the organization is considered capable of leadership. Healthy, integrated relationships among health-care workers are based on the value of caring.

Allen and Vitale-Nolen (2005) studied the use of the relationship-based care model among 70 nurses in an acute psychiatric setting over a 3-year period. The care delivery model is decentralized and formulated on responsible relationships. An implementation goal of the study was for unit teams to develop healthy interpersonal relationships within the team, including between nurses and patients, nurses and nurses, nurses and physicians, nurses and assistants, and nurses and the organization. The relationship-based care model comprises three essential relationships: care provider with patients and families, care provider with self, and care provider with colleagues

(Koloroutis, 2004, p. 5). To assess the effectiveness of the model, the outcome of nurse satisfaction was measured annually. Results of the study indicated significantly improved job satisfaction each year since the implementation of the model. Allen and Vitale-Nolan attributed the rise in job satisfaction in part to employees' finding meaning in their work and understanding their contributions make a difference.

Evaluating the outcome of job satisfaction among nurses demonstrates effectiveness of the model. Schmalenberg and Kramer (2007) identified job satisfaction and achievement of organizational objectives as the two outcomes that characterize a healthy work environment. The American Association of Critical Care Nurses (2005) identified six critical components necessary to achieve the outcomes of nurse satisfaction and productivity as "skilled communication, true collaboration, effective decision-making, staffing that matches patients' needs and nurses' competencies, meaningful recognition, and authentic leadership" (p. 188). Although Schmalenberg and Kramer reported on standards for the work environment of intensive care nurses, the six relationship processes are equally applicable throughout all nursing units in a hospital.

The six relationship processes critical to job satisfaction relate or fall within the six forms of servant leadership. The six components are values people (meaningful recognition), develops people (matches patients' needs and nurses' competencies), builds community (true collaboration), displays authenticity (skilled communication), provides leadership (authentic leadership), and shares leadership (effective decision making). The six relational factors that contribute to nurses' job satisfaction are congruent with the dimensions of attributes associated with the theory of servant leadership. The underlying

constructs of caring and relationships identified in Watson's theory of personal caring and the relationship-based care model are congruent with servant leadership.

### Research Setting

The primary purpose of the nursing profession is to provide patient-centered nursing care that is individualized, holistic, and of high quality (Triola, 2006). The purpose is evident in the mission, vision, and organizational values of the health-care organization serving as the research site for the study. The specific setting for the study is two hospitals affiliated with one nonprofit health-care organization located in the northwestern United States. The mission of the health-care organization is to deliver the highest quality and personalized care to patients. Personalized, attentive care requires a holistic approach to patient care. The mission also encompasses the goal of providing comprehensive, community-based nonprofit health care.

The vision of the organization includes transforming health care to achieve the highest levels of quality and service. To achieve the vision, organizational leadership identified the need to develop a highly integrated system for all stakeholders. The goal is to develop an environment that fosters the ability of health-care workers to provide extraordinary care. The pursuit and achievement of high standards of care by health-care organizations leads to healthier work environments, increased job satisfaction for nurses, and improved patient outcomes (Steefel, 2007). Such an environment is supportive of nursing. Organizational leadership envisioned both patient and staff satisfaction as integral to the success of the hospital organization.

The underlying organizational values of the health-care system include caring, respect, excellence and quality, compassion, honesty and integrity, and community.

Caring, respect, and compassion are essential in the delivery of health care and contribute to high-quality, personalized nursing care. Schumacher (2007) described caring as the fundamental component of nursing that provides a practice framework. Teaching and caring aspects of nursing practice are essential in health care. Organizational leadership is committed to optimizing nursing practice through education and training, ensuring a safe environment, and offering competitive salary and benefits to help retain experienced staff.

Values of honesty and integrity underlie the ethical foundation of the organization. An ethical foundation is necessary to achieve excellent patient care as well as support nursing practice (Strandell-Laine et al., 2005). Community is a value and the organization is determined to strengthen its community building. Through endeavors to become a learning organization, leadership seeks increased communication of ideas and best practices. Kramer and Schmalenberg (1998) averred autonomy, quality care, open communication, innovation, excellence, and personnel development contribute to an organizational climate of excellence and satisfaction.

Boyd, Collins, Pipitone, Balk, and Kapustay (1990) contended job satisfaction among nurses derives from a match between the nurse's expectations and the hospital's vision and values. Job satisfaction relates in part to nursing leadership. Alspach (2007) confirmed, "Managers who are passionate and compassionate, competent, honest, and ethical" (p. 16) increase nurses' job satisfaction as well as their likelihood to continue practice. Servant leadership and its orientation toward ethical constructs should produce increased job satisfaction among nurses.

## Job Satisfaction

Health-care organizations operate in a dynamic and changing environment, affected by downsizing, advances in technology, globalization, increasing diversity, and legal constraints (Vecchio, 1997). Amid organizational challenges, leaders are intent on maximizing productivity and economic viability. The nursing shortage poses a considerable challenge to health-care organizations. Health-care leaders are concerned with the ramifications of the nursing shortage, including threats to access to care, quality of care, and organizational sustainability (Williams, 2006). Effective nurse recruitment and retention are essential methods employed by hospital-based nurse leaders to stabilize the nursing workforce (Donley, 2005). Ma, Samuels, and Alexander (2003) confirmed, “Job satisfaction and retention of qualified nurses is currently one of the primary concerns of hospital administrators” (p. 294). Employee satisfaction is a crucial ingredient to a successful and productive organization, particularly in the service-focused health-care industry. Nurse leaders are increasingly aware that “as RNs’ [registered nurses’] job satisfaction decreases, the likelihood of their leaving their employment setting increases” (Ma et al., p. 293).

According to Valesquez (1992), job satisfaction derives from two factors: (a) experienced meaningfulness and (b) knowledge of results. Experienced meaningfulness occurs when employees perceive their work is worthwhile or important according to their values. Knowledge of results refers to a worker’s understanding of personal work outcomes on a regular basis. Intrinsic factors, such as perceived respect and recognition, often have a greater effect on the job satisfaction of health-care workers than extrinsic factors of pay and benefits (McGuire, Houser, Janar, Moy, & Wall, 2003). R. S.

Thompson (2002) reported, “Achievement, recognition, responsibility, possibility of advancement, and salary” (p. 40) relate to job satisfaction. Research demonstrated many factors that relate to job satisfaction among employees. An examination of particular factors that affect job satisfaction of registered nurses is presented, followed by empirical evidence supporting a direct relationship between leadership and nurses’ job satisfaction. The empirical evidence regarding servant leadership and job satisfaction is also discussed.

### *Registered Nurses and Job Satisfaction*

The construct of job satisfaction in nursing was examined as both an independent variable and a dependent variable. As an independent variable, research studies linked job satisfaction of registered nurses to improved nurse retention (Buerhaus et al., 2005; Halfer & Graf, 2006; Ribelin, 2003) as well as decreased absenteeism and increased productivity (Ma et al., 2003). Aiken et al. (2001) contended increasing the level of job satisfaction among nurses leads to a higher quality of nursing care. Improved job satisfaction and retention of experienced nurses benefits the individual nurse, the patients, the coworkers, and the hospital organization (Hayhurst et al., 2005). As a contributing factor to positive organizational outcomes, job satisfaction is an increasingly significant issue in nursing (Kovner et al., 2006).

As a dependent variable, job satisfaction among registered nurses is associated with or predicted by various factors. In a study of nurses in a multihospital system, Scher (2006) identified collegiality with peers and factors as related to the nature of nursing itself as primary determinants of job satisfaction. Benner (2001) described nurses’ job satisfaction as influenced by human connection and sense of competency and

accomplishment (p. 153). N. A. Maxwell (2007) attributed job satisfaction among nurses to a sense of effectiveness and meaningfulness derived from work. Earlier studies by Adams, Bond, and Adams (2000) and Trossman (2005) supported the premise that interpersonal working relationships among nurses and other members of the health-care team are directly related to nurses' job satisfaction.

Relationships with supervisors are a major factor in nurses' level of job satisfaction. Hall (2007) reported job satisfaction among hospital nurses increased as relationships with supervisors improved. Because nursing is a field that interacts with multiple health-care disciplines, relationships with colleagues, supervisors, and other health-care workers are certain to affect job satisfaction. In a survey of 76,000 nurses conducted by the American Nurses Association, nurses were highly satisfied with peer interactions ("Job Satisfaction," 2005). Satisfaction derived from being a nurse and positive peer relationships may explain why Buerhaus, Donelan, Ulrich, DesRoches, and Dittus (2007) determined most nurses are at least somewhat satisfied with being a nurse, irrespective of their present jobs.

Job dissatisfaction is especially prevalent among hospital-based registered nurses, with over 40% of nurses reporting dissatisfaction with their jobs in one study (Aiken et al., 2001). Nurses identified a negative health-care work environment as a contributing factor to dissatisfaction and the nursing shortage (Buerhaus et al., 2007). Donley (2005) acknowledged several factors contribute to dissatisfaction among nurses, including the hospital work environment. Kovner et al. (2006) surveyed over 1,500 nurses employed in nursing and determined job satisfaction was significantly related to work factors. Sojka (2003) explored the relationship between job satisfaction and organizational attributes



among 720 nurses from 12 facilities associated with one organization. Results from the study revealed nurses reported high satisfaction with their nursing colleagues and work hours, although they desired increased involvement in organizational decision making. Other factors, including demographic characteristics, demonstrated positive relationships with job satisfaction of registered nurses, albeit of less significance than work environment factors (Adams et al., 2000; McNeese-Smith, 1999).

The organizational culture is a critical factor that influences job satisfaction for nurses. A supportive and encouraging environment promotes a sense of acceptance for the nurse and integration into the organization and leads to increased commitment to the organization (Strachota, Normandin, O'Brien, Clary, & Krukow, 2003; Winter-Collins & McDaniel, 2000). Beheri (2007) determined nurses' job satisfaction correlated with valuing differences and trust. Zurmehly (2004) studied factors of educational preparation, autonomy, critical thinking, and job satisfaction and reported positive correlations existed between both perceived autonomy and critical thinking and job satisfaction. Zurmehly concluded fostering autonomy and critical thinking in the work environment might lead to increased job satisfaction among nurses.

Greater peer cohesion, supervisor support, and autonomy were linked to job satisfaction and nurse retention (Hayhurst et al., 2005; Zurmehly, 2004). Shermont (2006) contended nurse leaders could directly influence organizational cultures, resulting in greater job satisfaction among nurses. Aiken et al. (2001) portended management must address organizational factors to address job dissatisfaction, alleviating the nursing shortage and ensuring quality of patient care.

*Nursing Leadership and Job Satisfaction*

Research studies illustrated a connection between job satisfaction and leadership since the 1920s (Bass, 1997). Empirical evidence supported the hypothesis that positive attitudes toward supervisors affect employees' satisfaction (Bass, 1997). Studies in nursing indicated positive perceptions of the nurse manager or nursing supervisor and leadership behaviors are integral to nurses' job satisfaction (Laschinger, Purdy, & Almost, 2007; Ribelin, 2003; Shirey, 2006). In a study by Ulrich et al. (2006), nurses cited better leadership as the number one reason that would lead them to re-evaluate their decision to resign their position (p. 52).

The influence of leadership on nurses' job satisfaction gained increasing empirical evidence. In a survey of over 2,000 clinical nurses in three hospitals, Ribelin (2003) reported positive perceptions of the nurse managers' leadership style were directly related to overall satisfaction and intent to stay. Positive leadership characteristics included recognition, direct communication, feedback, and behaviors perceived as supportive. Beheri (2007) concluded in a study of nearly 200 nurses that nursing leaders are instrumental in developing an organizational climate that increases job retention of nurses, improves level of professional nursing practice, and increases positive interaction among cultural groups.

Not all studies demonstrated conclusive findings. Scher (2006) surveyed 257 nurses in a multihospital system to determine if a relationship existed between the style of conflict management of nurse managers and job satisfaction of the nurses. Scher discovered the primary conflict management style used by nurse managers was problem solving and could not relate a particular conflict management style with job satisfaction.

Kovner et al. (2006) demonstrated a positive relationship between support from supervisors and registered nurses' job satisfaction (p. 77).

Nursing leadership plays a significant role in creating favorable work environments (Ulrich et al., 2006) and is therefore crucial in sustaining an adequate nursing workforce (Shirey, 2006). Nurse leaders are in a position to influence directly and affect the work environment. Nurse leaders' roles, responsibilities, and efforts can positively affect the quality of the work lives of employees and influence the overall functioning of the organization. Effective leadership styles are related to increased job satisfaction among nurses (Friedrich, 2001), retention (Shobbrook & Fenton, 2002), and organizational productivity (McNeese-Smith, 1999). Research indicated nurse leadership behaviors of supporting and demonstrating concern for staff, visibility, and promoting empowerment increase nurse retention (Kleinman, 2004).

The leadership style of the nurse is a factor that affects nurses' job satisfaction. Hayhurst et al. (2005) demonstrated a nurturing leadership style is a characteristic of nurse managers that increases job satisfaction among nurses. J. M. Thompson (2006) determined a participative or consultative management style positively correlated with nurses' satisfaction with both their manager and their job. Although studies on servant leadership in health care are rare, McCutcheon (2004) indicated transformational leadership was positively linked to nurses' job satisfaction. Other leadership styles, such as management by exception and laissez-faire, were inversely related to job satisfaction. Vecchio (1997) noted hospital leaders "need a deeper understanding of how to marshal and manage human resources" (p. ix) to address the issue of job satisfaction.

### *Servant Leadership and Job Satisfaction*

Empirical studies examining the role of servant leadership and job satisfaction began in the late 1990s. R. S. Thompson (2002) noted employees who work in an organization that endorses and promotes the principles of servant leadership experience high levels of job satisfaction. Miers (2004) and K. P. Anderson (2005) also determined a positive relationship exists between servant leadership and job satisfaction. The only reported study that examined servant leadership in a health-care setting with job satisfaction of nurses was conducted by Swearingen (2004). Swearingen examined and reported a positive relationship between servant leadership and job satisfaction among nurses of different generational cohorts from two central Florida nonprofit hospitals.

Kovner et al. (2006) advised determining factors that increase job satisfaction and “are mutable by management or governmental policy” (p. 78) is of particular interest. In a national survey of nurses, Buerhaus et al. (2007) reported only 25% of nurses attribute “magnet-like” (p. 69) characteristics to be highly practiced, such as autonomy, recognition, and professional development. The characteristics are consistent with dimensions of servant leadership as described by Laub (1999) and relate to nurses’ job satisfaction (Halfer & Graf, 2006). The current study determined the degree to which nurses perceive the behaviors in a community-based nonprofit hospital organization in the northwestern United States. The relationship of servant leadership behaviors with nurses’ job satisfaction was also determined.

### Conclusion

Nursing leaders are tasked with improving recruitment and retention in the face of a severe nursing shortage. Increasing nurses’ job satisfaction leads to increased retention

(Adams et al., 2000). Servant leadership is identified as a leadership model that correlates with job satisfaction and is appropriate for nursing environments. By positively influencing the organizational culture to incorporate spirituality through a servant leadership approach, nurse leaders may create a positive, humanistic work environment that increases satisfaction among the registered nursing staff. Servant leadership can foster healthy, satisfying, and positive work environments (Greenleaf, 1977). When individuals perceive their leaders genuinely care for them and their development, intrinsic motivation and job satisfaction result (Kotter, 1997). Giampetro-Meyer et al. (1998) asserted,

If the servant leader can help those they serve become healthier, wiser, freer, more autonomous, and more likely themselves to become leaders, the servant leader will have achieved significant success in his or her working life, no matter what their contribution to the corporation's bottom line. (p. 1735)

If employees perceive themselves to have benefited from growing personally and professionally, increased job satisfaction is likely.

The literature review revealed empirical support for a relationship between job satisfaction and servant leadership behaviors, primarily in organizational settings outside health care (K. P. Anderson, 2005; Laub, 1999; Miears, 2004; R. S. Thompson, 2002). Not enough evidence exists regarding the relationship of job satisfaction and servant leadership in acute health care settings. Implications that servant leadership may be a tenable leadership approach in the nursing environment are evident, based on the tenets of servant leadership and the values associated with the nursing profession. The study involved determining the extent of servant leadership behaviors exhibited in a nonprofit

health-care organization in the northwestern United States as perceived by registered nurses and determining if any correlation exists with job satisfaction.

### Summary

Chapter 2 presented an overview of historical and contemporary literature that addressed the theoretical construct of servant leadership, leadership traditions in nursing, and job satisfaction among registered nurses. Effective leadership involves marshaling forces within individuals to help them adapt to change and overcome barriers to change (Kotter, 1997). Major leadership theories with an ethical foundation were reviewed as applicable to the nursing environment. Of the spiritual-based theories, servant leadership was identified as an effective leadership model for the nursing profession. Servant leadership, which emphasizes service to customers, teamwork, and community (Greenleaf, 1977; Van Tassell, 2006), was discussed as a viable approach for increasing job satisfaction and mitigating the current nursing shortage. Leaders who employ servant leadership behaviors are likely to motivate and inspire followers using six dimensions: values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership (Laub, 1999, p. 25).

The second major topic presented in the literature review was the nursing profession. A historical overview included an explanation of the spiritual foundation of the profession. The discussion included the evolution of nursing theories and models that provide a framework for nursing practice. The construct of caring, identified by Nightingale as an integral part of nursing practice (Dossey, 2002), continues to be a fundamental component of the nursing profession (Benner, 2001; Koloroutis, 2004; Watson, 1985). The specific setting for the research study was a health-care organization

consisting of two community-based nonprofit hospitals in the northwestern United States, was introduced. Information pertaining to the mission, vision, and organizational values of the setting was provided.

The third and final major section of the literature review discussed job satisfaction. After an introduction to the general concept of job satisfaction, the chapter included an examination of current research on job satisfaction among registered nurses. The effect of leadership upon nurses' job satisfaction was presented. Leadership was identified as a primary determinant of job satisfaction among nurses (Ribelin, 2003; Ulrich et al., 2006). The relationship between servant leadership and job satisfaction was reviewed. Empirical evidence exists for a relationship between servant leadership and job satisfaction (K. P. Anderson, 2005; R. S. Thompson, 2002), although mainly in settings outside health-care. The literature review showed a gap related to servant leadership in health care. The gap encompassed perceptions of nurses, nurse managers, and nurse leaders regarding servant leadership behaviors in health-care settings and in relation to job satisfaction.

Chapter 3 contains a review of the methodology used to address the research questions. Justification for a quantitative correlational research design is provided. The chapter also included a discussion on the research design, sample population, data collection, instrumentation, validity and reliability, feasibility and appropriateness, and data analysis.

## CHAPTER 3: METHOD

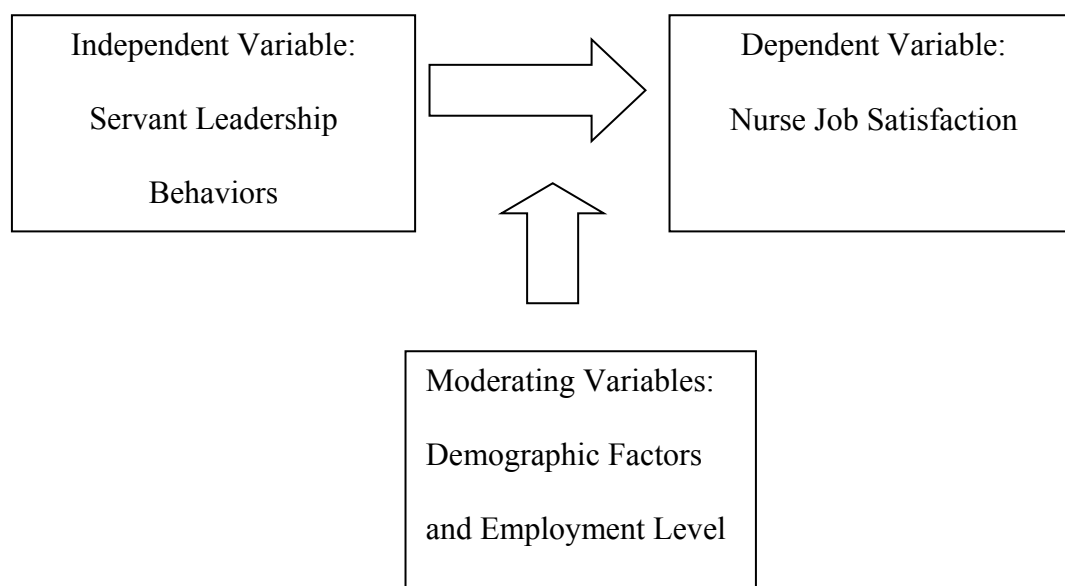
The purpose of the quantitative method research study with a correlational research design was twofold: first, to ascertain the extent that servant leadership behaviors are implemented in a nonprofit, acute health-care organization as perceived by registered nurses and, second, to measure the degree of correlation between the servant leadership and registered nurses' job satisfaction. Chapter 2 presented an overview of historical and contemporary literature that addresses job satisfaction among registered nurses, leadership traditions in nursing, and the theoretical construct of servant leadership. The literature review revealed empirical support for a relationship between job satisfaction and servant leadership behaviors, with implications that servant leadership may be a tenable leadership approach in the nursing environment. Chapter 3 includes an examination of the methodology selected to investigate the research questions and the justification for the selected research approach. The chapter also presents the research design, sample population, data collection, instrumentation, force and reliability, feasibility and appropriateness, and data analysis.

### Research Design

A quantitative, nonexperimental correlational design was selected as the optimal method to address the research questions. The research questions related to the level of servant leadership behaviors implemented in a nonprofit health-care organization and whether the presence of servant leadership behaviors in the acute health-care setting correlates with job satisfaction among registered nurses. Servant leadership characteristics as perceived by registered nurses in two hospitals represented the independent variable in the study and job satisfaction among registered nurses was the



dependent variable. Intervening variables are composed of demographic factors, including nursing employment level in the organization. The employment level, including top leadership, management, and clinical workforce, is an intervening variable because a nurse's position may affect both perceptions of servant leadership behaviors in the organization and job satisfaction. Figure 2 illustrates the relationships of the variables in the study.



*Figure 2.* Relationship of variables.

The research design incorporated data collection through a validated survey instrument, the OLA (Laub, 1999). The OLA instrument measures the independent variable of servant leadership as perceived by study participants and the measured level of job satisfaction as self-reported by the same participants. The use of a quantitative, correlational research design was appropriate for ascertaining the direction and degree of association between variables without manipulating the variables (Gall et al., 2003). The study design also included an investigation of the effect the nursing position may have on perceptions of servant leadership in the organization. A random sample of registered

nurses from a nonprofit health-care organization consisting of two hospitals in the northwestern United States was targeted for voluntary participation in the study.

#### Appropriateness of Design

Leedy and Ormrod (2001) indicated quantitative descriptive research involves “either identifying the characteristics of an observed phenomenon or exploring possible correlations among two or more phenomena” (p. 191). The quantitative, correlational research study involved doing both by generating empirical data on the perceptions of servant leadership in a health-care organization and determining if any relationship exists between servant leadership behaviors and nurses’ job satisfaction. Creswell (2002) posited quantitative methods are especially appropriate when “the problem is identifying factors that influence an outcome, the utility of an intervention, or understanding the best predictors of outcomes” (p. 22).

Deductive analysis, hypothesis testing, and the use of standardized instruments characterize quantitative methods (Creswell, 2002). Such methods are positivist and well suited to data that can be observed, measured, and numerically analyzed (Gall et al., 2003). Servant leadership characteristics are discernible and quantifiable. The standardized OLA instrument (Laub, 1999), designed to measure the perceptions of servant leadership behaviors, was used to gather data in the study.

A quantitative research method was preferred over qualitative and mixed methods approaches for the study, primarily because of the nature of the hypotheses. The first hypothesis required an exploration of the existence of servant leadership behaviors in the health-care organization. Although a qualitative approach may yield data on perceptions of employees pertaining to servant leadership, the volume of data required for

establishing representativeness and forming a meaningful analysis in a large health-care organization would be vast. Practical issues including sufficiency of sample size, time constraints, and the aim to generalize results of participants to the entire health-care organization precluded the use of a qualitative method. Berg (2004) confirmed qualitative research involves a search to explore a deep understanding and requires significantly more time to conduct. A mixed methods approach incorporates both qualitative and quantitative research and adds considerable time requirements for completing the study.

The second and third hypotheses pertained to possible relationships between the variables of servant leadership and job satisfaction among nurses and relationships between nurse employment level and perceptions of servant leadership, respectively. A quantitative approach provides “the statistical testing of empirical hypotheses” (Berg, 2004, p. 11) through analysis of “rigorous, reliable, and verifiably large aggregates of data” (p. 11). Gall et al. (2003) confirmed data for causal relationship studies, such as correlational studies, needs to be obtainable in a quantifiable format (p. 326). Zikmund (1997) corroborated the assertion that examining statistical measures of association is encompassed under quantitative research.

The correlational research design is quantitative research (Creswell, 2002). Creswell (2002) affirmed a correlational design is well suited to studying a problem “requiring the identification of the direction and degree of association between two sets of scores” (p. 379). Although a correlational design approach does not establish cause and effect as an experimental design or quasi-experimental design infer, prospective causal factors can be ascertained from the extent and direction of relationships among variables (Gall et al., p. 330). Zikmund (1997) purported the complexity of organizational

environments confounds the ability of researchers to establish causation. Concomitant variation, or “the occurrence of two phenomena or events that vary together” (Zikmund, p. 40), can be demonstrated through correlational research, indicating a relationship between variables. In the study, the direction and degree of the relationship between servant leadership behaviors in the hospitals and registered nurses’ job satisfaction were determined.

Measurement of both the servant leadership variable and the job satisfaction variable occurred at the same time through one validated instrument, the OLA research instrument (Laub, 1999). The OLA was as an effective and reliable instrument for measuring the degree of servant leadership in an organization while concurrently measuring the job satisfaction for individual workers (Laub, 1999; Miers, 2004; R. S. Thompson, 2002). Measuring the variables simultaneously is appropriate in correlational studies that search for relationships (Gall et al., 2003).

The use of a correlational research design accomplished the intended purpose of the research study because correlational studies are especially useful in deriving knowledge regarding the extent of the association between the variables being examined (Gall et al., 2003, p. 324). Correlational analysis provided an answer to the research question of whether any correlation or relationship exists between the two variables of servant leadership characteristics and nursing job satisfaction. Creswell (2002) reported a quantitative research approach with subsequent data analysis provides an optimal method for identifying trends, comparing different groups, or linking variables (p. 24). A quantitative research method approach and correlational design in particular were appropriate because numeric data were generated that were indicative of the social

environment (Gall et al.) and by which statistical relationships were determined. The quantitative, nonexperimental correlational research design assisted in an exploration of the relationships between servant leadership and job satisfaction among a population of registered nurses employed at a large nonprofit health-care organization located in the northwestern United States.

### Research Questions

Research questions provide the primary direction and intent for research (Creswell, 2002). The study involved an examination of the implementation of servant leadership in the hospital setting as perceived by registered nurses, through six distinct characteristics of servant leadership: (a) values people, (b), develops people, (c) builds community, (d) displays authenticity, (e) provides leadership, and (f) shares leadership (Laub, 1999, p. 25). Job satisfaction among registered nurses was also measured. The following research questions guided the study:

1. To what degree do nursing leaders and managers implement servant leadership as perceived by registered nurses in two nonprofit, community-based hospital facilities owned by one hospital organization in the northwestern United States?
2. To what degree does the perceived implementation of servant leadership in two nonprofit, community-based hospitals owned by one hospital in the northwestern United States correlate with the level of job satisfaction among registered nurses?
3. Are there differences in the perceptions of servant leadership based on the level of position in the organization (e.g., top nursing leadership, nursing management, or clinical nursing staff)? Do demographic factors, including employment level in the

organization, have an effect on the relationship between perceptions of servant leadership and job satisfaction?

Demographic factors, including nursing educational preparation, time employed as a registered nurse, time employed at a particular acute care facility, age, and gender were examined in relation to the concepts of servant leadership and job satisfaction but were not of primary interest in the study.

### Research Hypotheses

The results from the study were expected to support one of three hypotheses, each based on a corresponding research question. The first hypothesis addressed the research question about opinions of servant leadership in the hospital organization. Although nursing organizational structure traditionally relied on hierarchical authority, growing evidence supported servant leadership characteristics in nursing and health-care organizations (Cunningham, 2003; Swearingen, 2004). The OLA instrument was devised to measure the extent of servant leadership behaviors in an organization, as perceived or not perceived by employees (Laub, 1999). The study extended the investigation of servant leadership behaviors to a new setting—a nonprofit, community-based acute health-care organization in the northwestern United States.

H1<sub>0</sub>: Servant leadership behaviors are not perceived at a nonprofit, community-based acute health-care organization by registered nurses.

H1<sub>A</sub>: Servant leadership behaviors are perceived at a nonprofit, community-based acute health-care organization by registered nurses.

Research studies established a relationship between servant leadership and job satisfaction (K. P. Anderson, 2005; Laub, 1999; Miears, 2004; R. S. Thompson, 2002),

although in organizational settings other than health care. Only one study involved an examination of the relationship between servant leadership and job satisfaction among nurses (Swearingen, 2004). Although Swearingen's findings revealed a positive relationship, the study was limited to the southwestern region of the United States. The current study expanded the investigation of the relationship between servant leadership and job satisfaction to a different population and setting than previously examined, namely registered nurses from a community-based, nonprofit acute health-care organization in the northwestern United States.

H2<sub>0</sub>: No significant correlation exists between perceived implementation of servant leadership and level of job satisfaction among nurses and administrative leaders at two community-based nonprofit hospital facilities owned by one health-care organization in the northwestern United States.

H2<sub>A</sub>: A significant correlation exists between perceived implementation of servant leadership and level of job satisfaction among nurses and administrative leaders at two community-based nonprofit hospital facilities owned by one health-care organization in the northwestern United States.

Laub (1999) anticipated differences in perceptions of servant leadership characteristics based on level of job classification and incorporated the component of employment level into the OLA instrument. Kamencik (2003) determined perceptions of leadership vary among nurse leaders and nurse managers, because nurse leaders perceived themselves to demonstrate more behaviors associated with transformational leadership than their respective managers did. Kamencik asserted optimal leadership

requires congruence between leaders and followers' core values, organizational vision, and the intended strategies to accomplish the vision.

H3<sub>0</sub>: No significant differences exist in perceptions of servant leadership behaviors based on level of nursing position, including top leadership, management, and clinical workforce.

H3<sub>A</sub>: Significant differences exist in perceptions of servant leadership behaviors based on level of nursing position, including top leadership, management, and clinical workforce.

### Population

The general population for the study encompasses the total population of registered nurses employed by a large nonprofit health-care organization located in the northwestern United States. The health-care organization consists of seven hospitals in one particular northwest region of the United States. The target population includes the total population of registered nurses employed at either of two acute care hospitals affiliated with the health-care organization. Approximately 1,600 registered nurses, categorized as top nursing leadership, nursing management, and clinical staff nurses, are employed at the two affiliated hospitals.

Demographic characteristics were included in the survey, in part to allow for inferences and generalizability as well as to analyze relationships between demographics and the study variables of servant leadership behaviors and job satisfaction. Potentially significant demographic variables that can lead to determinations of generalizability, if they are similar to the target population, include "gender, socioeconomic status, ethnicity, age, and academic ability" (Gall et al., 2003, p. 169). Demographic characteristics



included in the study were gender, age, level of education, number of years as a registered nurse, and number of years employed at the hospital organization. The nurses were categorized as clinical staff, management, or top leadership.

### Informed Consent

Informed consent, involving the purpose of the study, the nature of the study, the potential risks and benefits, and the right to refuse participation, must be explained to potential research participants prior to data collection (Berg, 2004). The information was presented in writing to each participant, through the cover letter (see Appendix A) and the informed consent form (see Appendix B). The participant was instructed to sign the informed consent form and return it with the completed survey in an enclosed, stamped, and preaddressed envelope.

### Sampling Frame

Permission to contact potential participants randomly selected from the total target population was requested from a senior administrator of the health-care organization for voluntary participation in the study. The total target population includes approximately 1,600 registered nurses employed at one of two hospitals associated with a nonprofit health-care organization in the northwestern United States. A stratified listing of registered nurses that distinguished the nurses by management and leadership position in the organization was obtained. A list of the registered nurses classified as clinical staff nurses or workforce was not available. Job position indicates the leadership role in the organization, including clinical staff nurses or workforce, nurse managers in the middle management level, and nurse leaders at the top leadership level.

Probability sampling was applied to the target population to select the sample for the study. Creswell (2002) asserted probability sampling is “the most rigorous form of sampling in quantitative research” (p. 164) and allows for generalizability to the study population. Stratified sampling helped to ensure sufficient representation of nurses employed in leadership and management positions in the organization. To obtain sufficient representation of nurses in management and leadership positions, the stratified sample population encompassed all registered nurses from the target population distinguished by a leadership or management position in the organization. Gay and Airasian (2000) reported for populations less than 100 members sampling is not recommended because the entire population should be surveyed.

A random sample size of 320 registered nurses, equivalent to 20% of the target population, was sufficiently robust to provide data representative of the target population with a 95% level of confidence (Gay & Airasian, 2000). To achieve sufficient participation, 815 potential participants were contacted to participate voluntarily in the study and complete the OLA survey instrument. The basis for the sample number of 815 was an estimate of a 40% survey return rate. Creswell (2002) asserted many studies in quality journals report a response rate of 50% or higher with mailed surveys. Cooper and Schindler (2003) indicated a 30% return rate is satisfactory for self-administered paper-based surveys. Recent studies involving nurses completing questionnaires reported return rates of 40 to 78% (DeCicco, Laschinger, & Kerr, 2006; Kirkwood, 2006; Miller, 2007).

#### Confidentiality

Ensuring confidentiality is a critical component of the research design and process and is incumbent upon the researcher, who has a moral obligation to maintain

confidentiality (Berg, 2004). The credible assurance of confidentiality contributes to truthful responses and a greater likelihood of participation (Gall et al., 2003). Potential participants were informed in writing that their privacy and confidentiality are guaranteed. A confidentiality statement on the informed consent form (see Appendix B) included an explanation regarding how anonymity would be maintained throughout data collection, analysis, and reporting. Surveys were coded numerically and did not include any personal identifiers. Confidentiality and anonymity were ensured as names were not associated with survey data. The informed consent forms will be maintained in a secure, locked safe until destroyed after a minimum of 3 years.

#### Geographic Location

The research study was limited by geographical location. The study was conducted in a northwestern state in the United States. Two community nonprofit hospitals owned by one health-care organization served as the research sites.

#### Instrumentation

The aim of the quantitative correlational study was to determine the degree to which perceptions of servant leadership characteristics in the hospital work environment correlate with job satisfaction among registered nurses. The validated OLA survey instrument (Laub, 1999) was designed to measure both servant leadership behaviors in an organization and job satisfaction. The OLA survey instrument, which uses a 5-point Likert-type scale was used in the study to gather quantifiable data on the perceptions of servant leadership characteristics in the hospital organization and job satisfaction among registered nurses.

The OLA was developed in response to the “the lack of scholarly research and measurement instruments pertaining to servant leadership” (Van Tassell, 2006, p. 64). Although the number of empirical studies focused on servant leadership grew considerably since 2000, little attention was given to developing additional measurement instruments. The literature review located only one instrument that focused directly on servant leadership—a 42-item survey instrument developed by Dennis and Bocarnea (2005). A survey instrument developed by Reinke (2004) was rejected because of the expanded scope of the survey, an assessment of attitudes toward the performance appraisal process (p. 44). Reinke’s survey was also limited in its ability to assess the scope of servant leadership, examining only four constructs. Twenty-six survey items measure the four constructs of openness, stewardship, vision, and trust.

Dennis and Bocarnea (2005) created a survey designed to measure the effectiveness of a servant leader based on seven factors associated with servant leadership. The survey instrument reportedly measured five of seven factors, failing to measure concepts of altruism and service (Dennis & Bocarnea). Dennis and Bocarnea concluded construct validity was not established and recommended item refinement and development to address the limitations of the survey. The tool, designed as an employee assessment of an individual leader, was not appropriate for the present study because it would not provide an overall assessment of servant leadership behaviors in an organizational setting. The OLA emerged as an efficacious instrument to measure servant leadership from an organizational perspective (Arfsten, 2006; Ross, 2006; R. S. Thompson, 2002; Van Tassell, 2006).

Laub (1999) constructed the OLA instrument as an assessment tool to determine the presence of servant leadership characteristics within an organizational setting. A Delphi study was incorporated into the initial development of the instrument to identify servant leadership characteristics. A panel of 14 individuals who were recognized experts on servant leadership was tasked to identify and rate attributes of servant leadership (Laub, 1999). Three successive surveys were used to gain consensus and authenticate the final list of attributes of servant leadership, which were deemed either “necessary” or “essential” by the expert panel (Laub, 1999, p. 45). Based on the constructs, 74 items were developed for the OLA, with 6 additional items to assess job satisfaction (Laub, 1999, p. 50).

The OLA instrument was subsequently field tested among 828 people from 41 different organizations (Laub, 1999). The sample population was located throughout the United States and the Netherlands, with the organizations characterized as religious nonprofit, secular nonprofit, for-profit, or public agencies (Laub, 1999, p. 54). Measurements of reliability for the OLA instrument assessed through Cronbach’s alpha revealed a coefficient of .98 (Laub, 1999, p. 66). Each of the six dimensions or subgroups of the OLA instrument demonstrated considerable reliability, as indicated in Table 2.

The OLA instrument provides a means to gather quantifiable data on servant leadership in an organization. Laub (1999) successfully reduced the number of test items from 80 to 60, eliminating items “of lower item-to-test correlations” (p. 78) and redundancy while concomitantly maintaining “the same reliability and adherence to the foundational constructs” (p. 79). The underlying basis for the test item reduction was to increase ease in administration through shortening the time required to complete the

instrument (Laub, 1999, p. 78). Laub (1999) anticipated the availability of a valid and reliable instrument to measure data on servant leadership in an organization would likely increase research on the topic of servant leadership (p. 37).

Table 2

*Cronbach's Alpha Results for Subgroups of Organizational Leadership Assessment (OLA)*

	Cronbach's alpha coefficient
OLA subgroup	
Values people	.91
Develops people	.90
Builds community	.90
Displays authenticity	.93
Provides leadership	.91
Shares leadership	.93
OLA instrument	.98

Including test items about job satisfaction broadens the scope of the instrument (Laub, 1999). Reliability measures for the job satisfaction score in the OLA as shown by Cronbach's alpha revealed a coefficient of .81 (Laub, 1999, p. 73). Pertaining to the correlation of job satisfaction and servant leadership, a Pearson correlation revealed "a significant ( $p < .01$ ) positive correlation of .635" (Laub, 1999, p. 73). Laub (1999) concluded a larger score on the OLA is indicative of a greater amount of job satisfaction (p. 73).

Selection of the OLA instrument as the data collection tool for the study was appropriate because the survey instrument was designed to determine the level of servant leadership exhibited in an organization. The instrument was also devised to measure job satisfaction, the dependent variable. The tool provided the optimal means available for answering the research questions and testing the hypotheses. The reliability and validity of the OLA, as noted previously, contributed to a rigorous study that produce meaningful data and led to robust analysis and conclusions.

### Data Collection

The use of a survey instrument is advantageous in communication-based studies in which perceptions of individuals are measured (Cooper & Schindler, 2003). Creswell (2002) considered surveys of particular benefit when the researcher aims to “describe the attitudes, opinions, behaviors, or characteristics of the population” (p. 396). A cross-sectional survey design fosters the ability to compare groups, determine current attitudes, and evaluate practices (Creswell). The choice of a distributed self-administered questionnaire as a survey instrument was a suitable approach for data collection in the study because the aim of the study was to assess perceptions of nurses and make comparisons based on different levels of employment. Neuman (2003) cited additional advantages of questionnaires, including quick data collection, cost-effectiveness of method, and a simple-to-complete format for the participant. Gall et al. (2003) affirmed the questionnaire’s highly uniform arrangement is compatible with quantitative research.

Quantitative interviews represent an alternative method for generating data on perceptions of individuals (Cooper & Schindler, 2003). The method of conducting interviews with each participant was considered unfeasible for the study because of

geographical dispersion of the population and the large data requirements necessary to determine the level of servant leadership in the health-care organization. The electronic questionnaire method was also evaluated, but discarded because of limited accessibility to computers in U.S. homes. Charness (2006) indicated only 50% of U.S. homes have Internet access. The aging of the nursing workforce compounds the issue of limited Internet access, because increasing age correlates with decreased computer usage (Charness).

A combined approach employing a distributed questionnaire with an electronic option may have potentially bolstered return rates by offering potential participants a choice in method for completing the questionnaire. The option was not available for administration of the OLA instrument. All three methods, self-administered questionnaires, interviews, and electronic questionnaires, have a potential disadvantage of disinterest in the study by prospective participants (Creswell, 2002). Actions to address suboptimal return rate are presented later in this section. Another disadvantage to questionnaires is the lack of clarification procedures if the participant has questions (Gall et al., 2003).

The OLA instrument employs a Likert-type scale to assess quantitatively the level of servant leadership in the organization and the level of job satisfaction among employees. Cooper and Schindler (2003) declared a Likert-type scale is “the most frequently used variation of the summated rating scale” (p. 253) and consists of statements that allow for a numerical measurement of a person’s attitude based on a range of favorable or unfavorable responses. Neuman (2003) noted the use of a Likert-type scale is a valuable technique to assess attitudes and opinions through a survey instrument.



The data collected from the Likert-type scale responses on the OLA instrument allowed for statistical analysis of the degree of the relationship and association between variables. Cooper and Schindler (2003) explained Likert-type scales produce interval data that facilitate comparisons of variables and increase the power potential of statistical analysis. Zikmund (1997) cited additional advantages of using a Likert-type format, including the ability to generate large quantities of data, the increased capacity for establishing reliability, and the easy to administer format.

Survey methodology, and specifically the OLA instrument, was appropriate for the research design and for addressing the research questions and hypotheses. The research study encompassed responses among three levels of nurses in the organization: top leadership, management, and clinical staff. The study included an examination of the effects of the nursing employment level upon perceptions of servant leadership in the organization. Demographic factors, including gender, age, level of education, number of years as a registered nurse, and number of years employed at the hospital organization, were also analyzed for effects upon the perceptions of servant leadership behaviors and nurses' job satisfaction.

Upon obtaining Institutional Review Board approval from the University of Phoenix, surveys were distributed to the stratified random sample of registered nurses employed at either of two nonprofit, community-based hospitals affiliated with one health-care organization in the northwestern United States. Creswell (2002) identified follow-up procedures, a research problem of particular interest, the use of a brief instrument, and incentives as methods to optimize response rates for questionnaires (p. 410). The opportunity for participants to be entered in a raffle in which six prizes of \$100

would be awarded was noted in boldface, italicized type in the cover letter and informed consent form. Incentives or procedures are recommended to optimize volunteer participation rates (Gall et al., 2003, p. 186).

In conjunction with the OLA instrument (see Appendix C), a brief questionnaire pertaining to demographic data (see Appendix D) was distributed to the intended participants. An informed consent and confidentiality form (see Appendix B) and a request for participation in the study (see Appendix A) were included. The letter requesting participation included information on how the study may benefit the nursing profession as well as assurances of anonymity. Expectations of the respondent, such as completing the survey in an estimated time of 15 to 20 minutes (Laub, 1999) and mailing the completed survey in an enclosed, addressed, stamped envelope to the researcher were explicit.

In the data collection phase of the study, a raffle ticket was attached to the informed consent form (see Appendix B) as an incentive for selected nurses to participate in the study and return the survey in an enclosed envelope. The participant retained one numbered raffle ticket and returned the other one with the signed informed consent form and survey. After the forms were received, the informed consent form and raffle ticket were separated from the survey and entered into a drawing. The only linkage system, the informed consent form and corresponding raffle ticket, prevented association of participants with particular data (Gall et al., 2003). As identifiers were not used in the data collection process, anonymity was ensured. Four weeks following survey distribution, the 6 participants with winning raffle ticket numbers were notified and received their prizes. The completed surveys were subsequently tabulated for data

analysis. Appendix E contains permission to use the OLA instrument. Permission was obtained from appropriate sources prior to contacting the employees of the health-care organization for participation in the study.

### Data Analysis

Quantitative data analysis is a critical component of the research study upon which the interpretation of results is determined (Creswell, 2002). Gall et al. (2003) described data analysis in causal relationship research as “correlating (1) scores on a measured variable that represents the phenomenon of primary interest with (2) scores on a measured variable thought to be related to that phenomenon” (p. 326). The scores based on perceptions of servant leadership behaviors in the hospital setting were tabulated to determine the level of servant leadership in the organization and subsequently correlated with a measured level of job satisfaction among registered nurses.

Laub (1999) identified six organizational categories that illustrate a progressive degree of servant leadership behaviors as perceived by individuals in the organization (see Table 3). Relative to Hypothesis 1, a determination of the level of servant leadership in the health-care organization as perceived by registered nurses was calculated based on the population mean of the total score of the OLA survey instruments. The calculation represented the organization’s mean OLA score. Each higher level or category indicated a progressively greater level of servant leadership integration in the organization as perceived by the members of the organization.

Once established, the mean OLA score were correlated with the measure of job satisfaction among registered nurses. The data analysis included bivariate correlational statistics with Pearson’s *r* to test the hypotheses. Descriptive statistics, including

population mean and standard deviation, preceded inferential statistical analysis to determine if the population scores were normally distributed. Parametric statistics such as Pearson's  $r$  are dependent upon the assumption of a normal distribution of population scores (Creswell, 2002, p. 237). Other assumptions of interval data and independent responses on the instrument (Creswell) were met. Demographic variables, including the level of nursing position, were analyzed based on one-way analysis of variance (ANOVA). Descriptive statistics of each item provided further analysis of research data.

Table 3

*Organization Categories and Organizational Leadership Assessment (OLA) Score*

*Ranges*

Organizational category	OLA score ranges
Absence of servant leadership characteristics	060.0-119.4
Autocratic organization	119.5-179.4
Negatively paternalistic organization	179.5-209.4
Positively paternalistic organization	209.5-239.4
Servant-leader organization	239.5-269.4
Servant-minded organization	269.5-300.0

The Statistical Package for Social Sciences (SPSS) computer software program (Version 16.0) was used to generate statistical information based on data obtained from the completed OLA (Laub, 1999) survey instruments. Quantitative data obtained from the completed instruments were input into SPSS on receiving each survey instrument. The correlation coefficient statistical test was employed and results displayed in a correlation matrix. Additional analysis required for data obtained from surveys included reporting

the response rate (Creswell, 2002). Chapter 4 addresses both statistically significant and nonsignificant results in the data analysis.

### Validity and Reliability

Cooper and Schindler (2003) described validity as the degree to which an instrument actually measures what the instrument was designed to measure, whereas reliability “has to do with the accuracy and precision of a measurement procedure” (p. 231), producing the same results. J. A. Maxwell (2005) considered validity a goal and not an end. Validity relates to the relationship between a study’s findings and reality. Creswell (2002) described validity as the ability to “draw meaningful and justifiable inferences from scores about a sample or population” (p. 183). Two major forms of validity, internal and external, and reliability are discussed in relation to the study. The three characteristics represent “a frame of reference for evaluating the quality of research designs” (Polit & Hungler, 1987, p. 196).

Selecting a valid and reliable instrument is crucial for accurate analysis and interpretations of the study’s findings. Laub (1999) describes the OLA instrument as both reliable and valid. Studies by Miears (2004), R. S. Thompson (2002), and others (Hebert, 2003; Ledbetter, 2003) determined a high level of reliability of the OLA survey instrument. Measurements of reliability for the OLA instrument assessed through Cronbach’s alpha revealed a coefficient of .98 (Laub, 1999, p. 66). Internal validity of the OLA instrument was addressed by the use of content experts and statistical procedures confirmed content and construct validity. Use of the OLA survey instrument eliminated untoward effects related to biases of the researcher. Creswell (2002) contended a benefit of self-administered surveys is the anonymous solicitation of participants without any

influence of the researcher (p. 421). Potential threats to validity with a survey instrument include the possibility of dishonest or inaccurate responses, the inability to seek clarification for any questions the participant may have, and the lack of flexibility in responding to items (Creswell). To mitigate the threats to internal validity, a large sample was used.

External validity refers to “the data’s ability to be generalized across persons, settings, and times” (Cooper & Schindler, 2003, p. 231). Gall et al. (2003) explained “It is valid to generalize the research findings” (p. 375) from the participants to the accessible population when participants are randomly selected. Because the design of the study incorporated the random selection of sample participants, the findings from the study were generalized to the specific nursing population the sample was drawn from. To make inferences beyond the accessible population to the target population, the sample population must have similar characteristics to the target population (Creswell, 2002). The questionnaire included demographic characteristics to expand inferences to similar populations and provide further analysis of the findings.

Validity of the study can be vulnerable if claims of causality are made. The OLA instrument was used to determine the level of servant leadership behaviors perceived in the hospital organization and subsequently determine if any correlations exist with job satisfaction among nurses. The presence of servant leadership behaviors in the organization correlated positively with job satisfaction. Many factors besides leadership behaviors can impact job satisfaction, including job-related stress, patient acuity, inadequate levels of staffing (Sumner & Townsend-Rocchiccioli, 2003), lack of perceived support of colleagues, health status, environmental factors, and use of

technology. Analysis of the data revealed if relationships exist between variables, but did not prove cause and effect. Additional measures taken to fortify the validity of the study included obtaining a “good sampling frame list” (Creswell, 2002, p. 402), selecting a large sample, using a strong instrument designed to reduce errors of measurement, and “rigorous administration procedures to achieve as large a return rate as possible” (Creswell, p. 402).

Reliability can be impacted by the lack of standardized procedures (Creswell, 2002). Creswell noted, “When procedures vary, bias is introduced into the study and the data may not be comparable for analysis” (p. 187). To reduce potential bias, data collection took place using standard procedures. The process of analysis and interpretation was reviewed carefully to ensure all steps were clearly articulated and documented in the study. The validation process supports study replication in which similar conclusions are expected (Berg, 2004).

### Summary

Chapter 3 included a description of the methodology of the research study. A survey-based, quantitative, nonexperimental correlational design effectively addressed the research questions pertaining to the level of servant leadership behaviors implemented in the nonprofit health-care organization and if the presence of servant leadership behaviors in the acute hospital setting correlates with job satisfaction among registered nurses. Correlational research was valuable for providing information on the direction and degree of association between the variables of perceptions of servant leadership and reported job satisfaction of registered nurses. The use of a survey for data collection provides an efficient and convenient method for determining perceptions,

including opinions and attitudes, and facilitates replication of the study (Cooper & Schindler, 2003, p. 52). Random sampling of the target population with demographic assessments allows for generalizability to similar registered nursing populations employed by a major health-care organization in the northwestern United States.

Chapter 3 entailed a description of the research design, research questions and hypotheses, sample population, instrumentation, data collection and analysis, and validity and reliability measures. The generation of valid, empirical data contributed new knowledge applicable to the field of nursing leadership. Chapter 4 provides the findings from the study obtained through survey methodology. A detailed analysis of the data is presented and formulated around the research questions and hypotheses.



## CHAPTER 4: RESULTS

The purpose of the quantitative research study with a correlational design was to (a) examine the perceptions of registered nurses pertaining to the existence of servant leadership behaviors in the nonprofit, acute health-care environment and (b) determine if any relationship existed between evidence of servant leadership and job satisfaction among registered nurses, nurse managers, and nurse leaders. Data were collected from 313 registered nurses who voluntarily participated in the study and completed the OLA instrument. Chapter 4 consists of an analysis of the data with findings structured by the research questions and hypotheses. Data collection procedures, data analysis procedures, and demographic findings precede the results section, and a summary concludes the chapter.

### Data Collection

The chief nurse executive of the nonprofit health-care organization granted access to the research site and to the nursing directors' meeting. During the meeting, nursing directors learned the potential benefits of the organizational assessment survey. The chief nurse executive approved the project and the directors agreed to deliver the surveys to registered nurses in their departments. As privacy considerations restricted the availability and use of personal addresses, direct mail to the participants was prohibited.

When the Institutional Review Board granted approval for the research study, survey packets were delivered to each director. Each survey packet included a cover letter requesting voluntary participation, an informed consent form, the OLA survey instrument, a demographic questionnaire, and a duplicated raffle ticket. The survey packet also included a stamped envelope addressed to the researcher for returning the

informed consent form, OLA survey, demographic form, and one of the raffle tickets. The forms were stapled together to increase the likelihood of completeness. The cover letter included instructions for the participant to mail the items through the postal service.

The 26 directors received written and verbal directions for delivering the survey packets to the registered nurses. Instructions included giving out the surveys randomly to one half of the clinical registered nurse staff, to each management-level registered nurse, and to each director. The directors agreed to select randomly every other registered nurse in clinical status for survey participation based on their respective personnel lists. Excluded from participating in the survey were registry nurses, travel nurses, or nurses from the health-care organization who were working externally to both hospitals. Each director received a \$10 gift certificate as a token of appreciation.

During the last week of January 2008, the nurse leaders received 815 survey packets. Participants returned the surveys by mail throughout February. Three hundred twenty-three surveys were returned for a response rate of 39.5%. Although the response exceeded the target sample size of 320, 10 surveys were eliminated because of incompleteness, resulting in 313 surveys used for data. The adjusted response rate was 38.4%. The 313 participating nurses represented 19.6% of the population, a slight decrease from the proposed 20%. The slight change in the research design decreased the reliability of the responses from .95 to .93 (Gay & Airasian, 2000).

#### Data Analysis Procedures

On receipt of the surveys, a preliminary analysis was performed to check for missing data. Three surveys returned did not have a signed informed consent form. One of the surveys was in the group of 10 surveys removed because of incompleteness. The

remaining two surveys were included in the data analysis, as the return of the completed survey was considered to have implied consent by the participants to take part in the survey.

On the first page of the Organizational Leadership Survey, participants were asked to indicate their role in the organization. This item was not marked in 52 of the 313 surveys, equivalent to 16.6% of the returned surveys. To correct the omission, the name on the informed consent form was cross-referenced with the personnel directory for the health-care organization. The job title was used to determine employment level in the organization for the 52 participants. The position was then noted on the OLA form, correcting the omission.

Following the identification of missing personnel information, the informed consent form was removed from the survey packet and stored separately. No identifiers remained in the survey packet or on the survey instrument. There was no longer any connection between the identity of the participant and the responses on the survey instrument, ensuring anonymity for the participants.

Data from the OLA instrument and demographic form were entered into an Excel spreadsheet file. The OLA instrument has 60 items, all requiring a response on a Likert-like scale ranging from 1 to 5. Ten surveys with seven or more missing responses were removed from the study. Thirty-one surveys had one ( $n = 24$ ), two ( $n = 2$ ), three ( $n = 1$ ) or four ( $n = 4$ ) missing responses. The missing data were replaced by inserting the mean of the respective group item. Once completed, the file was imported to an SPSS (Version 16.0) file for statistical analysis.

### Sample Demographics

Participants completed a demographic questionnaire that was included in the survey packet. Demographic attributes included on the form were age, gender, educational preparation, number of years of experience as a registered nurse, number of years working at the health-care organization, and area of work. The frequency counts for selected demographics are displayed in Appendix G. Most (72.2%) of the nurses were at Hospital M, and 27.8% were at Hospital G. For their roles at the hospital, most (81.5%) were part of the clinical workforce, with fewer nurses in management (16.3%) or top leadership (2.2%) roles. Almost all (92.7%) of the nurses were female and the median age was 44.50 years. For education level, 61.4% had at least a bachelor's degree and the median amount of experience as a nurse was 18.0 years. The most common current practice areas were Labor Delivery (17.3%) and Special Care Nursery (16.3%). The median amount of time working at their hospital was 8 years (see Appendix G).

### Results of Data Analysis

The study had three research questions with associated hypotheses. The hypotheses were tested by data analysis. The OLA was used to measure the independent variable of evidence of servant leadership behaviors and the dependent variable of job satisfaction. The reliability of the OLA instrument was .98 in Cronbach's alpha. Table 4 displays the Cronbach alpha internal reliability coefficients for the eight scale scores. The coefficients ranged from  $r = .86$  to  $r = .98$ , with .98 representing the reliability coefficient of the total OLA instrument.

Table 4

*Psychometric Characteristics for Summated Scales (N = 313)*

Scale score	Number of items	<i>M</i>	<i>SD</i>	Alpha
1. OLA total score	60	210.73	37.76	.98
2. OLA values people score	10	3.65	0.63	.88
3. OLA develops people score	9	3.38	0.76	.91
4. OLA builds community score	10	3.63	0.60	.88
5. OLA displays authenticity score	12	3.50	0.67	.92
6. OLA provides leadership score	9	3.42	0.71	.90
7. OLA shares leadership score	10	3.47	0.69	.91
8. Job satisfaction	6	3.71	0.71	.86

*Hypothesis 1*

Hypothesis 1 indicated servant leadership behaviors are perceived at a nonprofit, community-based acute health-care organization by registered nurses. Table 5 categorizes the OLA total scores based on Laub's (1999) study. The OLA total scores for the nurses in the current sample ranged from 94 to 300 ( $M = 210.73$ ,  $SD = 37.76$ ) with the mean score being in the fourth organizational category. Laub (2008) described an organization in the fourth category as moderately healthy or positively paternal.

Table 5

*Extent of Servant Leadership Behaviors Perceived by Registered Nurses (N = 313)*

Category	Range of scores <sup>a</sup>	<i>n</i>	%
Toxic	60.0 to 119.4	6	1.9
Poor	119.5 to 179.4	49	15.7
Limited	179.5 to 209.4	74	23.6
Moderate	209.5 to 239.4	118	37.7
Excellent	239.5 to 269.4	57	18.2
Optimal	269.5 to 300.0	9	2.9

<sup>a</sup>  $M = 210.73$ ,  $SD = 37.76$ .

Nurses perceived the leaders of the organization practice a positive version of paternalism. Although 66 nurses (21.1%) rated their hospital as being either excellent or optimal, indicating a servant organization, the overall mean for the sample shows a score less than that of a servant-minded or servant-led organization. The combination of findings provided insufficient support for Hypothesis 1 (Table 5). The analysis did not find enough evidence to reject the null hypothesis.

### *Hypothesis 2*

Hypothesis 2 suggested a significant correlation exists between perceived implementation of servant leadership and job satisfaction among nurses and administrative leaders at the health-care organization. The research setting included two community-based, nonprofit hospitals owned by one health-care organization in the northwestern United States. Product moment correlation coefficient statistics were used to assess the connection between the total score of the OLA and each of the subscales

with job satisfaction. Table 6 displays the intercorrelations for the seven servant leadership scores as well as the job satisfaction measure.

Table 6

*Intercorrelations for the Summated Scale Scores (N = 313)*

Scale score	1	2	3	4	5	6	7	8
1. OLA total	1.00							
2. OLA values people	.93	1.00						
3. OLA develops people	.95	.85	1.00					
4. OLA builds community	.91	.87	.83	1.00				
5. OLA displays authenticity	.96	.89	.89	.85	1.00			
6. OLA provides leadership	.91	.77	.86	.78	.84	1.00		
7. OLA shares leadership	.94	.83	.89	.79	.88	.83	1.00	
8. Job satisfaction	.83	.80	.78	.72	.80	.72	.82	1.00

*Note.* All correlations were significant at the  $p < .001$  level.

For the seven correlations for job satisfaction with each of the servant leadership scores, the smallest of the correlations was  $r = .72$  ( $p < .001$ ). The Pearson correlation for total OLA score and job satisfaction was  $r = .83$ . This series of findings provided support for Hypothesis 2. Consequently, the null hypothesis was rejected.

### *Hypothesis 3*

Hypothesis 3 suggested significant differences exist in perceptions of servant leadership behaviors based on nursing position, including top leadership, management, and clinical workforce. To test the hypothesis, a series of one-way ANOVA tests with Scheffe post hoc tests was used to compare the nursing position with the seven OLA

scores. The overall  $F$  test for five of the seven comparisons was statistically significant at the  $p < .05$  level.

For the OLA total score, the overall test was significant ( $p = .05$ ), but none of the Scheffe post hoc differences between the three nursing position levels were significant at the  $p = .05$  level. The same pattern ( $F$  test was significant but no significant post hoc differences occurring) was also noted for OLA values people, OLA displays authenticity, and OLA shares leadership. However, for the OLA develops people, the overall  $F$  test was significant ( $p = .02$ ). In addition, the clinical workforce had significantly lower scores when compared with the management group ( $M = 3.32$  versus  $M = 3.64$ ,  $p = .02$ ).

Appendix H contains the one-way ANOVA test for job satisfaction matched with nursing level. The overall  $F$  test was significant ( $p = .01$ ). The clinical workforce had significantly lower scores when compared with the management group ( $M = 3.65$  versus  $M = 3.94$ ,  $p = .03$ ).

Table 7 displays the Pearson product moment correlations for the nurse's level in the organization and the seven OLA scores. Five of the seven relevant correlations reflected significant, positive correlations at the  $p < .05$  level. The combined findings in Appendix G and Table 7 provided support for Hypothesis 3. Accordingly, the null hypothesis was rejected.

#### *Additional Findings*

Added statistical analysis was conducted to discover if there were any significant differences in perception of servant leadership behaviors between the two hospitals. In Table 7 are the correlations between each hospital with the seven OLA scores and job satisfaction. None of the correlations were statistically significant at the  $p < .05$  level.



Table 7

*Correlations for Scale Scores with RN Level and Hospital (N = 313)*

Scale scores	Level <sup>a</sup>	Hospital <sup>b</sup>
1. OLA total	.14 **	.03
2. OLA values people	.17 ***	-.01
3. OLA develops people	.16 ***	.03
4. OLA builds community	.07	.05
5. OLA displays authenticity	.17 ***	.03
6. OLA provides leadership	.04	.04
7. OLA shares leadership	.17 ***	.02
8. Job satisfaction	.17 ***	.01

<sup>a</sup> Level: 1 = workforce, 2 = management, 3 = top leadership. <sup>b</sup> Hospital: 1 = Hospital G, 2 = Hospital M

\*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .005$ .

Table 8 displays the Pearson product moment correlations for the same seven OLA scores plus job satisfaction with five selected variables (gender, age, education, years as an RN, and years at current hospital). For the resulting 40 correlations, only 1 was statistically significant. Specifically, there was a significant, negative correlation between the age of the nurse and the OLA builds community score ( $r = -.13, p < .05$ ; see Table 8).

Table 8

*Correlations for Scale Scores with Selected Variables (N = 313)*

Scale scores	Gender <sup>a</sup>	Age	Education	Years as registered nurse	Years at hospital
1. OLA total	.02	-.05	.05	-.03	-.07
2. OLA values people	.00	-.06	.08	-.02	-.06
3. OLA develops people	.04	-.01	.04	.01	-.02
4. OLA builds community	.01	-.13 *	.03	-.10	-.11
5. OLA displays authenticity	.00	-.03	.08	-.02	-.06
6. OLA provides leadership	.07	-.04	-.02	-.05	-.08
7. OLA shares leadership	.02	-.03	.05	-.01	-.06
8. Job satisfaction	.02	.00	.03	.00	-.01

<sup>a</sup> Gender: 1 = male, 2 = female.\*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .005$ .

Table 9 displays the results of the multiple regression model that examined the association of job satisfaction with the OLA total score after controlling for seven background characteristics. The overall model was significant ( $p < .001$ ) and accounted for 68.6% of the variance in job satisfaction. Inspection of the predictors found none of the seven background characteristics to be statistically significant but the nurse's OLA total score was positively related to job satisfaction ( $p < .001$ ; see Table 9).

Table 9

*Examination of the Relationship of Job Satisfaction With OLA Total Score After Controlling for Background Characteristics (N = 313)*

Source	<i>B</i>	<i>SE</i>	$\beta$	<i>p</i>
Intercept	0.34	0.24		.15
Hospital	0.00	0.05	.00	1.00
Gender <sup>a</sup>	0.00	0.09	.00	1.00
Age	0.02	0.03	.03	.48
Education	-0.02	0.02	-.03	.45
Years as RN	-0.02	0.02	-.05	.39
Years at current hospital	0.02	0.02	.04	.38
Level of nursing position <sup>b</sup>	0.08	0.06	.05	.15
OLA total score	0.02	0.00	.83	.001

*Note.* Full model:  $F(8, 304) = 86.06, p < .001. R^2 = .686$ .

<sup>a</sup> Gender: 1 = male, 2 = female. <sup>b</sup> Level: 1 = workforce, 2 = management, 3 = top leadership.

### Summary

The quantitative research study with a correlational design involved an examination of the association between perceived evidence of servant leadership behaviors and job satisfaction among registered nurses. The primary finding of the study revealed evidence that perceptions of servant leadership behaviors in the organization are strongly associated with job satisfaction among nurses ( $r = .83, p < .001$ ). The second major finding of the study was that employment level was a significant moderating factor

in the relationship between perceptions of servant leadership and job satisfaction ( $p = .05$ ). Third, demographic characteristics were not found to have any statistically significant effect except for the negative correlation between the age of the nurse and the OLA builds community score ( $r = -.13, p < .05$ ). Lastly, from an organizational leadership perspective, the registered nurses perceived the organization to be functioning as a positively paternalistic organization, not as a servant-minded or servant-led organization ( $M = 210.73, SD = 37.76$ ). Chapter 5 includes the conclusions, implications, and recommendations of the study.

## CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

The purpose of the quantitative correlational research study was to examine the extent to which registered nurses perceived servant leadership behaviors in acute health-care settings and to determine if the behaviors correlate with job satisfaction. The literature review in chapter 2 provided support for the expectations that servant leadership behaviors would positively correlate with nurses' job satisfaction. Studies examining perceptions of servant leadership in health-care organizations are limited. The present study extends the investigation of servant leadership to a different population and setting than previously examined, namely a nonprofit community-based acute health-care organization in the northwestern United States. Chapter 3 included a discussion of the research method, the research procedures, and the statistical tests selected for data analysis.

The sample for the research study consisted of 313 registered nurses employed at two community hospitals affiliated with a nonprofit health-care organization in the northwestern United States. Data were collected by using the OLA survey (Laub, 1999) and a demographic survey. Chapter 4 contained an analysis of the data and the findings from the study. Chapter 5 presents a discussion and interpretation of the research findings from the study of registered nurses in acute health-care settings. Conclusions regarding each research question and associated hypothesis reference current relevant research. Implications, recommendations, and a summary end the chapter.

### Research Questions

The study investigated the extent that perceptions of servant leadership behaviors are implemented in the hospital setting as measured by the OLA survey (Laub, 1999).

The OLA instrument measures the presence of servant leadership through perceptions of six characteristics: (a) values people, (b) develops people, (c) builds community, (d) displays authenticity, (e) provides leadership, and (f) shares leadership (Laub, 1999, p. 25). Job satisfaction among registered nurses in acute care hospital settings was also assessed. The following research questions guided the study:

1. To what degree do nursing leaders and managers implement servant leadership as perceived by registered nurses in two nonprofit, community-based acute care hospital facilities owned by a health-care organization in the northwestern United States?

2. To what degree does the perceived implementation of servant leadership in two nonprofit, community-based hospitals owned by one health-care organization in the northwestern United States correlate with the level of job satisfaction among registered nurses?

3. Are there differences in the perceptions of servant leadership based on level of position in the organization (e.g., top nursing leadership, nursing management, or clinical nursing staff)?

Demographic factors, including type of nursing educational preparation, length of time employed as a registered nurse, length of time employed at the particular acute care facility, age, and gender, were examined for effect on perceptions of servant leadership and job satisfaction.

### Hypotheses

The results from the study were expected to support three hypotheses, each based on a corresponding research question. The first hypothesis addressed the research question about perceptions of servant leadership in the hospital organization. Although

nursing organizational structure traditionally relied on hierarchical authority, growing evidence supported servant leadership characteristics in nursing and health-care organizations (Cunningham, 2003; Swearingen, 2004). The study extended the investigation of servant leadership behaviors to a new setting—a nonprofit, community-based acute health-care organization in the northwestern United States.

H1<sub>0</sub>: Servant leadership behaviors are not perceived at a nonprofit, community-based acute health-care organization by registered nurses.

H1<sub>A</sub>: Servant leadership behaviors are perceived at a nonprofit, community-based acute health-care organization by registered nurses.

Data were collected using the OLA survey instrument (Laub, 1999). The OLA instrument was devised to measure the extent of servant leadership behaviors in an organization, as perceived or not perceived by employees (Laub). Descriptive statistics were used to determine the extent of servant leadership in the health-care organization as perceived by registered nurses.

The second hypothesis addressed the research question about correlation between perceptions of servant leadership behaviors and the measure of job satisfaction among registered nurses. Research studies established a relationship between servant leadership and job satisfaction (K. P. Anderson, 2005; Laub, 1999; Miears, 2004; R. S. Thompson, 2002), although primarily in organizational settings other than health care. The current study expanded the investigation of the relationship between servant leadership and job satisfaction to a different population and setting than previously examined, namely registered nurses from a community-based, nonprofit acute health-care organization in the northwestern United States.

H2<sub>0</sub>: No significant correlation exists between perceived implementation of servant leadership and level of job satisfaction among nurses and administrative leaders at two community-based nonprofit hospital facilities owned by one health-care organization in the northwestern United States.

H2<sub>A</sub>: A significant correlation exists between perceived implementation of servant leadership and level of job satisfaction among nurses and administrative leaders at two community-based nonprofit hospital facilities owned by one health-care organization in the northwestern United States.

Hypothesis 2 was tested using a Pearson product moment correlation statistic to determine any correlation between perceptions of servant leadership characteristics and job satisfaction of registered nurses. Testing Hypothesis 2 determined the direction and degree of correlation between the two variables. Both variables were measured by using the OLA survey instrument (Laub, 1999).

The third hypothesis addressed the research question about levels of position in the organization. Laub (1999) anticipated differences in perceptions of servant leadership characteristics based on level of job classification and incorporated the component of employment level into the OLA instrument. A study by Kamencik (2003) determined perceptions of leadership vary among nurse leaders and nurse managers.

H3<sub>0</sub>: No significant differences exist in perceptions of servant leadership behaviors based on level of nursing position, including top leadership, management, and clinical workforce.



H3A: Significant differences exist in perceptions of servant leadership behaviors based on level of nursing position, including top leadership, management, and clinical workforce.

Hypothesis 3 was tested using a one-way analysis of variance to determine any significant differences among registered nurses' perceptions of servant leadership based on employment level. Scheffe post hoc tests were applied to the data to determine precise differences. A multiple regression model was used to determine whether demographic variables had any significant effect upon perceptions of registered nurses.

### Research Findings

Relative to Hypothesis 1, the extent of perceived servant leadership behaviors noted by registered nurses in the health-care organization studied indicated a Level 4 organization, which equates to a positively paternalistic organization (Laub, 2008). The organization is not a servant-minded organization as Laub (2008) described. Relative to Hypothesis 2, findings revealed a strong positive correlation between nurses' perceptions of servant leadership behaviors in the organization and nurses' job satisfaction. Relative to Hypothesis 3, the nurses' employment classification was a statistically significant moderating variable for perceptions of servant leadership and job satisfaction. Nurses in top leadership positions perceived more servant leadership behaviors and reported greater job satisfaction than managerial nurses, who in turn reported more servant leadership behaviors and greater job satisfaction than clinical nurses. The effects of demographic moderating variables were negligible and not statistically significant except for a negative correlation between the age of the nurse and subscale of builds community on the OLA instrument.

### *Research Question 1 and Hypothesis 1*

The first research question guiding the study referred to the extent of perceived evidence of servant leadership behaviors of nursing leaders and managers in two hospitals owned by a nonprofit, community-based health-care organization. Three hundred thirteen registered nurses from three employment levels—clinical, management, and top leadership—completed the OLA instrument. The OLA measures perceptions of servant leadership behaviors. Descriptive statistics of the survey data revealed a total mean score of 210.73. Laub (2008) classified organizations that score between 209.5 and 239.4 as positively paternalistic organizations of moderate health.

Results of studies using the OLA instrument showed most organizations falling short of the servant organization classification (Drury, 2004; Klamon, 2006; Ledbetter, 2003; Miers, 2004; Ross, 2006; Van Tassell, 2006). To reach a servant-led organizational level, the mean OLA score must be equal to or greater than 240 out of a potential score of 300 or equal to or greater than 4.0 on a scale that reaches 5.0. Six of 10 studies had organizations classified as Level 4, and one organization was classified as a Level 3 or negatively paternalistic organization. Servant-led describes three organizations identified in three studies (K. P. Anderson, 2005; Kong, 2007; Witter, 2007), represented by Level 5.

The studies involved organizations external to health care. Only one study examined a health-care organization using the OLA instrument. A religious-affiliated hospital in the Midwest was the setting for a master's level study conducted by Freitas (2003). Freitas surveyed health-care personnel from five departments in the hospital: (a) presidency and human resources, (b) strategic planning and business development, (c)

nursing, (d) clinical and support services, and (e) finance. Although the differences in scores among the hospital departments were not significant, the scores from the nursing department were consistently in the median range of scores for the five departments. The scores from the nursing personnel ranged from a mean of 3.77 to 3.93 among the six subscales. All scores were consistently in the category of positively paternalistic and did not reach servant led or servant minded.

Empirical evidence exists for the presence of servant leadership in health-care organizations (Cunningham, 2003; Swearingen, 2004). The finding that the nonprofit acute health-care organization in the present study did not reach the servant led or servant minded classification was unexpected. Laub (1999) reported individuals from community service organizations reported higher perceptions of servant leadership than individuals in other types of organizations, including business, religion, government, and education. The mission, vision, and organizational values of the nonprofit, acute health-care organization are congruent with principles of servant leadership.

The mission and vision of the health-care organization are based on service. The organizational values include caring, respect, compassion, honesty, integrity, and community. The framework for nursing practice is caring, excellence, and holistic care. Organizational leadership is committed to optimizing nursing practice in part through education and training. Although the structure of the organization is conducive to behaviors associated with servant leadership, the perceptions of the registered nurses indicate that the organization does not meet the servant led designation.

Laub (2008) reported most organizations fall into Level 4, or positively paternalistically led organizations. With one exception (Freitas, 2003), the organizational

settings identified in the literature as paternalistically led were not health-care related. Results of the current study extended the investigation of servant leadership to a different population and setting than previously examined. The health of the nonprofit, community-based health-care organization in the northwestern United States was determined to be a Level 4 or positively paternalistic organization based on perceptions of registered nurses, nurse managers, and nurse executives.

Assessing the nonprofit acute health-care organization as a paternalistic organization indicates opportunities for leadership growth. Implementing a new leadership model by advancing servant leadership behaviors may mitigate the nursing shortage by fostering a work environment that increases job satisfaction for nurses. The three aspects of servant leadership perceived the least by nurses were (a) develops people, (b) provides leadership, and (c) shares leadership. Improving education and training, communication, and involvement in decision-making for nurses will encourage leadership growth at all levels of the organization. When registered nurses act as servant leaders, the organization has the potential to change from a paternalistic mind-set or culture into a servant-led or servant-minded organization.

#### *Research Question 2 and Hypothesis 2*

The second research question of the research study related to the relationship between perceptions of servant leadership and job satisfaction among registered nurses. The second hypothesis indicated a relationship exists between the two variables. Analysis of the data reported on the OLA surveys reveals a strong, positive correlation ( $r = .83$ ) between registered nurses' perceptions of servant leadership in two community-based, nonprofit hospitals and nurses' job satisfaction.

Correlation was measured for each nurse's perceptions of servant leadership in the organization and the individual nurse's job satisfaction. Based on 313 surveys, the cumulative correlation of .83 indicates a very strong association between servant leadership and job satisfaction. Based on Cohen's scale of correlations, .83 falls between a very large and nearly perfect correlation (Hopkins, 2002). Although the summative score for the organization indicated a Level 4, or less than servant-led organization based on Laub's classifications, more than 20% of the nurses considered the organization to be servant led or servant minded. As nurses perceived greater amount of servant leadership behaviors, job satisfaction increased. Nurses who perceived fewer servant leadership characteristics in the organization were also less satisfied with their jobs.

The correlation results between perceptions of servant leadership behaviors and job satisfaction in the current study exceed corresponding correlations reported in the literature. Several studies found a statistically significant, positive relationship between perceptions of servant leader behaviors and employee job satisfaction (Anderson, 2005; Laub, 1999; R. S. Thompson, 2002), although to different degrees. Kong (2007) and Van Tassell (2006) reported a correlation of .577, and Miears (2004) reported a correlation of .723. Freitas (2003) incorporated the OLA instrument to examine a health-care organization and reported a correlation of .78 between servant leadership behaviors and job satisfaction. The correlation between job satisfaction and perceptions of servant leadership behaviors is highest in the acute health-care settings of the present research study ( $r = .83$ ).

The current study found the strongest positive correlation ( $r = .83$ ) between perceptions of servant leadership behaviors and job satisfaction. The two studies that

examined health-care organizations, Freitas (2003) and the current study, revealed the highest correlations between job satisfaction and perceived evidence of servant leadership compared to studies examining non health-care organizations. The strong positive relationship between job satisfaction and an organizational culture of servant leadership in the health-care field indicates that in a health-care environment in which servant leadership is apparent to the employees, greater job satisfaction is reported.

### *Research Question 3 and Hypothesis 3*

The final research question in the study addressed the moderating variable of employee position classifications. The hypothesis indicated the role of the registered nurse would affect perceptions of servant leadership behaviors and reported job satisfaction. Data analysis through ANOVA showed a significant difference between the three roles of clinician, management, and senior leadership. Although the differences were statistically significant, post hoc analysis revealed none of the differences was significant at the  $p < .05$  level. However, examining the individual subscales of the servant leadership variable revealed a significant difference for the OLA construct develops people.

Several investigators found similar results with significant differences among employee roles. Van Tassell's (2006) study revealed a perception mismatch among both job level and divisions. Kong (2007) noted differences in levels between pastors and ministers. Horsman (2001) found significant differences between the workforce and top leadership. Drury (2004) found differences in levels and confirmed the differences by post hoc analysis. All of these researchers used the OLA instrument to gather research data.

Witter (2007) came to a different conclusion about the relationship between job role and job satisfaction. Witter did not find any differences between administrative levels, contradicting previous findings. Witter's study entailed 49 churches associated with the Plymouth Brethren movement. The roles of the respondents included senior church leaders, mid-level ministry leaders, and various workers in the congregation. Although the sample size of 547 was adequate, the personnel roles were inconsistent among the churches. Comparing data from respondents with dissimilar roles may have compromised the validity and reliability of the data analysis. Also, a contact person at each church distributed the surveys, which may have led to bias in the selection of participants who support the leadership. The scope of Witter's study was much greater and did not focus on one distinct organization as other studies had.

R. S. Thompson (2002) also concluded there were no differences among levels of employment. R. S. Thompson's sample size of 116 employees may have been too small to reveal differences in administrative levels. Despite the small sample, Thompson discovered differences in subgroups based on professional focus. In health-care organizations, evidence supports the finding that top leadership has higher or more favorable perceptions of leadership behaviors (Freitas, 2003; Kamencik, 2003).

The findings from the current study did not reveal significant correlations between perceptions of servant leadership and the demographic factors, with one exception. A significant negative correlation existed between the age of the nurse and the servant leadership dimension of building community. Laub (1999) described the concept of building community as building strong personal relationships, working collaboratively with others, and valuing the differences of others. Although the finding of an inverse

relationship with age and perceptions of building community was unexpected, the results may be related to current organizational change. Recent economic events contributed to decreased job security and uncertainty in the organization. It may be that older nurses have noticed a change in the commitment level of organizational leaders to strengthen community ties and internal relationships while leading the organization through fiscal challenges.

### Conclusions and Implications

Health-care leaders expect the nursing shortage to intensify as an aging nurse workforce reaches retirement age concomitantly with increased demands for health care for an aging population (Woods & Craig, 2005). Consistent with national trends, demographic findings from the study show 40% of nurses are approaching retirement age. Nursing, health care, and government leaders must take action to ensure a sufficiently robust and skilled nursing workforce will be available to meet the health-care needs of people in the United States. If health-care leaders are unable to address adequately the growing nursing shortage, the ramifications include threats to quality of health care, access to health care, and organization sustainability. As the nursing shortage worsens, health-care organizations may close hospital beds and deny treatment to people with health-care needs. To avert the serious threats to health care, leaders must take action to retain older nurses, recruit more candidates into nursing, and retain nurses who are at high risk of leaving the profession.

In order to recruit and retain nurses, leaders in health-care organizations are increasingly committed to fostering a satisfying work environment for nurses (Dracup & Bryan-Brown, 2006). Although a multitude of factors affect job satisfaction, several



studies have revealed a positive association between job satisfaction of employees and perceptions of servant leadership practices in an organization (K. P. Anderson, 2005; Kong, 2007; Miears, 2004; Van Tassell, 2006). The results from the current study indicate a higher correlation between the two variables ( $r = .83$ ) in acute health-care organizations compared with other organizational settings, including religious educational settings, public schools, and churches. The strong positive correlation between the variables indicates that perceptions of servant leadership behaviors are connected to job satisfaction of nurses.

Since nurses report greater job satisfaction when they perceive evidence of servant leadership in their work environments, servant leadership is one factor that is associated with job satisfaction of nurses in acute health-care settings. Servant leadership may mediate the relationship between a nurse's core values and individual job satisfaction. Many nurses are drawn to the nursing profession reportedly as a calling to care for others (Jackson, 2004). Nurses seeking employment in a profession characterized by behaviors such as nurturing others, caring for others, and positively influencing the health of others likely seek an organizational culture in which leaders exhibit the same behaviors. A humanistic and ethical approach to leadership through servant leadership behaviors provides a health-care organization environment that is likely linked to increased job satisfaction for nurses.

In the current study, registered nurses in acute health-care settings were increasingly satisfied if they perceived their leaders to display nurturing, encouraging, empowering, and ethical behaviors. If registered nurses perceive servant leadership behaviors as an integral part of the workplace environment, job satisfaction increases

(Swearingen, 2004). The findings from the current study support the conclusion that nurses are increasingly satisfied if they perceive their leaders to exhibit servant leadership behaviors. The findings of a positive link between servant leadership behaviors and nurses' job satisfaction have implications for health-care leaders who are concerned about retention because of the predictive link between job satisfaction and retention.

Besides retention, the findings could be extrapolated to recruitment issues as well. Nurse leaders may choose to market organizations as servant minded if caring, supportive work environments are in place. In a market expected to become increasingly competitive as the nurse shortage worsens, prospective nurse hires may become more selective about the philosophy of leadership expected or wanted in the workplace. Leaders of acute health-care organizations may also market the organizations as caring, servant minded organizations to allied health-care employees and patient populations.

Data to support evidence of servant mindedness in a health-care organization can be obtained through an OLA assessment conducted with the copywriter's permission. In the present study, the OLA survey data indicate the participating health-care organization is a positively paternalistic organization. Although 21% of nurses rated the organization as servant oriented or minded, the overall rating of the organization did not reach Level 5 or 6, which are servant organizations based on Laub's (2008) organizational categories. In a positively paternalistic organization, power and decision making primarily occur at the top levels of the organization unless delegated to particular positions or tasks (Laub, 2008).

Health-care organizations were traditionally paternalistic and hierarchical (Dracup & Bryan-Brown, 2006). In a traditional pyramid style of leadership, the top level holds

the power of the organization. Leadership, decision making, and vision originate at the top of the pyramid and are dispersed throughout the organization to the bottom of the pyramid. Although nurses in the present study agreed that power is shared in the organization, important decisions and vision are perceived to originate at the top leadership level. The nurses' perceptions are consistent with paternalism. Findings from the current study correspond to Freitas' (2003) study results where nurses and other health-care workers perceived a church-affiliated hospital in the Midwest as a positively paternalistic organization. Developing a servant-minded organization will require increasing collaboration among health-care workers and promoting the exercise of leadership throughout all levels of the organization.

The results of the present study indicate the potential for augmenting perceptions of positive servant leadership behaviors in acute health-care settings associated with the health-care organization in the northwestern United States. Implications for health-care leaders include incorporating a new leadership model with servant leadership principles throughout the organization through leadership training and fostering leadership development throughout all levels of employment. Registered nurses in the United States are well-educated and progressive professionals who by professional code act in an ethical and legal manner to provide holistic care to patients (Hollinger, 2003). Developing the leadership potential of nurses from all position classifications through a servant leadership framework will likely increase the perceptions of servant leadership in the organization and may result in increased job satisfaction of nurses and increased nurse retention.

### Limitations

Although participants received assurances of confidentiality and anonymity, some nurses may have chosen not to participate because of concerns related to confidentiality or anonymity. Nurses in senior leadership positions handed out the survey packets. The survey packet included an informed consent form that required a signature by the participant. The spouse of the researcher held a top leadership position in the health-care organization. Any of these factors may have raised concerns for nurses regarding confidentiality and anonymity and may have led to reduced participation in the study.

Besides the participation rate, the study was limited to a quantitative method approach with correlational design and the use of a single method of data collection. The study sample was also limited to registered nurses employed at two acute care facilities associated with one health-care organization in the northwest. Limitations imposed on the research design affect the ability to generalize research findings to settings and populations that are decidedly different from those in the research setting.

Delimitations imposed on the study include leadership theories or models beyond that of servant leadership and additional characteristics or factors that may affect job satisfaction in addition to perceptions of servant leadership practices. In consideration of the limitations, findings from the study can be generalized to similar populations of acute care facilities associated with the particular health-care organization. The findings from the study add to knowledge in the fields of servant leadership and nursing job satisfaction.

## Recommendations

Health-care leaders must commit to creating a satisfying workplace environment for registered nurses as a means of addressing the critical nursing shortage. Promoting an environment characterized by servant leadership is recommended for acute health-care organizations as nurses who perceived evidence of servant leadership behaviors reported greater job satisfaction than nurses who did not perceive servant leadership behaviors. Recommendations for action by key stakeholders, including legislative leaders, health-care leaders, and academic leaders are presented, followed by recommendations for further research.

### *Recommendations for Action by Key Stakeholders*

*Legislative leaders.* Informed policy making is needed by national, state, and local leaders to address the impending loss of experienced nurses compounded by an inadequate number of novice nurses entering the workforce. Legislative leaders and accrediting agencies must collaborate with hospital administrators, board members, nurse executives, physicians, and nurses to address issues of sustainability for health-care organizations, including an adequate and qualified nurse workforce. An accurate national database on health-care training and employment needs must be established, disseminated, and used to determine health-care policies and to fund policies accordingly. Valid and reliable data on factors that will increase nurses' job satisfaction and retention are critical for mitigating the impending shortage.

Regulatory and accrediting bodies for nursing practice should incorporate servant leadership behaviors as expected standards of nursing leadership practice if additional research in other health-care settings supports the findings from the current study.

Servant leadership is recommended as a leadership framework for addressing the needs of practicing nurses and fostering a satisfying work environment in nonprofit, acute health-care settings. Findings from the current study indicate that nurses who perceive servant leadership behaviors in the organization are increasingly satisfied with their jobs. Promoting factors that provide a satisfying work environment to nurses, namely leadership behaviors associated with servant leadership, could help retain nurses who may otherwise choose to retire early or leave the profession altogether.

Industry leaders and professional organizations such as the American Hospital Association and the American Nurses Association must augment national workforce planning to increase the number of nurses who will become established in the profession. Benner (1984) asserted advancing novice nurses to proficient nurses requires several years of experience. Sochalski (2002), however, affirmed a third of nurses younger than 30 reported plans to leave hospital nursing before reaching proficiency. Strategies to improve the organizational culture and provide a satisfying work environment for nurses may increase retention of nurses in the profession, avert early retirements, and potentially attract registered nurses on inactive status to reenter the nursing workforce.

Recruitment strategies could be aimed at nearly 2.7 million inactive nurses ("Study Finds," 2002) who might consider reentering the profession if a satisfying work environment were available. Factors associated with servant leadership, such as (a) developing personnel, (b) sharing power, (c) leading effectively, (d) promoting community, (e) valuing personnel, and (f) authentic ethical leadership, are related to job satisfaction and an optimal workplace environment. Recapturing qualified nurses would necessitate programs and availability of experienced nurses to reintroduce and orient

nurses to current nursing practices. Orientation programs tailored for re-entry nurses should be competency-based, have flexible timelines, and include mentoring and training by experienced nurses who model servant leadership.

*Health-care leaders.* Recommendations for hospital administrators, board members, physician leaders, and nursing leaders of the acute health-care organization relate to the impending loss of experience, both clinical expertise and leadership, in the next decade. A noteworthy finding is the experience level of the registered nurses is skewed significantly toward greater levels of experience and increased age. The high levels of experience match the high ages of the nurses. Considering the prospect of up to 20% of nurses retiring early (Chaguturu & Vallabhaneni, 2005), the health-care organization is likely to be confronted not only with an insufficient number of nurses, but correspondingly with a dearth in experience and proficiency.

Leaders of the nonprofit, acute health-care organization should cultivate servant leadership factors that are associated with satisfying work environments in an attempt to minimize losses of experienced nurses. The multiple regression analysis in the current study revealed the total servant leadership score as a statistically significant predictor for job satisfaction. To achieve a servant-minded organization, all six components of servant leadership should be implemented as an integrated, creative leadership style. A servant leadership development program should be adapted to emphasize training in the areas of servant leadership that were perceived the least in the organization. In the nonprofit acute health-care organization, addressing the lowest scoring dimensions of (a) develops people, (b) provides leadership, and (c) shares leadership should improve collaboration, teamwork, and empowerment in nursing practice.

Experienced nurses are likely to report greater job satisfaction if particular servant leadership behaviors, such as shares leadership, are perceived in the work environment (Laschinger, Purdy, & Almost, 2007). Nurses need to be actively involved in decision-making across all levels of the organization if shared leadership is to be realized. The data analysis in the current study revealed a positively paternalistic organization, congruent with a traditional top-down power approach common in health-care organizations. Augmenting the participation of nurses in institutional decision-making and taking measures to improve the quality and degree of communication among nurses throughout all employment levels should contribute to shared awareness, increased collaboration, and empowerment. Implementing servant leadership training will provide opportunities to optimize the constructs associated with job satisfaction.

Another critical issue is the impending loss of nurses in high levels of organizational leadership. Effective nurse leaders implement improved processes, systems, and structures to achieve organizational goals including positive patient outcomes. Nurses in leadership roles are influential in creating satisfying work environments that improve nurse retention (Upeniecks, 2003). Servant-minded leaders are committed to improving the quality of care for patients, developing personnel to reach their potential, and achieving positive organizational outcomes. As senior nurse executives retire, an effective succession plan can avert a negative impact upon organizational outcomes, particularly patients' quality of care and nurses' job satisfaction and retention.

In acute health-care settings, organizational commitment is demonstrated in part through succession planning. Succession planning requires ongoing leadership



development throughout the nurse workforce. Adequately preparing nurses for advancing leadership roles requires early development and opportunities to lead with supportive mentoring. Developing leaders across all levels of nursing practice requires information sharing, decentralized decision making, and collaborative practices. Considering the advancing ages of the nurse executives, successfully developing leaders and initiating succession planning in acute health-care organizations cannot be delayed.

Organizational leaders must demonstrate a commitment to developing nurses as leaders. A leadership development plan should be annotated for each nurse based on the nurse's professional goals, abilities, and interests. Goals should be identified and training accomplished to augment leadership skills congruent with the nurse's career mobility goal. Training must be accompanied by opportunities to develop and display leadership skills with the support of a leadership mentor.

Each management level nurse should be evaluated on leadership competencies based on specified servant leadership behaviors, such as the ability to provide meaningful recognition for nurses. As liaisons between top leadership and the clinical workforce, the nurse manager must also effectively communicate and interpret the vision, values, and goals of the organization. Managers should receive individualized education and mentoring to augment leadership skills. The responsibilities of the manager should be structured to provide adequate time to supervise clinical nurses and provide leadership based on servant leadership principles.

Developing an effective succession plan requires a strategic evaluation of each management and top leadership position. The projected availability of the position should be estimated based on the current employee's goals, opportunities for advancement, and

historical data. Potential candidates should be identified from within the organization and should possess leadership goals and abilities commensurate with the position and philosophy of servant leadership. If a suitable candidate is not available, the organizational leadership should seek a qualified applicant that exhibits servant leadership behaviors and is committed to developing the leadership potential in nurses.

The perceptions of nurses in the study show that behaviors classified as *develops persons* were the weakest area of organizational nursing leadership. A significant perception mismatch also existed among the levels of nurses, with decreasing perceptions of the construct *develops persons* among clinical staff compared with managers and leaders. The findings indicate a perceived deficiency in servant leader attributes that develop personnel, including mentoring novice nurses. Nurse leaders must increase awareness of how they are perceived by the nurses they supervise, model effective servant leadership behaviors, and actively cultivate prospective nurse leaders. Developing future nurse leaders must be prioritized, because as the experienced nurse workforce retires, the availability of experienced and expert nurses who are adept at instructing and mentoring novice or relatively inexperienced nurses will be limited.

*Academic leaders.* Academic leaders of nursing preparation programs must develop partnerships with leaders of health-care organizations, nursing professional organizations, and regulatory and accrediting agencies to align educational and practice goals for registered nurses. Developing strong, supportive relationships with health-care leaders will facilitate communication of expectations, current issues, and respective requirements of each organization. Academic leaders should take action to address the leadership needs of entry-level registered nurses in the practice setting. The need to

develop leadership capabilities in nurses should begin at the earliest opportunity, which is during the nursing preparation program.

Leaders in nursing education should incorporate comprehensive leadership preparation for nurses beginning at the associate level of nursing education programs. Traditionally the associate degree nursing program prepares nurses to function as a technical nurse, whereas the baccalaureate program prepares nurses to function as a registered professional nurse (Poster et al., 2005). Although nurse graduates from baccalaureate programs and graduate level programs are expected to be able to assume leadership roles (Waddell & Stephens, 2000), inclusion of leadership preparation is necessary among all levels of registered nurse education programs to prepare nurses to work effectively as a leader in nursing practice settings. The entry level registered nurse, regardless of educational preparation, must be able to lead in a complex health-care environment and demonstrate competency in clinical leadership skills.

Students in nursing programs will benefit from a curriculum in which servant leadership behaviors are expected learning outcomes. Students who learn how to communicate with meaningful and respectful dialogue, collaborate with peers in decision making, and engage effectively in multi-disciplinary patient care planning will be increasingly prepared to assume professional nurse roles in acute care settings. In addition to a designated course on leadership, servant leadership principles should be integrated into the clinical courses. As servant leadership principles are congruent with the nursing profession's core values of caring, compassion, and respect, the inclusion of learning experiences based on servant leadership should strengthen the curriculum especially with leadership development.

For nurses who are currently practicing, development of nursing leadership should be addressed by the leaders of the health-care organization. In addition, nurses who did not receive leadership training in their nursing preparation programs could benefit from completing the requirements for a baccalaureate degree. Completing degree requirements would require completion of leadership courses and would likely prepare the nurse for expanded roles or promotion in nursing practice.

Besides focusing on the development of servant leadership abilities in nursing students, academic leaders have the ability to develop servant minded cultures in the academic setting. Academic leaders can model servant leadership behaviors while promoting a supportive, caring learning environment. Academic leaders can also apply servant leadership principles to design nursing education programs. Developing a servant minded academic culture is expected to provide a satisfying learning environment for nursing students, although further research is recommended to provide support for the premise.

#### *Recommendations for Further Study*

Further research is necessary to explore variables contributing to nurses' dissatisfaction and to provide empirical evidence for viable solutions to mitigate the nursing shortage. Recommendations for future research include conducting qualitative inquiry to explore the connection between servant leadership behaviors and job satisfaction and to identify themes that may explain factors affecting job satisfaction. The analysis of quantitative data in the present study revealed a strong positive correlation between perceived servant leadership behaviors and nurses' job satisfaction. Results also indicated significant differences in perceptions of servant leadership behaviors depending

upon the employee position in the organization. As correlational research does not indicate cause and effect, a qualitative research may yield relevant information on how servant leadership characteristics affect job satisfaction in a particular research setting, may help identify additional factors affecting job satisfaction, and may provide insight into why employee role affects perceptions of servant leadership. Exploring the lived experiences, perceptions, and understandings of the nurses may reveal themes that could explain factors that influence job satisfaction.

A qualitative study may provide insight on primary factors affecting job satisfaction. In the present study, participants indicated agreement, indecision, or disagreement with the statements provided on the survey instrument. One statement, for example, referred to valuing differences in culture, race, and ethnicity. Quantitative data yielded a score for the item, indicating the degree to which the item was perceived in the organization based on the number of participants who agreed or disagreed with the statement. In the diverse work environment, understanding how leaders demonstrate they value differences in culture, race, and ethnicity can provide nurse leaders with specific information on how to improve the particular behavior. Qualitative inquiry allows research participants to provide detailed information on their perceptions beyond the degree of agreement offered on survey instruments with Likert-type scales.

Qualitative inquiry provides participants an opportunity to expand their input and provide complete responses. In particular, participants can address the responses indicated as undecided on the Likert-type survey instrument. Qualitative data can increase nurse leaders' understanding of how particular behaviors are perceived in the organization and how the behaviors influence job satisfaction. Nurse leaders can use the

detailed information to develop tailored leadership training programs aimed at developing a culture that positively promotes job satisfaction among nurses.

Qualitative information could be obtained from either interviews or focus groups. Nineteen participants in the research study signaled a desire to have their voice heard by writing comments after the questions or at the end of the survey or by making exclamation marks or checkmarks to provide emphasis on a particular rating. Two participants provided e-mail addresses to indicate their willingness to provide follow-up information. A qualitative study would yield more detailed information on factors influencing the job satisfaction of nurses, enriching the knowledge of how leadership practices affect the job satisfaction of nurses.

Replication of the study is recommended if action is taken by hospital and nursing leaders to implement a new leadership model aimed at creating a servant minded organization. Leadership training based on servant leadership principles could be incorporated throughout the organization, reaching employees of all levels of employment and all health-care disciplines. The leadership training plan could detail specific measures aimed at bolstering the weakest servant leadership behaviors based on results in the current study. Expanding the study sample to include a large cross section of other health-care employees will provide comprehensive information about the functions of the entire organization. Replication of the study would indicate whether the training programs were successful in creating a servant minded organization.

In addition to replication of the study, future research studies examining health-care settings outside the scope of the current study, including health-care facilities not characterized as acute, are recommended. The findings of the current study may be

generalized in a limited context to registered nurses of nonprofit community-based acute health-care organizations. Although the impact of the nursing shortage is greatest in acute inpatient settings (Upenieks, 2003), a worsening nurse shortage is affecting other health-care practice settings. Adding other organizational settings, including for-profit, church-affiliated, and government health care, will add to the knowledge base of how servant leadership is perceived in related health-care organizations. Discovering whether particular health-care settings are more or less favorable to servant leadership practices will increase the understanding of cultural factors amenable to servant leadership and job satisfaction of nurses. The continued use of the validated OLA instrument (Laub, 1999) in future studies provides a consistent framework to compare findings.

Organizational outcomes beyond the scope of job satisfaction could be a focus for examining the influence of servant leadership. Greenleaf (1977) believed health-care organizational settings could achieve greater productivity from a servant leadership model. Research should be conducted to assess if a culture of servant leadership correlates with increased efficiency, resource management, and other productivity measures. White and Ozcan (1996) found that church-owned hospitals were more efficient than secular hospitals, although they did not examine effect of leadership style. Bass (1990) described considerable research that relates leadership and positive perceptions of supervisors to both employees' job satisfaction and employees' job performance. Expanding study parameters to include outcomes in health-care organizations, including the impact of servant leadership on quality of patient care, safety issues, and productivity in the workplace, would contribute to the knowledge of leadership theory.

A few studies examined servant leadership and outcomes beyond job satisfaction, although in settings outside health care. In an educational environment, Lambert (2004) found student achievement positively related to servant leadership behaviors. Rauch (2007) as cited in Laub (2008) discovered servant leadership was associated with decreased absenteeism and attrition, but did not find any relationship with accident rates, severity of accidents, or production of defective parts in a manufacturing setting. Empirical evidence supports the positive effects of job satisfaction and student achievement in higher education. Thus, future studies that incorporate the academic environment of nursing programs are recommended as well.

An administratively oriented recommendation is to add an employment-level query to the demographic attachment. Nearly 50 participants returned surveys without marking the nurse's role in the organization. The question of employee role was on the first page of the OLA survey. Although many participants did not complete this question, only 1 survey participant failed to complete the demographic form that was attached to the OLA survey. Although the omitted employment level was corrected by cross-referencing the participant's name with the staff directory, other researchers may not have access to an organizational directory.

### Summary

Amid a growing nursing shortage, health-care leaders are increasingly interested in determining how to raise job satisfaction among registered nurses. Many nurses are dissatisfied with their jobs, especially in the hospital setting (Upenieks, 2003). Job dissatisfaction leads to high turnover (Fleming et al., 2003), early retirements (Chaguturu & Vallabhaneni, 2005), and new nurse graduates leaving the profession (Sparacio, 2005).



Nursing leaders recognize that job satisfaction among nurses leads to improved job retention and lower vacancy rates, which affect both quality and availability of health care.

Leadership practices are commonly reported as a primary cause of nurse dissatisfaction (Cline et al., 2004). Many health-care leaders are creating changes to create satisfying work environments in acute care facilities (Dracup & Bryan-Brown, 2006). Healthy, collaborative work environments based on humane, respectful, and rewarding practices increase staff satisfaction in health-care settings (A. R. Smith, 2006). In the 1970s, Greenleaf (1977) recommended servant leadership as a suitable model of leadership for health-care settings. Servant leadership provides an ethically based humanistic leadership approach that incorporates human factors. Empirical evidence supports a relationship between servant leadership behaviors and job satisfaction, with implications that servant leadership is a tenable leadership approach in the nursing environment.

The current quantitative correlational research study included an examination into the perceptions of registered nurses in nonprofit acute health-care settings, representing clinical, management, and senior leadership. The purpose of the study was to (a) ascertain the extent that perceptions of servant leadership behaviors are implemented in an acute health-care organization in the northwestern United States and (b) determine the relationship between perceptions of servant leadership behaviors and job satisfaction among nurses. The OLA survey instrument was used to gather data on perceptions of servant leadership practices and job satisfaction of registered nurses. The OLA survey uses a Likert-like scale to measure servant leadership through six component variables:

(a) values people, (b) develops people, (c) builds community, (d) displays authenticity, (e) provides leadership, and (f) shares leadership (Laub, 1999). Data from 313 registered nurses were analyzed through descriptive statistics, Pearson correlations, and one-way ANOVAs.

The findings from the research study indicate that perceptions of servant leadership do relate to nursing satisfaction. As nurses perceive greater evidence of servant leadership behaviors in the work environment, job satisfaction increases accordingly. The positive link of servant leadership behaviors with nursing satisfaction indicates that nurse leaders may implement a servant leadership approach as a new or creative leadership style in acute health-care settings if nurse leaders are committed to increasing nurse job satisfaction. Satisfied nurses do not seek employment elsewhere, but remain in the current health-care institution. With the nursing shortage expected to worsen, nurse leaders should initiate actions to increase nurses' job satisfaction and therefore nurse retention. Keeping nurses satisfied will improve nurse retention and might mitigate the number of nurses choosing to retire early or leave the nursing profession.

The study yielded data on leadership factors influencing job satisfaction among nurses in a nonprofit acute health-care organization in the northwestern United States. Results of the data analysis illustrate a strong link between servant leadership behaviors and job satisfaction of registered nurses. Although the analysis showed significant differences for perceptions of nurses among levels of employment, post hoc analysis revealed the differences, although significant, were slight. Opportunities exist for augmenting servant leadership in the acute health-care environment, as perceptions point to a level less than servant minded or servant led according to Laub's (2008) definitions.

Insights derived from study data may assist nursing and health-care leaders of the health-care organization to determine effective strategies and policies to promote a satisfying work environment for nurses. Incorporating servant leadership training and implementing a nursing model that advances nursing practice and leadership beyond a paternalistic pattern are recommended. Replication of the study at a later date is suggested, as is expanding the investigation to include increased numbers and types of health-care settings, locations, and health-care professionals in future studies. Adding qualitative inquiry and data collection methods to verify outcomes such as productivity is recommended. The growing health-care needs of an aging American populace and a worsening nurse shortage show that action through national policy initiatives is warranted.

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## APPENDIX A: COVER LETTER

Dear Nursing Colleague,

The current nursing shortage is predicted to continue and progressively worsen, especially in acute inpatient care settings. Job satisfaction among Registered Nurses is a significant factor in nurses' decisions to remain in nursing or leave the profession, thus impacting the nursing shortage. To investigate this issue further, you have been selected as a potential participant in a research study entitled "Servant Leadership and Registered Nurse Job Satisfaction in Nonprofit Acute Healthcare Settings: A Correlational Study." Your insight as a Registered Nurse at your acute care facility is needed as your perspective will provide valuable information on factors affecting job satisfaction, especially in relation to leadership behaviors. Your participation will also help me complete the requirements for a degree in Doctor of Education in Educational Leadership at the University of Phoenix.

Your answers to the survey, *which will take approximately 15 minutes to complete*, will contribute to knowledge of how leadership behaviors relate to nursing job satisfaction in hospital organizations. While your participation is desired, it is voluntary. Your confidentiality and anonymity are completely guaranteed. ***By participating, you will be entered into a raffle, in which six Registered Nurses will win \$100 each.*** The results of the research study may be published but your responses are completely anonymous. Please contact me via phone or email (noted below) if you have any questions concerning this research study.

If you agree to participate, **please sign the informed consent form, complete the enclosed questionnaire and mail them within ten days in the enclosed, addressed, stamped envelope.** If you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit to yourself. **I greatly appreciate your time and genuinely thank you for your participation in this research.**

Sincerely,

Carol Amadeo

## APPENDIX B: INFORMED CONSENT FORM

Dear Nursing Colleague,

Thank you in advance for your interest and voluntary participation in this study. Your views are important, and your perspective will be helpful in understanding how leadership in nursing affects job satisfaction in your organization. If you agree to participate, **please sign the informed consent form at the bottom of this letter, complete the enclosed questionnaire and mail them within ten days in the enclosed, addressed, stamped envelope.** If you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit to yourself. There are not any anticipated risks with completing the survey, except for the potential of discomfort in relation to questions pertaining to job satisfaction.

Your responses are completely confidential and anonymous. Once your survey is received, it will be immediately separated from the informed consent form. No names will be associated with the survey results. *By enclosing the raffle ticket, you will be entered into a drawing in which six nurses from your hospital organization will be selected for a prize of \$100 each. Please detach the raffle ticket “Keep This Coupon” and leave the other raffle ticket attached to the informed consent form.*

Thank you, for your commitment to nursing, your time, and your support.

Carol Amadeo

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**By signing this form I acknowledge that I understand the nature of the study, the potential risks to me as a participant, and the means by which my identity will be kept confidential. My signature on this form also indicates that I am 18 years old or older and that I give my permission to voluntarily serve as a participant in the study described.**

**Signature of Participant** \_\_\_\_\_

**Date** \_\_\_\_\_

## APPENDIX C: ORGANIZATIONAL LEADERSHIP ASSESSMENT INSTRUMENT



4243 North Sherry Drive  
Marion, IN 46952  
jlaub@indwes.edu  
(765) 677-2520

## Organizational Leadership Assessment

### General Instructions

The purpose of this instrument is to allow organizations to discover how their leadership practices and beliefs impact the different ways people function within the organization. This instrument is designed to be taken by people at all levels of the organization including workers, managers and top leadership. As you respond to the different statements, please answer as to what you believe is generally true about your organization or work unit. Please respond with your own personal feelings and beliefs and not those of others, or those that others would want you to have. Respond as to how things *are* ... not as they could be, or should be.

Feel free to use the full spectrum of answers (from Strongly Disagree to Strongly Agree). You will find that some of the statements will be easy to respond to while others may require more thought. If you are uncertain, you may want to answer with your first, intuitive response. Please be honest and candid. The response we seek is the one that most closely represents your feelings or beliefs about the statement that is being considered. There are three different sections to this instrument. Carefully read the brief instructions that are given prior to each section. Your involvement in this assessment is anonymous and confidential.

Before completing the assessment it is important to fill in the name of the organization or organizational unit being assessed. If you are assessing an organizational unit (department, team or work unit) rather than the entire organization you will respond to all of the statements in light of that work unit.

### IMPORTANT ..... please complete the following

Write in the name of the organization or organizational unit (department, team or work unit) you are assessing with this instrument.

**Organization (or Organizational Unit) Name:** \_\_\_\_\_

Indicate **your present role/position** in the organization or work unit. Please **circle one**.

- 1 = Top Leadership (top level of leadership)
- 2 = Management (supervisor, manager)
- 3 = Workforce (staff, member, worker)

Please provide your response to each statement by placing an **X** in one of the five boxes

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

### **Section 1**

In this section, please respond to each statement as you believe it applies to **the entire organization** (or organizational unit) including workers, managers/supervisors and top leadership.

#### **In general, people within this organization ....**

	1	2	3	4	5
1 Trust each other					
2 Are clear on the key goals of the organization					
3 Are non-judgmental – they keep an open mind					
4 Respect each other					
5 Know where this organization is headed in the future					
6 Maintain high ethical standards					
7 Work well together in teams					
8 Value differences in culture, race & ethnicity					
9 Are caring & compassionate towards each other					
10 Demonstrate high integrity & honesty					
11 Are trustworthy					
12 Relate well to each other					
13 Attempt to work with others more than working on their own					
14 Are held accountable for reaching work goals					
15 Are aware of the needs of others					
16 Allow for individuality of style and expression					
17 Are encouraged by supervisors to share in making <i>important</i> decisions					
18 Work to maintain positive working relationships					
19 Accept people as they are					
20 View conflict as an opportunity to learn & grow					
21 Know how to get along with people					

Please provide your response to each statement by placing an **X** in one of the five boxes

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

## **Section 2**

In this next section, please respond to each statement as you believe it applies to the **leadership** of the organization (or organizational unit) including managers/supervisors and top leadership

Managers/Supervisors and Top Leadership in this Organization		1	2	3	4	5
22	Communicate a clear vision of the future of the organization					
23	Are open to learning from those who are <i>below</i> them in the organization					
24	Allow workers to help determine where this organization is headed					
25	Work alongside the workers instead of separate from them					
26	Use persuasion to influence others instead of coercion or force					
27	Don't hesitate to provide the leadership that is needed					
28	Promote open communication and sharing of information					
29	Give workers the power to make <i>important</i> decisions					
30	Provide the support and resources needed to help workers meet their goals					
31	Create an environment that encourages learning					
32	Are open to receiving criticism & challenge from others					
33	Say what they mean, and mean what they say					
34	Encourage each person to exercise leadership					
35	Admit personal limitations & mistakes					
36	Encourage people to take risks even if they may fail					
37	Practice the same behavior they expect from others					
38	Facilitate the building of community & team					
39	Do not demand special recognition for being leaders					
40	Lead by example by modeling appropriate behavior					
41	Seek to influence others from a positive relationship rather than from the authority of their position					
42	Provide opportunities for all workers to develop to their full potential					
43	Honestly evaluate themselves before seeking to evaluate others					
44	Use their power and authority to benefit the workers					
45	Take appropriate action when it is needed					

Please provide your response to each statement by placing an **X** in one of the five boxes

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

Managers/Supervisors and Top Leadership in this Organization		1	2	3	4	5
46	Build people up through encouragement and affirmation					
47	Encourage workers to work <i>together</i> rather than competing against each other					
48	Are humble – they do not promote themselves					
49	Communicate clear plans & goals for the organization					
50	Provide mentor relationships in order to help people grow professionally					
51	Are accountable & responsible to others					
52	Are receptive listeners					
53	Do not seek after special status or the “perks” of leadership					
54	Put the needs of the workers ahead of their own					

### Section 3

In this next section, please respond to each statement as you believe it is true about you personally and your role in the organization (or organizational unit).

In viewing my own role ...		1	2	3	4	5
55	I feel appreciated by my supervisor for what I contribute					
56	I am working at a high level of productivity					
57	I am listened to by those <i>above</i> me in the organization					
58	I feel good about my contribution to the organization					
59	I receive encouragement and affirmation from those <i>above</i> me in the organization					
60	My job is important to the success of this organization					
61	I trust the leadership of this organization					
62	I enjoy working in this organization					
63	I am respected by those <i>above</i> me in the organization					
64	I am able to be creative in my job					
65	In this organization, a person's <i>work</i> is valued more than their <i>title</i>					
66	I am able to use my best gifts and abilities in my job					



## APPENDIX D: DEMOGRAPHIC FORM

Please respond to the following demographic questions.

Your Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Your Age Range: 20 – 29 \_\_\_\_\_  
 30 – 39 \_\_\_\_\_  
 40 – 49 \_\_\_\_\_  
 50 – 59 \_\_\_\_\_  
 Over 59 \_\_\_\_\_

Highest Level of Education Completed:

Associates Degree \_\_\_\_\_  
 Diploma in Nursing \_\_\_\_\_  
 Baccalaureate Degree \_\_\_\_\_  
 Masters Degree \_\_\_\_\_  
 Other \_\_\_\_\_

Total Number of Years of Experience as Registered Nurse:

Less than 1 year \_\_\_\_\_  
 1 – 2 \_\_\_\_\_  
 3 – 5 \_\_\_\_\_  
 6 –10 \_\_\_\_\_  
 11–15 \_\_\_\_\_  
 16–20 \_\_\_\_\_  
 >20 \_\_\_\_\_

Total Number of Years Employed at Current Hospital Organization:

Less than 1 year \_\_\_\_\_  
 1 – 2 \_\_\_\_\_  
 3 – 5 \_\_\_\_\_  
 6 –10 \_\_\_\_\_  
 11–15 \_\_\_\_\_  
 16–20 \_\_\_\_\_  
 >20 \_\_\_\_\_

Area of Current Nursing Practice:

Pediatrics _____	Labor/Delivery _____	Cardiac ICU _____
Special Care Peds _____	Special Care Nursery _____	Telemetry _____
Med/Surg/Oncology _____	Maternal/Newborn _____	ICU _____
Surgery/PACU _____	High Risk Maternity _____	CV Intervention _____
Ambulatory Care _____	Gynecology _____	Emergency _____
Neuro/Ortho _____	Women/Children _____	Case Mx _____
Rehab _____	Administration _____	Radiology/Cath _____
Other _____		

## APPENDIX E: PERMISSION TO USE THE ORGANIZATIONAL LEADERSHIP

## ASSESSMENT

## UNIVERSITY OF PHOENIX

## PERMISSION TO USE AN EXISTING SURVEY

Date 11-26-07

Ms. Carol Amadeo

Thank you for your request for permission to use Organizational Leadership Assessment (OLA) survey instrument in your research study. We are willing to allow you to reproduce the instrument as outlined in your letter at no charge with the following understanding:

- You will use this survey only for your research study and will not sell or use it with any compensated management/curriculum development activities.
- You will include the copyright statement on all copies of the instrument.
- You will send your research study and one copy of reports, articles, and the like that make use of this survey data promptly to our attention.

If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it to us.

Best wishes with your study.

Sincerely,

  
\_\_\_\_\_  
Signature

I understand these conditions and agree to abide by these terms and conditions.

Signed \_\_\_\_\_ Date 11-26-07

  
\_\_\_\_\_

Expected date of completion 3-1-08

## APPENDIX F: FREQUENCY COUNTS FOR SELECTED VARIABLES

Variable	Category	<i>n</i>	%
Hospital			
	G	87	27.8
	M	226	72.2
Role at Hospital			
	Top leadership	7	2.2
	Management	51	16.3
	Workforce	255	81.5
Gender			
	Male	23	7.3
	Female	290	92.7
Age Range <sup>a</sup>			
	20 to 29 years	38	12.1
	30 to 39 years	74	23.6
	40 to 49 years	78	24.9
	50 to 59 years	102	32.6
	Over 59 years	21	6.7

<sup>a</sup> Age: *Mdn* = 44.50 years.

Table Continued

Table *Continued*

Variable	Category	n	%
Education			
	AA degree	93	29.7
	Diploma	28	8.9
	BS degree	153	48.9
	MS degree	39	12.5
Experience as RN <sup>b</sup>			
	Less than 1 year	11	3.5
	1 to 2 years	24	7.7
	3 to 5 years	36	11.5
	6 to 10 years	47	15.0
	11 to 15 years	36	11.5
	16 to 20 years	35	11.2
	Over 20 years	124	39.6

<sup>b</sup> Experience: *Mdn* = 18.00 years.

Table *Continued*

Table Continued

Variable	Category	<i>n</i>	%
Current Practice Area			
	Labor/Delivery	54	17.3
	Special Care Nursery	51	16.3
	Telemetry	17	5.4
	Maternal/Newborn	19	6.1
	ICU	20	6.4
	Surgery/PACU	25	8.0
	Neuro/Ortho	16	5.1
	Administration	18	5.8
	Other Area	93	29.7
Years at Current Hospital <sup>c</sup>			
	Less than 2 years	54	17.3
	3 to 5 years	60	19.2
	6 to 10 years	50	16.0
	11 to 15 years	23	7.3
	16 to 20 years	33	10.5
	Over 20 years	93	29.7

<sup>c</sup> Experience: *Mdn* = 8.00 years.

APPENDIX G: PERCEPTIONS OF SERVANT LEADERSHIP AND JOB  
SATISFACTION BASED ON LEVEL OF NURSING POSITION

Score	Nursing level	<i>n</i>	<i>M</i>	<i>SD</i>	<i>eta</i>	<i>F</i>	<i>p</i>
OLA Total <sup>a</sup>	1. Work force	255	208.29	38.49	.14	3.13	.05
	2. Management	51	220.27	32.31			
	3. Top leadership	7	230.14	35.26			
	Total	313	210.73	37.76			
OLA Values People <sup>b</sup>	1. Work force	255	3.60	0.64	.17	4.49	.01
	2. Management	51	3.82	0.52			
	3. Top leadership	7	4.09	0.60			
	Total	313	3.65	0.63			
OLA Develops People <sup>c</sup>	1. Work force	255	3.32	0.77	.16	4.29	.02
	2. Management	51	3.64	0.66			
	3. Top leadership	7	3.68	0.70			
	Total	313	3.38	0.76			

*Table Continued*

Table Continued

Score	Nursing level	<i>n</i>	<i>M</i>	<i>SD</i>	eta	<i>F</i>	<i>p</i>
OLA Builds							
Community <sup>d</sup>	1. Work force	255	3.61	0.63	.07	0.79	.45
	2. Management	51	3.70	0.45			
	3. Top leadership	7	3.80	0.59			
	Total	313	3.63	0.60			
OLA Displays							
Authenticity <sup>e</sup>	1. Work force	255	3.45	0.67	.17	4.20	.01
	2. Management	51	3.68	0.61			
	3. Top leadership	7	3.99	0.49			
	Total	313	3.50	0.67			
OLA Provides							
Leadership <sup>f</sup>	1. Work force	255	3.41	0.72	.05	0.41	.67
	2. Management	51	3.51	0.65			
	3. Top leadership	7	3.41	0.92			
	Total	313	3.42	0.71			

<sup>d</sup> Scheffe Post Hoc Tests: 1 = 2 ( $p = .61$ ); 2 = 3 ( $p = .92$ ); 1 = 3 ( $p = .71$ ).

<sup>e</sup> Scheffe Post Hoc Tests: 1 < 2 ( $p = .09$ ); 2 = 3 ( $p = .51$ ); 1 < 3 ( $p = .11$ ).

<sup>f</sup> Scheffe Post Hoc Tests: 1 = 2 ( $p = .67$ ); 2 = 3 ( $p = .95$ ); 1 = 3 ( $p = 1.00$ ).

Table Continued

Table *Continued*

Score	Nursing level	<i>n</i>	<i>M</i>	<i>SD</i>	eta	<i>F</i>	<i>p</i>
OLA Shares							
Leadership <sup>g</sup>	1. Work force	255	3.42	0.69	.17	4.53	.01
	2. Management	51	3.66	0.64			
	3. Top leadership	7	3.96	0.54			
	Total	313	3.47	0.69			
Job Satisfaction <sup>h</sup>	1. Work force	255	3.65	0.71	.17	4.60	.01
	2. Management	51	3.94	0.65			
	3. Top leadership	7	4.07	0.55			
	Total	313	3.71	0.71			

<sup>g</sup> Scheffe Post Hoc Tests: 1 < 2 ( $p = .07$ ); 2 = 3 ( $p = .56$ ); 1 < 3 ( $p = .12$ ).

<sup>h</sup> Scheffe Post Hoc Tests: 1 < 2 ( $p = .03$ ); 2 = 3 ( $p = .90$ ); 1 = 3 ( $p = .30$ ).