

A STUDY ON THE RELATIONSHIP BETWEEN PERCEIVED LEADERSHIP STYLES
OF HOSPITAL CLINICAL LEADERS AND PERCEIVED EMPOWERMENT,
ORGANIZATIONAL COMMITMENT, AND JOB SATISFACTION OF SUBORDINATE
HOSPITAL NURSES IN A MANAGEMENT POSITION

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Abstract

Empowerment, job satisfaction, and organizational commitment are essential to building and sustaining a committed, nursing, management staff as hospital facilities face heightened competition and rapid changes at almost every organizational level. Research has shown that effective clinical leadership is essential to nurses' (in management positions) empowerment, job satisfaction, and organizational commitment. The purpose of this study is to describe and analyze, through a quantitative design, the effect hospital, clinical leadership styles have on job empowerment, job satisfaction and organizational commitment of nurses in management positions in a hospital setting. A total of four hypotheses were developed based on one independent variable (perceived leadership styles), four dependent variables (job satisfaction, organizational commitment, empowerment) and demographic questions. The results of this study suggest that hospital clinical leaders display transformational leadership styles with a higher degree of frequency, as perceived and rated by their subordinate nurse managers. Evaluation of this study's data indicated that Idealized Influence (attributed), Idealized Influence (behavioral) and Inspirational Motivation were the primary predictors of job satisfaction, organizational commitment and workplace empowerment.

Dedication

I dedicate this dissertation to my remarkable husband, Steve. His steadfast support and loving encouragement kept me at task in completing my doctorate.

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CHAPTER 1. INTRODUCTION

Introduction to the Problem

Hospital nurses in management positions face heightened responsibility in demanding positions within exceedingly complex, increasingly diverse and fast changing environments. It is vital that hospital clinical leaders foster a supportive work environment to empower their subordinate nurses in management positions and to help assure their job satisfaction and organizational commitment (Laschinger, Wong, McMahon, & Kaufmann, 1999; Sofarelli & Brown, 1998; Upenieks, 2003). Researchers have found that leadership styles of the hospital clinical leaders play a vital role in promoting workplace empowerment, organizational commitment and job satisfaction amongst nurses in management positions in a hospital setting (Arruda, 2005; Dumdum, Lowe, & Avolio, 2002; Falk-Rafael, 2001; Gifford, Zammuto, Goodman, & Hill, 2002; Laschinger et al., 1999; Medley & LaRochelle, 1995; Upenieks).

Hospital clinical leaders face many unique challenges, such as what leadership style is appropriate in leading nurses in management positions in a hospital setting (Apker, Ford & Fox, 2003). In particular, these leaders must exhibit a leadership style that communicates empathy respect and trust; which are essential elements for the occurrence of positive team cohesion (Larrabee, Janney, & Ostrow, 2003). Researchers have concluded that transformational leadership styles are preferred in this regard over transactional leadership styles (Barling, Weber & Kelloway, 1996; Bass & Avolio, 1990; Bolman & Deal, 2003; Leatt, Baker, Halverson, & Aird, 1997; Lowe, Kroeck, & Sivasubramaniam, 1996; Masi, 2000; Mrayyan, 2004; Prothero, Marshall, Fosbinder, & Hendrix, 2000; Warden, 1999).

Transformational leadership instills a higher level of commitment in employees, reduces employee stress and increases morale; which enhances employee job satisfaction (Bass & Avolio, 1994; Bolman & Deal, 2003; Garrett, 1991; Lowe et al., 1996; Masi, 2000). By implementing transformational leadership styles, hospital clinical leaders will be empowering their nurses in management positions; encouraging commitment to the organization; and solving employee morale problems (Leatt et al. 1997; Prothero et al. 2000). Conversely, some researchers have found that autocratic leadership styles are widely recognized as a source of stress, strain and job dissatisfaction (Kuokkanen & Katajisto, 2003; Morrison, Jones, & Fuller, 1997; Moss & Rowles, 1997).

Kuokkanen and Katajisto (2003) defined autocratic leadership style when a leader wields absolute power over his or her subordinates. In turn, subordinates have little input, autonomy, or opportunity for making suggestions; irregardless if those ideas are suited for improved organizational outcomes (Kuokkanen & Katajisto; Morrison, Jones, & Fuller, 1997). Wilmore & Thomas (2001) found that traditional autocratic structures create layers of bureaucracy that prevents autonomy; which creates a higher organizational turnover giving way to increased training costs.

In short, hospital clinical leaders must not only be consistent and knowledgeable, they must also empower their subordinate leaders and/or managers by promoting autonomy through delegation (Nehls, 2000; Strachota, Normandin, O'Brien, Clary, & Krukow, 2003). This autonomy establishes mutually beneficial relationships that favor job satisfaction, because it encourages the nurses in management positions to assume job ownership, and enjoy workplace empowerment (Nehls; Strachota et al.). Due to the increased demands placed on nurses in management positions, this form of leadership is

most desirable in the everyday workings of a nursing managerial environment (Nehls; Strachota et al.).

Under an autocratic leadership style, nurses in management positions are frequently under increased pressure to provide quality care because task-oriented, cost reduction measures are stressed by those leaders who exercise this task oriented style (Anderson & McDonald, 2000). By contrast, the collective energy of shared leadership enables nurses in management positions to form strong empowering networks that build personnel infrastructures that produce superior, long-term work performance (Healy & McKay, 2000; Keuter, Byrne, Voell, & Larson, 2000). Such a positive leadership style involves nurses in managerial positions participating in a common organizational commitment that contributes to an optimal work environment (Healy & McKay; Keuter et al.).

Because an organization's success is often measured by organizational cohesiveness that transcends personal self-interests (Altman, 2002), nurses in management positions and their supervisory leaders must act collectively in their decision making process (Al-Ma'aitah, Cameron, Horsburg, & Armstrong-Stassen, 1999; Kluska, Laschinger, & Kerr, 2004). An ineffective leadership style can undermine the efforts of nurses in management positions in their work environment (Aiken & Patricia, 2000; Altman; Kluska et al.). Effective hospital clinical leaders must build collaborative relationships and employ participatory leadership styles that empower, create job satisfaction and organizational commitment in their nurses in management positions (Falk-Rafael, 2001).

Background of the Study

America's healthcare delivery system is experiencing hospital downsizing, increasing competition, and consumer driven changes; all of which are exacerbating the ongoing nursing retention issue (Khowaja, Merchant & Hirani, 2005; Kleinman, 2004; Lok, Westwood, & Crawford, 2005; Mrayyan, 2005). Increased workloads, stress, clinical errors, poor management support, and lack of employee control are but a few of the adverse effects arising from this chronic staffing problem (Foley, 2001; Kleinman, 2004; Lok et al.; Mrayyan, 2004). Work overload increases stress and attrition; leaving many healthcare organizations struggling for new ways to retain their nursing and management staff (Kuokkanen & Kaatajisto, 2003).

In Sochalski's (2002) survey, it was found that 1 out of 3 staff nurse participants (manager and staff level) were dissatisfied in their job. Increasing job satisfaction, as it positively correlates with empowerment and organizational commitment, is a strategy to help retain employees (Laschinger, Finegan, Shamian, & Casier, 2000). As patient care becomes more technologically advanced and complex, (requiring greater experience on the part of nursing staff to perform the job correctly), workplace stability and autonomy become invaluable in a hospital setting (Laschinger et al.).

Many researchers have concluded that building collaborative decision making teams will empower both nursing and managerial staff; which boosts morale and work performance (Cowin, 2002; Foley, 2001; Kluska et al., 2004). Ellefsen and Hamilton (2000) concluded that nurse empowerment encourages nurses in management positions to perform their duties efficiently and with confidence and competence. The question is:

how are nurses' (in management positions) empowerment, job satisfaction, and organizational commitment to be achieved in a hospital setting?

Researchers have found hospital leadership to be an influential factor in subordinate job satisfaction (Acorn, Ratner, & Crawford, 1997; Larrabee et al., 2003). Research suggests when hospital leadership encourages subordinate empowerment; there is a direct link to increased subordinate job satisfaction and motivation (Laschinger, Finegan, Shamian, & Wilk, 2001). Evidence has shown that empowered nurses shift their self perceived role from that of a subordinate to collaborator; which encourages consensus building, improves job ownership, improves trust and the follower's motivation, sense of responsibility and organizational commitment (Nehls, 2000; Falk-Rafael, 2001; Wagner, 2006; Watson, 2002).

Ever-changing organizational arrangements within the healthcare setting mean that hospital clinical leaders face additional challenges in managing the human relations aspect of the enterprise (Prybil, 2003). Hospital clinical leaders have always had to know how to motivate their managers by creating performance management systems that change unproductive behaviors, but the strategies for doing so while imperative, have become more complex in contemporary healthcare settings where the urgency for retention is profound (Laschinger & Sabiston, 2000; Lowe & Barnes, 2002; Trott & Windsor, 1999). Given the weight of the evidence in favor of empowering hospital staff, hospital clinical leaders must exhibit leadership styles that nurture collaborative high-performance nurse management teams (Tzeng & Ketefian, 2002).

Medley and LaRochelle (1995) found that leadership style is a major factor in job satisfaction, and in particular they concluded that transformational leadership styles were

preferred in this regard over transactional leadership. Burns (1978) characterized transformational leadership as placing the employee in a proactive role. When possessing a transformational leadership style, a person inspires his or her followers with a shared organizational vision (Burns).

Transformational leaders are highly communicative and visible, with the tendency to delegate responsibility (Bass, 1990; Bass, 1997). These leaders implement initiatives that add value to an organization's work atmosphere (Bass, 1990). By implementing a transactional leadership style, an employee is forced to respond in a reactive role, placing motives to change through negative circumstances (Bass, 1997).

Transformational leaders tend to embody the following attributes: (a) charisma, (b) a strong ethical base, (c) a motivational orientation (d) mentoring attributes and (e) creativity. Whereas, transactional leaders are characterized by (a) contingent reward methods (b) reactive management approach and (c) passive management approach (Bass & Avolio, 2000). Bass and Avolio (2000) advocated transformational leadership as being most sensitive to developing a shared vision of a more desirable work culture; whereas, they found that transactional leadership creates a less desirable work culture with little concern for working towards an organizational vision (Bass & Avolio).

Many researchers have concluded that transformational leadership is the most effective model of management in a healthcare setting to achieve the aforementioned constituents of job satisfaction, organizational commitment, and empowerment, in order to create the necessary positive relationship between leaders and workers (Ellefsen & Hamilton, 2000; Falk-Rafael, 2001; Kezar, 2000, Laschinger, Finegan, & Shamian, 2001; Medley & LaRochelle, 1995; Schmieding, 1993; Shortell & Kaluzny, 2000; Thyer,

2003). Empowerment not only increases job satisfaction, but inspirational and visionary transformational leadership encourages the highest level of staff efficiency and productivity (Keuter, Byrne, Voell, & Larson, 2000; Laschinger, et al., 2003; Moss & Rowles, 1997). Masi (2000) concluded that empowerment provides opportunities for choice and promotes autonomy, which allows subordinates to demonstrate their competencies.

One of the primary tenets of transformational leadership is that effective leaders work together with, rather than separate from their subordinates achieve organizational goals (Konczak, Stelly, & Trusty, 2000; Masi, 2000). Empowerment emerges from shared governance of an organization, accompanied by shared respect between leaders and subordinates (Masi; Paterson, 2001). When leaders involve subordinates in decision making, they are gaining power by design rather than losing any power, and moreover, the relationship is an ongoing function of reciprocal gains: the employee gains autonomy, self-esteem, and job satisfaction, and the employer gains in terms of productivity and cost savings associated with lowered turnover (Masi; Reilly, 2003).

Active participation of subordinates in the decision making process elevates their status, giving them more control and satisfaction (Laschinger & Finegan, 2005; Morrison, Jones, & Fuller, 1997; Porter, Steers, Mowday, & Boulian; 1974). Hierarchical management arrangements and mute participation can signal problems, as Laschinger and Finegan (2005) found, that nurses in organizations with a high level of bureaucracy were not satisfied in their job positions. Research has shown how mechanistic bureaucratic structures tend to create autocrats (Mrayyan, 2005; Nakata & Saylor, 1994); whereas,

flatter more organic organizational structures create status hierarchies that lends itself towards bureaucratic management styles.

Laschinger et al. (2000) found that, as nurses' perceptions of legitimacy of their organization's structure increases, their job satisfaction also increases. Again, there is a reciprocal relationship between organizational behavior and nurse retention, and leadership style, decision-making, and communication; which all influence nursing job satisfaction in healthcare settings (Laschinger et al.). Therefore, it is important to further examine what types of leadership practices influence job satisfaction, organizational commitment and empowerment in order to improve nurse manager relations and retention.

Problem Statement

Research has shown that, as leaders interact with their subordinates, their leadership style significantly affects their subordinates' perceptions and organizational outcomes (Altman, 2002; Roberts, 2001; Spencer, 1993). The relationships between leadership style, employee satisfaction and organizational commitment are particularly important in a hospital setting (Barrett & Myrick, 1998; Beckham, 2002; Bratt, Broome, Kelber, & Lostocoo, 2000; Fletcher, 2001). There is also much evidence regarding the relationship between leadership styles and workplace empowerment (Ellefsen & Hamilton, 2000; Falk-Rafael, 2001; Kluska et al.; Konczak et al.; Laschinger & Sabiston, 2000; Mrayyan, 2004; Sullivan & Deckers, 2001).

However, it is important to ask the following question: Does a hospital clinical leader's leadership style lead to *both* job satisfaction and organizational commitment for the nurses they supervise in management positions? Does the same hold true for job

empowerment of nurses in management positions? By identifying the range of perceived leadership styles of hospital clinical leaders and the correlation to factors associated with job satisfaction, organizational commitment, and job empowerment, this research will contribute to the professional growth of leadership administration at a hospital in pursuit of its organizational goals, but particularly to the hospital's attempt to retain nursing management employees. The research community has recognized the importance of hospital clinical leadership, but further research is necessary to understand the extent of the relationships between leadership style practices of hospital clinical leaders (as perceived by subordinate hospital nurses in management positions), and subordinate hospital nurses' (in management positions) job satisfaction, subordinate hospital nurses' (in management positions) organizational commitment and subordinate hospital nurses' (in management positions) workplace empowerment.

Significance of the Study

This study highlighted how the hospital clinical leadership styles (as perceived by subordinate hospital nurses in management positions) affected their subordinate hospital nurses' (in management positions) job satisfaction, subordinate hospital nurses' (in management positions) organizational commitment and subordinate hospital nurses' (in management positions) workplace empowerment. Also a demographic questionnaire asked job tenure, age, gender, educational background, years in the field, years at current employment, salary range, current title and state location of employment.

The study examined any correlation between hospital clinical leadership styles (as perceived by subordinate hospital nurses in management positions) affected their

subordinate hospital nurses' (in management positions) job satisfaction, subordinate hospital nurses' (in management positions) organizational commitment and subordinate hospital nurses' (in management positions) workplace empowerment. Higher job satisfaction, organizational commitment, and empowerment suggested a satisfied work staff, which predicted lower rates of turnover, higher rates of retention, and increased work effectiveness.

Research has shown that hospital nurses in management positions dislike autocratic leaders (Kuokkanen & Katajisto, 2003). Studying the leadership styles of hospital clinical leaders (as perceived by subordinate hospital nurses in management positions) revealed what styles are conducive to empowerment, organizational commitment, and job satisfaction. A better understanding of the relationship of perceived leadership style relative to job satisfaction, empowerment, and organizational commitment can enhance the leadership of the hospital administration and nursing profession.

Purpose of the Study

The purpose of this study was to investigate if a relationship exists between the hospital clinical management leadership styles (as perceived by subordinate nurses in management positions) and subordinate nurse job satisfaction, organizational commitment and workplace empowerment. Other demographic variables were examined, such as participant age, gender, educational background, years in the field, years at current employment, salary, state location of employment and current title. This study examined three perceived leadership styles: transformational, transactional, and non-transactional (*laissez-faire*) to find an effect (if any) on the two aspects (intrinsic and

extrinsic) of job satisfaction, three aspects (reciprocity, synergy, and ownership) of workplace empowerment, and organizational commitment.

Rationale

Research has supported the conclusion that leadership styles of hospital clinical leaders play an important role in nursing management job satisfaction and empowerment (Acorn, Ratner, & Crawford, 1997; Keuter, Byrne, Voell, & Larson, 2000). Due to the complexity of today's healthcare setting, it is crucial that hospital clinical leaders create a work environment that supports a committed and confident staff of nurses in management positions (Acorn et al.; Keuter et al.; Kuokkanen, Leino-Kilpi, & Katajisto, 2003; Schein, 2004). Moreover it is imperative that nurses in management positions, as vital human resources, be retained (Acorn et al.; Albaugh, 2005; Keuter et al.).

Researchers have found that nurses in management positions leave hospitals do to personal frustration over ineffective management and leadership issues, i.e., lack of support which coercive direction, which undermine motivation (Cimete, Gencalp, & Keskin, 2003; Cline, Reilly, & Moore, 2004; Kane-Urrabazo, 2006; Shader et al. 2001; Wallick, 2002). Hospitals in particular are looking for strategies to retain all staff levels of nurses (Moss & Rowles, 1997), and one strategy for employee retention that research indicates is vital to organizational stability is increasing employee satisfaction and empowerment (Arruda, 2005; Ingersal, Olsan, Drew-Cates, DeVinney, & Davies, 2002; Laschinger et al., 2001; Moss & Rowles). Research has linked employee retention to transformational leadership (Acorn et al.; Adams, & Bond, 2000; Albaugh, 2005; Breruggren & Severinsson, 2003; Cimete et al.; Dahlen, 2002; Ellefsen, & Hamilton,

2000; Fletcher, 2001; Keuter et al., 2000; Khowaja et al., 2005; Konczak et al., 2000; Larrabee et al., 2003.; Laschinger et al., 2001; Moss, & Rowles; Parkman, 2001; Strachota et al., 2003; Upenieks, 2003).

Research has shown that transformational leadership works better than other alternatives and certain leadership traits are part of the model for nurse retention (Breggren & Severinsson, 2003; Dahlen, 2002; Effken & Stetler, 1997; Fletcher, 2001; Laschinger, & Sabiston, 2000; Tang, 2003). These traits include, but are not limited to, intellectual stimulation, charisma, trustworthiness, autonomy, in order to enhance retention and employee satisfaction (Kalliath & Morris, 2002; Mrayyan, 2004). These leadership traits have proven to result in work satisfaction, organizational commitment and empowerment (Laschinger, Almost, & Tuer-Hodes, 2003; Sengin, 2003).

Conceptual Framework

The theoretical framework that guided this study was Burns's transformational leadership theory, developed in 1978, as later modified by Bass (1997). For the purposes of this study, leadership styles were conceptualized as relating to job satisfaction, organizational commitment and employee empowerment. The demographic variables measured participant age, gender, educational background, years in the field, years at current employment, salary range, and current title.

These concepts were studied in order to examine possible relationships between the results of the Multifactor Leadership Questionnaire, the Mohrman-Cooke-Mohrman Job Satisfaction Scale, the Organizational Commitment Questionnaire and the Reciprocal Empowerment Scale. The conceptual framework for the study is shown in Appendix A.

Research Questions

The research questions guiding this study are:

1. Is there a relationship between the hospital's clinical leader leadership style (either transactional (TA), transformational (TF) or laissez-faire to subordinate hospital nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment in a hospital setting?
2. Is there a relationship between leadership styles and job satisfaction, organizational commitment (job-longevity), perceived empowerment, in a hospital setting and the selected demographic variables? (Demographic variables included will measure participant age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title)__

Hypotheses Statements

The hypotheses that guided this study were:

Null Hypothesis. There is no difference between clinical leaders Transactional (TA), and Laissez Faire leadership styles and subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment

Hypothesis 1. Transactional (TA) and laissez-faire leadership styles of hospital clinical leaders will have lower positive correlations to subordinate nurse in a management position job satisfaction, organizational commitment, and perceived empowerment than Transformational leadership styles.

Null Hypothesis. There is no difference between Transactional (TA) leadership styles and Transformational leadership styles of hospital management clinical leaders as

they correlate to subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment.

Hypothesis 2. Transformational (TA) leadership styles of hospital management clinical leaders will have higher positive correlations to subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment, than Transactional leadership styles.

Study Variables

The independent variables in the study included the perceived transformational, transactional, and laissez faire leadership behaviors of hospital clinical leaders in hospital settings, and the dependent variables of subordinate nurse (in a management position) job satisfaction (intrinsic, extrinsic), organizational commitment, and empowerment (reciprocity, synergy, and ownership). A demographic questionnaire was administered to address participant age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title.

Definition of Terms

Empowerment. Thomas and Velthouse (1990) define empowerment as personal power that flows from professional growth, which is correlated with job satisfaction. Klakovich (1995) states that the “empowerment of nursing staff may be the critical variable in achieving positive organizational outcomes while maintaining the caring values of the nursing profession” (p. 127). Klakovich (1996) defines three dimensions of empowerment as reciprocity, synergy, and ownership.

Empowerment is a reciprocal leader-follower relationship that advances and aligns strategies, both organizational and individual (Klakovich, 1995). The Reciprocal Empowerment Scale tool reports in three subscales: reciprocity and synergy sub-scales represent the interactive leader/follower process; the ownership subscale represents the outcomes (Klakovich). Reciprocity involves a leadership behavior pattern of sharing power, support and information.

Hospital Clinical Leader. For the purposes of this research project, a hospital clinical leader serves as a member of the hospital clinical leadership team. This position has overall accountability for all staff in the nursing services and is an active participant in developing organization-wide goals and strategies. In a hospital setting, this position often requires a leader, who is committed to creating a supportive and accountable environment that encourages the nursing managing staff by providing a venue for learning and professional development. This position has the role of authority figure with clinical and administrative decision making powers. For this study, the hospital clinical leader will be a direct supervisor of one or more nurse managers

Job Satisfaction. Most researchers describe job satisfaction as the level or degree an employee likes his or her job (Mohrman, Cohen, & Mohrman, 1995; Rakich, Longest, & Darr, 1985; Schmerrmerhorn, 1984). However, some researchers have based job satisfaction on a theoretical framework as it relates to motivation and how the workplace environment provides for the individual by nurturing a sense of satisfaction (Mohrman, et al., 1995; Rakich, et al.; Schmerrmerhorn). Job satisfaction is therefore defined as the degree to which an employee has a positive affective orientation toward their employment by their organization (Rakich, et al.; Schmerrmerhorn).

Leadership. Rost (1993) defines leadership as “an influence relationship among leaders and followers who intend real changes that reflect their mutual purposes” (p. 102). Baker (1992) defines leadership as the ability to influence and shape values, beliefs, attitudes, and behaviors that increase employee commitment to the mission of the organization. Hersey and Blanchard (1984) were the first to distinguish between management and leadership, attributing a broader realm to leadership and attaching the act of influencing the behaviors of one’s followers or subordinates.

Non-transactional Leadership (Laissez-faire). Minimal leadership functions that give no direction and do not praise or punish followers.

Nurse in a Management Position. For the purposes of this research project, a nurse in a management is given the job duties of planning, organizing, directing and supervising a group of staff nurses. The title can range from CNE, VP, CNO, Manager, or Director. The title varies from one hospital setting to the next. In a hospital setting, a group of staff nurses are assigned to a specific patient care unit. The majority of nurses in management positions have the direct responsibility of maintaining an effective group unit of nurses.

Organizational Commitment. Organizational commitment is the extent to which a nurse psychologically identifies with their organization’s values and consequently exerts energy to achieve these values. Low OC reflects dissatisfaction, lower motivation, and higher turnover and burnout, whereas high OC leads is correlated with greater satisfaction, longer job tenure and greater work output (Cohen, 1996; Mowday, 1998; Mowday, Steers, & Porter, 1979).

Transformational Leadership. Burns defines this as “leaders and followers raise one another to higher levels of motivation and morality” (Burns, 1978, p. 20).

Transformational leadership includes the following dimensions:

1. **Attributed Charisma.** The leader possesses tremendous energy, a high level of self-confidence, assertiveness, a strong conviction in their ideals and belief system, a strong need for power, and the ability to make their followers feel more confident (Bass, 1997; Bass & Avolio, 1994)
2. **Idealized Influence (behavior).** The leader displays a strong conviction, promotes trust, takes a stand on hard issues, displays solid values, and exhibits the importance of purpose, commitment, and ethical consequences of decisions and is often considered a role model in the organization (Bass, 1997; Bass & Avolio, 1994).
3. **Inspirational Motivation.** The leader articulates him or herself as a visionary, which encourages followers to meet any new challenges with a positive attitude, and talks with optimism, enthusiasm, and encouragement (Bass, 1997; Bass & Avolio, 1994).
4. **Individual Consideration.** The leader recognizes followers as individuals who have their own set of needs, abilities, and goals; listens attentively and furthers any followers’ development; advises, teaches, and takes great care to treat everyone equally (Bass, 1997; Bass & Avolio, 1994).
5. **Intellectual Stimulation.** The leader creates a work environment that encourages followers to review their attitudes and values by maintaining creativity and innovation through reframing problems and changing

assumptions (Bass, 1997; Bass & Avolio, 1994)

Transactional Leadership. The leadership process that takes place when one “pursues a cost-benefit, economic exchange to meet subordinates’ current material and other needs in return for contracted services” (Bass, 1997, p.14). Grounded in exchange theory, this leadership style is where leaders and followers agree on goals and the path to achieving these goals; resulting in the exchange of rewards and punishments to obtain compliance (Bass).

Transactional leadership includes the following dimensions:

1. Contingent Reward. The leader influences follower motivation and performance through positive and negative feedback (Bass, 1997).
2. Management-by-Exception (active). The leader is constantly reviewing and monitoring followers’ job performance reviews, looking for problems and taking immediate corrective action (Bass, 1997).
3. Management-by-Exception (passive). The leader takes corrective action to poor job performance only if said performance is sub-par and mistakes are brought to the leader’s attention (Bass, 1997).

Assumptions & Limitations

The following assumptions and limitations are recognized as part of this study:

1. Only subordinate nurses (in management positions), in hospital settings have been surveyed in this study; therefore, results may only be applied to this group and not generalized for other groups in other healthcare settings. Surveys like the

- instruments being used in this study are highly fallible because the researcher may or may not be able to analyze the direction of causal relationships (Leedy & Ormond, 2004).
2. Job satisfaction was measured by the Mohrman-Cooke-Mohrman Job Satisfaction (Mohrman, Cooke, & Mohrman, 1978) survey. Eight questions on the questionnaire were developed to be used in various occupations, and the instrument was not specifically designed for nurses in management positions. The results are self-reported, and therefore, may not correspond to what the participants actually experience. Response bias may also be an issue.
 3. Empowerment was measured by the Reciprocal Empowerment Scale (Klakovich, 1995). Responding nurses in management positions may be more or less satisfied with their job regardless of the leadership style of their immediate supervisor. This is a commonly used survey and is often used in a cross-sectional design, which asks questions of its participants at one point in time. Such surveys are highly fallible because the researcher may or may not be able to analyze the direction of causal relationship (Leedy & Ormond, 2004).
 4. Organizational commitment was measured using the Organizational Commitment Questionnaire, developed by Mowday, Steers, Porter (1979). Responding nurses in management positions may be more or less committed to their organization regardless of the leadership style of their immediate supervisor. This survey can be used in a cross-sectional design, which asks questions of its participants at one point in time. Such surveys are highly fallible because the researcher may or may not be able to analyze the direction of causal

relationship (Leedy & Ormond, 2004).

Nature of the Study

This study employed a quantitative methodology utilizing a cross-sectional survey design. The sample consisted of 6,200 participants. A cross-sectional survey collects data from the participants at one single point in time (Leedy & Ormond, 2004). The Multifactor Leadership Questionnaire measured the leadership styles of the hospital clinical leaders as observed (perceived) by the nurses in management positions (self-reported).

The Mohrman-Cooke-Mohrman Job Satisfaction Scale measured the level of job satisfaction of the nurses in management positions (self-reported). The Reciprocal Empowerment Scale measured the empowerment level of the nurses in management positions (self-reported). Organizational Commitment Questionnaire measured organizational commitment level of the nurses in management positions (self-reported). Statistical analysis was performed to determine the causal relationship of the variables.

Organization of the Remainder of the Study

The remaining sections of this research study have been divided into four additional chapters. Chapter 2 addresses a review of the literature, which includes prior research on leadership style, empowerment, organizational commitment, and job satisfaction. Chapter 3 addresses the methodology and assessment tools used within this study.

Chapter 4 analyzed the data collected from the participating nurse managers. Within this chapter, the results of the MLQ, MCMJS, OCQ, and RES have been discussed. Also, chapter 4 has provided an analysis of the leadership styles of hospital clinical leaders and subordinate nurses in management positions job satisfaction, empowerment, and organizational commitment. Furthermore the study's hypotheses have been tested and the results illustrated.

Chapter 5 has summarized the findings of this dissertation. This chapter has reintroduced the study's purpose and illustrated any correlating findings. Finally, recommendations for future research have been offered.

CHAPTER 2. LITERATURE REVIEW

Leadership Theories

Many definitions of leadership are found in the literature (Antonakis, Cianciolo & Sternberg, 2004; Bass, 1990; Bennis & Nanus, 1997; Dubring, 2001; Kouzes & Posner, 2002;2003; Northouse, 2004). There is much overlap among these models where themes and percepts often reappear in slightly different forms (Antonakis, et al; Bass; Bennis & Nanus; Darcy & Kleiner, 1991; Northouse). A core principle found in leadership is the relationship between those who have the aspirations to lead and those who chose to follow (Antonakis, et al; Bass; Kouzes & Posner, 2002; 2003; Northouse).

The literature stresses the value of a leader's clear organizational vision, which inspires and guides employees to achieve organizational goals (Antonakis et al.; Kouzes & Posner, 2003a; Northouse, 2004; Rosen, 1996). Leadership is the relationship between those who have the aspirations to lead and those who chose to follow (Bass, 1997; Bruns & Shuman, 1988; Buchana, 1974; Goldsmith et al.; Kouzes & Posner; Northouse). Bennis and Nanus (1997) described leadership competence as the ability of a leader to engage people in their own organizational vision.

The literature offers numerous writings on the complex topic of leadership, (Adams, 1965; Antonakis et al., 2004; Bass, 1997; Bass & Avolio, 1990; Burns, 1978; Goldsmith et al.; Herzberg, 1982; Northouse, 2004; Townsend & Gebhardt, 1997). A mainstay of the leadership literature is the bureaucratic-managerial model (Fletcher & Taplin, 2002; Kotter, 1990; Kouzes & Posner, 2003). The visual imagery and agenda of bureaucratic leadership lends to be categorized as hierarchical, goal-centered, and

management-oriented (Fletcher & Taplin; Kouzes & Posner; Nicholls, 1993; Northouse, 2004; Townsend & Gebhardt).

The widely discussed bureaucratic-managerial model (Kouzes & Posner, 2003; Northouse, 2004; Townsend & Gebhardt, 1997) focuses on the leader's role in assuring higher productivity, greater efficiency and improved profits. This model tends to promote task oriented transactional leaders who largely rely upon win/lose rewards (Kouzes & Posner; Northouse; Townsend & Gebhardt). Nevertheless, bureaucratic organizations also realize that their leaders must also empower followers to promote job satisfaction in order to continuously improve organizational effectiveness (Bennis & Nanus, 1997; Kouzes & Posner; Rosen, 1996; Northouse; Townsend & Gebhardt).

The team-centered pluralistic leadership model provides a multi-cultural perspective in addressing organizational issues (Bruch, Jehangir, Lundell, Higbee, & Miksch, 2005; Kezar, 2001; Northouse, 2004). Kezar (2000, 2001) found this model to be effective in collecting diverse opinions of an organization, when one particular issue needs to be solved. Yet, researchers found utilizing this model to be time consuming and not effective in day-to-day operations (Bruch et al., 2005; Kezar, 2001; Northouse, 2004).

The leadership process requires a leader to apply the necessary knowledge to the vision (Bennis & Nanus, 1997; Kouzes & Posner, 2003; Northouse, 2004). From an analytical perspective, Kouzes and Posner (2003) have broken down strong leadership into five necessary practices: a) challenge the process, b) inspire a shared vision, c) enable others to act, d) model the way, and e) encourage the heart. According to Kouzes and Posner, credibility is a basic and most necessary element in the realization of exemplary leadership. They state:

“Honesty is absolutely essential to leadership. If people are going to follow someone willingly, whether it be into battle or into the boardroom, they first want to assure themselves that the person is worthy of their trust. They want to know that the would-be leader is truthful and ethical. No matter where we have conducted our studies – regardless of country, geographical region, or type of organization – the most important leadership attribute since we began our research in 1981 has always been honesty” (Kouzes & Posner, 2003, p. 226).

The review of literature raises some questions if new leadership practices are to be implemented in order to improve work collaboration in any organization (Antonakis et al., 2004; Avolio & Bass, 1995; Bennis & Nanus, 1997; Goldsmith et al., 2003; Northouse, 2004; Popper, 2004; Townsend & Gebhardt, 1997). These issues include (but are not limited to) the need to examine leadership arena as a place of interaction that occurs when leaders and employees come together to cooperate and work; the need to get beyond the ideas dominance and subordination to the idea of working in a cooperative relationship (Antonakis et al.; Baker, 1992; Goldsmith, et al., 2003; Kouzes & Posner; Northouse; Townsend & Gebhardt).

Transformational Leadership & Transactional Leadership

Transformational leadership can play an important role in promoting an organization’s mission (Bass & Avolio, 1990; Bryant, 2003; Bycio, Hackett, & Allen, 1995; Dvir, et al., 2002; Luthans & Avolio, 2003). A leader must have the ability to grow an organization to the next level through proven leadership styles and techniques (Bass & Avolio; Dvir, et al.; Luthans & Avolio). When a leader has a clear and defined vision, it improves the working lives of both leader and follower (Bolman & Deal, 2003; Dvir, et al.; Luthans & Avolio).

Transformational leadership instills a higher level of commitment in employees; reduces employee stress and increases morale (Bolman & Deal, 2003; Dvir, et al., 2002; Luthans & Avolio, 2003; Masi, 2000). These results lead to increased overall organizational performance and enhanced employee job satisfaction (Bass & Avolio, 1990; Dvir, et al.; Luthans & Avolio). The leader can “transform” employees beyond the feelings of jealousy and greed to higher ethical principles of humanitarianism and justice (Bass & Avolio; Burns, 1978; Dvir, et al.; Luthans & Avolio).

Transformational leaders are often found within any type of organizational structure and at various levels (Bass & Avolio, 1990; Bolman & Deal, 2003; Dvir, et al., 2002; Jick & Peiperl, 2003; Luthans & Avolio, 2003). Transformational leaders influence their followers by setting a solid example of an empowering mentor (Bass, 1990; Bolman & Deal; Dvir, et al.; Luthans & Avolio; Reinhardt, 2004). They can elevate and empower their employees to a higher level of job participation (Bolman & Deal; Luthans & Avolio; Masi, 2000; Meyer & Herscovitch, 2001).

Transformational leadership has been related to the long-standing literature on solid values, moral character and making ethical social choices (Bass, 1990; Bolman & Deal, 2003; Lowe, Kroeck, & Sivasubramaniam, 1996; Luthans & Avolio, 2003). A transformational leader possesses motivational charisma, provide intellectual stimulation and serve as a role model (Bass; Bolman & Deal; Luthans & Avolio). The transformational leader appeals to followers’ higher ideals and morals, which are based upon humanitarianism and equality (Burns, 1978; Bolman & Deal; Luthans & Avolio).

Bass (1990) developed his own transformational leadership concepts. He defined this leadership in supervisory terms of how a leader’s motivational style has an effect on

followers (Bass). Transformational leaders inspire to achieve higher-order organizational needs (Bass; Bolman & Deal, 2003; Luthans & Avolio, 2003).

Transactional leadership involves an exchange or transaction between a leader and a follower (Bass, 1997; Bolman & Deal, 2003; Luthans & Avolio, 2003). Burns (1978) describes transactional style as the way a leader speaks and directs their follower. Burns recognized transactional leadership style focuses on motivating subordinates by offering rewards for services rendered.

Bass (1997) considered transactional leadership being vital in identifying roles, expectations, performance parameters, and managing people in order to obtain the necessary results (Kouzes & Posner, 2003; Luthans & Avolio, 2003). Bass asserts this type of leadership includes behaviors such as reviewing performance and providing contingent rewards based on job completion (Kouzes & Posner; Luthans & Avolio). By using the path-goal concept as a framework, a leader relies on contingent rewards and on management by exception (active or passive) (Bass; Kouzes & Posner; Luthans & Avolio).

Leadership in a Hospital Setting

Effective leadership is necessary in a complex organizational matrix such as a hospital setting (Aiken, Clarke, Sloane, & Sochalski, 2001; Gifford, Zammuto, Goodman, & Hill, 2002; Griffith & White, 2002; Mrayyan, 2004; Thyer, 2003). It is an ever present challenge for hospital leadership to be effective and efficient in daily managerial process (Griffith & White; Mrayyan). Warden (1999) found there to be many leadership issues facing hospital leaders and many underlying concerns as to how leaders come to solving difficult issues (Popper, 2004; Thyer, 2003).

A hospital clinical leader's role can range from CEO to hospital administrator. Employers look to recruit hospital clinical leaders who understand the overall structure of a hospital network and who can bring a well rounded understanding of nursing leadership (Cowin, 2002; Thyer, 2003). Often awkward times, negotiation and conflict management skills are definitive characteristics of successful hospital leaders (Cowin, 2002; Keuter, Byrne, Voell, & Larson, 2000; Reichers, 1986).

It is the responsibility of hospital leaders to ensure competency of many departments and working collaboratively with other leaders in evaluating performance (Larrabee, Janney, & Ostrow, 2003; Sengin, 2003). With constant organizational changes, hospital leaders are challenged in managing the people side of their job duties (Bryant, 2003; Leatt et al., 1997; Prothero et al., 2000; Mrayyan, 2004). Hospital leaders must know how to motivate their staff; employ performance management systems; and solve poor employee performance problems (Bryant; Leatt, et al.; Prothero, et al.).

All the while, attention to staff workflow is necessary so that quality patient care is continuously met. Hospital clinical leaders must understand and counteract any influencing factors that may offset any efficient decision-making, lower staff morale and negate patient safety (Al-Ma'aitah, et al., 1999; Upenieks, 2003; Larrabee, et al., 2003; Neuhauser, 1983; Schein, 2004). They must deal with their subordinate managers' perceptions of their work environment (job satisfaction and burnout); while, improving and promoting autonomy (Beckham, 2002; Leatt, Baker, Halverson, & Aird, 1997; Popper, 2004; Prybil, 2003). The effectiveness of hospital clinical leadership is reliant upon many competencies for managing various staff within the healthcare organizational structure (Beehr & Gupta, 1987; Kushner, 1995; Mrayyan, 2004; Larrabee et al., 2003;

Prybil, 2003). These competencies are leadership style practices, human resource management techniques, and knowledge of the healthcare system and its processes (Larrabee et al., 2003; Luthans & Avolio, 2003; Manion, 2004; Tansky & Cohen, 2002; Wallick, 2002). The role of hospital clinical leader has clearly moved from a supervisory role to that of a business leader (Arruda, 2005; Fletcher & Taplin, 2002; Wallick; Prybil).

While schools teach the necessary skills to be a leader, they do not necessarily prepare their students to later become effective leaders in the healthcare arena (Al-Ma'aitah et al., 1999; Arruda, 2005; Upenieks, 2003). Rossiter, Green, and Kralewski (2000) have found that hospital clinical leaders can easily improve core managerial skills (Manion, 2004). These skills include; human resource management skills, personal time management competencies, quality improvement goals, applying management processes, critical analysis thinking and decision making, understanding healthcare organizational design, and applying transformational leadership competencies (Lucas, 1991; Rossiter, et al.; Manion; Stace & Dunphy, 1994).

In order to become effective leaders, hospital clinical leaders must have working knowledge in leadership development skill sets (Barrett & Myrick, 1998; Kane-Urrabazo, 2006; Thyer, 2003). As part of a comprehensive survey of nurses, Aiken, et al. (2001) found that less than half of the respondents considered their immediate leaders being responsive to their work concerns. This survey covered issues as, nurses' perceptions of their work environment, job satisfaction and burnout (Aiken, et al.)

Bratt et al. (2000) performed a cross-sectional survey of 1,973 staff nurses working in a pediatric critical care in 65 health facilities. The results revealed that job stress and nursing leadership were the most influential variables (Bratt et al.) The

researchers recommended that more research would be necessary to determine what managerial training programs would be necessary to support and empower the nursing staff (Bratt et al.)

Ribelin (2003) performed a convenience sample survey of 2,029 staff nurses, with a 70% return rate. The resulted findings demonstrated that leadership styles had a direct effect on job satisfaction and nurse retention (Ribelin). The participants preferred leaders who were involved, communicative, and gave recognition (Ribelin).

Nursing and Transformational Leadership

The theme of transformational leadership in the nursing research literature is often found. (Dahlen, 2002; Grossman & Valiga, 2000; Kane-Urrabazo, 2006; Manion, 2004; Parkman, 2001, Reinhardt, 2004; Sullivan, & Deckers, 2001; Thyer, 2003; Wilmore & Thomas, 2001). Medley & LaRochelle (1995) described transformational nursing leaders as inspiring nurses with a clear organizational vision in order to achieve excellence in patient care. Reinhardt (2004) furthers Medley & LaRochelle's definition by including staff involvement through mentoring and other innovative techniques.

Sofarell & Brown (1998) find that transformational leadership easily relates to situations that nurses commonly encounter. It is thought that this style is empowering and readily promotes change in a healthcare system (Sofarell & Brown; Kuokkanen & Leino-Kilpi, 2000; Laschinger, Almost, & Tuer-Hodes, 2003; Laschinger, & Finegan, 2005). Sofarell & Brown and other researchers found that this focus on change can be directly applied to nursing leadership (Kuokkanen & Leino-Kilpi, 2000; Laschinger, et al., 2003; Laschinger, & Finegan, 2005).

When reviewing old and new procedures and policies, hospital clinical leaders can use transformational leadership in their motivational tactics, by encouraging feedback on implementation procedures (Sofarell & Brown, 1998; Kuokkanen et al., 2003; Laschinger, et al., 2003). Masi (2000) believed that the key to transformational leadership is active listening through constant feedback (Bryant, 2003). This enhances avenues for meaningful nurse interaction and participation in formulating policies that remove barriers to success (Masi; Medley & LaRochelle, 1995; Kuokkanen, et al., 2003; Laschinger, et al.; Laschinger, & Finegan).

Transformational leadership is a process in which “leaders and followers raise one another to higher levels of motivation and morality” (Burns, 1978, p. 20). Grossman & Valiga (2000) found that this motivation gave individuals the ability to excel at their position, by giving them a sense of ownership and pride, while working towards a common goal (Jick & Peiperl, 2003; Kane-Urrabazo, 2006). By motivating through transformational leadership, employees become inspired and are willing to achieve organizational objectives and goals (Fletcher & Taplin, 2002; Grossman & Valiga; Schein, 2004).

As a leader develops, Bass (1997) discovered that he or she is aware of those around them (Luthans & Avolio, 2003; Northouse, 2004). They recognize the interests of others and organizes their professional world on what obligations must be met (Bass & Avolio, 1995; Beckham, 2002; Luthans & Avolio; Northouse). A good leader knows how to interact and communicate with followers by exchanging pertinent information and input; delegating authority appropriately; know how rise to the occasion when crises

occur; and meeting necessary work expectations (Bass, 1997; Bass & Avolio; Beckham; Kouzes & Posner, 2003; Luthans & Avolio; Northouse).

Bass & Avolio (1995) found that the outcome of transformational leadership will enhance productivity while encouraging job satisfaction. They believe that the innovative and proactive thinking, that transformational leadership provides, shapes the goals and values of its followers (Bass & Avolio; Bryant, 2003; Dvir, et al., 2002; Kouzes & Posner, 2003). This type of innovative leadership style has been observed as providing greater job satisfaction, improving team morale, and providing an atmosphere of empowerment (Bryant; Kouzes & Posner; Reinhardt, 2004; Whetstone, 2003).

Job Satisfaction

There are numerous theories on job satisfaction (Adams, 1965; Gibson et al., 2003; Herzberg, 1969; Herzberg, Mausner, & Snyderman, 1959; Lawler, 1994; Maslow, 1954; Vroom, 1964; Wright & Terrain, 1987). Maslow (1954) hierarchy of needs offers a progression including physiological, security, social, self-esteem, and self-actualization. Vroom's (1964) argument was the perception of a link between effort and reward being crucial to being motivated at work.

Adams (1965) believed that one important cognitive process involved people observing what efforts others were putting forth into their work and what rewards came from those efforts. Equity theory is a motivation theory that offers an explanation about the causes of job satisfaction and dissatisfaction (Lawler, 1994). The equity of a person's rewards determines his or her job satisfaction (Lawler, 1994).

As created by Herzberg, Mausner, Peterson and Capwell (1957), the two-factor theory posits that job factors either contribute to job satisfaction or job dissatisfaction (Lawler, 1994). These two variables are found not to be merely the opposite sides of the same coin, but two differing continuums that run from satisfaction to dissatisfaction (Lawler). The job satisfaction continuum ranges from dissatisfied to neutral and that a person could simultaneously be satisfied and dissatisfied (Lawler).

Motivators or intrinsic conditions include achievement, recognition, responsibility and promotion (Herzberg, 1969). If the intrinsic motivators are absent and do not cause dissatisfaction, a result of neutrality on the continuum of satisfaction will occur (Herzberg). Rather extrinsic factors that encourage dissatisfaction are administrative policies, salary grades, organizational structure, and work environment (Herzberg, Mausner, & Snyderman, 1959; Wright & Terrain, 1987).

Herzberg (1969) asserts that satisfaction and dissatisfaction are independent of each other. Factors involved in producing job satisfaction are separate from factors that produce job dissatisfaction (Herzberg). Work satisfaction and dissatisfaction are not opposite; rather they are separate and distinct (Herzberg).

Wright & Terrian (1987) believe that there are numerous factors that are associated with job satisfaction, such as; (intrinsic) satisfaction with one's work; (extrinsic) organizational climate and structure; co-worker relationships and supervisory roles; and role clarity/ambiguity. Gibson, Ivancevich, Donnelly, & Konopaske(2003) argued when work motivation and job satisfaction are higher, job performance has a strong correlation with job satisfaction. Other research suggests that leader and follower

relationships are clearly perceived as a factor in a subordinate's job satisfaction (Dvir, et al., 2002; Evans, 1999; Fletcher, 2001; Kuokkanen et al., 2003; Thyer, 2003).

Leadership & Job Satisfaction

Leadership and job satisfaction are basic components that influence an organization's overall productivity and effectiveness (Adams & Bond, 2000; Dvir, et al., 2002; Fletcher & Taplin, 2002; Jick & Peiperl, 2003; Luthans & Avolio, 2003; Schein, 2004; Mohrman et al., 1995). The literature explaining the relationship between transformational leadership and follower behavior is quite substantial (Bass & Avolio, 1994; Beckham, 2002; Bryant, 2003; Jick & Peiperl, 2003; Kalliath & Morris, 2002; Kouzes & Posner, 2003b; Medley & LaRochelle, 1995; Thyer, 2003). This ever-growing body of knowledge offers practical examples for leaders to utilize for improving employee satisfaction and curtail employee attrition (Albaugh, 2005; Chinnis, Summers, Doerr, Paulson, & Davis, 2001; Clancy, 2003; Garrett, 1991; Kalliath & Morris, 2002; Laschinger et al., 2001; Mahoney, 2000).

The literature on employers helping employees to achieve job satisfaction (for a person to perform their work duties at the highest level of productivity) is extensive (Albaugh, 2005; Altman, 2002; Chinnis et al., 2001; Houkes, Janssen, Jonge, & Arnold, 2003; Kalliath & Morris, 2002; Kuokkanen, et al., 2003; Laschinger, Almost, & Tuer-Hodes, 2003; Laschinger, Finegan & Shamian, 2001; Mahoney, 2000; Prybil, 2003; Roberts, 2001). Research has defined job satisfaction encompassing various factors; opportunity for advancement, solid leadership, high work standards, and autonomy (Acorn, Ratner, & Crawford, 1997; Adams & Bond, 2000; Chinnis, et al., 2001; Kalliath

& Morris, 2002; Kuokkanen et al., 2003; Laschinger et al., 2003; Laschinger & Finegan, 2005; Mrayyan, 2004; Popper, 2004). If these factors are low and stress is high, so is job satisfaction (Acorn et al., 1997; Adams & Bond, 2000; Chinnis, et al., 2001; Kalliath & Morris, 2002; Kuokkanen, Leino-Kilpi, & Katajisto, 2003; Laschinger et al, 2003; Laschinger & Finegan, 2005; Mrayyan).

The terms associated with organizations improving employee job satisfaction include job enrichment, achievement motive, and organizational workplace enhancements (Acorn et al, 1997; Adams & Bond, 2000; Becker, 1992; Chinnis et al., 2001; Effken & Stetler, 1997; Jenson, White, & Singh, 1990; Kalliath & Morris, 2002; Kuokkanen et al., 2003; Laschinger et al., 2003; Laschinger & Finegan, 2005; Mrayyan, 2004). The literature suggests that employees are highly motivated by positive feedback, work role autonomy, employing various skills, and contributing to organizational success (Albaugh, 2005; Altman, 2002; Dunham, Grube, & Castaneda, 1994; Dvir, et al., 2002; Evans, 1999; Kouzes, & Posner, 2003; Kuokkanen et al., 2003; Laschinger et al., 2003; Laschinger & Finegan, 2005; Mrayyan; Trott & Windsor, 1999). Research has been performed to identify how leadership styles can be utilized to influence employee behavior that will lead to superior organizational outcomes (Adams & Bond; Arruda, 2005; Bennis & Nanus, 1997; Bryant, 2003; Dvir, et al., 2002; Houkes et al., 2003; Jick & Peiperl, 2003; Keuter et al., 2000; Kouzes & Posner, 2003; Masi, 2000; Mohrman et al., 1995; Northouse, 2004; Townsend & Gebhardt, 1997; Wallick, 2002).

Empirical data supports the effectiveness of transformational and transactional leadership styles (Albaugh, 2005; Adams & Bond, 2000; Altman, 2002; Bass & Avolio, 1994; Bennis & Nanus, 1997; Dvir, et al., 2002; Gibson et al., 2003; Houkes et al., 2003;

Jick & Peiperl, 2003; Keuter, et al., 2000; Masi, 2000; Thyer, 2003; Wallick, 2002; Walumbwa, Wang, Lawler, & Shi, 2004). Researchers have found transformational leadership positively correlating to employee job satisfaction (Dumdum, Lowe, & Avolio, 2002; Walumbwa, et al., 2004), organizational commitment (Barling, Weber, & Kelloway, 1996; Gibson, et al., 2003; Lok, Westwood, & Crawford, 2005; Tansky & Cohen, 2002); and motivation and performance (Dvir, et al, 2002; Lowe & Barnes; 2002). Research has found effective transactional leadership to occur when subordinates know and successfully execute their job tasks in order to receive a desirable job reward (Avolio & Bass, 1995; Bass, 1994; Dumdum, et al.,; Walumbwa, et al.).

Empirical evidence has confirmed that transformational leadership is more highly correlated to perceived employee job satisfaction than transactional leadership (Bass & Avolio, 1990; Dvir, et al., 2002; Ribelin, 2003; Wilmore, & Thomas, 2001), specifically with hospital nursing staff (Boyle et al., 1999; Medley & Laroche, 1995; Tzeng & Ketefian, 2002; Upenieks, 2003; Watson, 2002). By measuring nurses' satisfaction with management style, Ribelin (2003) has found there is a need to improve leadership styles. Cline, Reilly, & Moore (2004) concur with Ribelin's findings and that more needs to be done in order to improve nursing job satisfaction.

Nursing Job Satisfaction

Hospital clinical leaders must focus on ways to increase employee job satisfaction and therefore reduce the high costs of recruitment, orientation, and turnover (Chinnis et al., 2001; Cline et al., 2004; Kuokkanen et al., 2003; Prothero et al., 2000; Ribelin, 2003; Thyer, 2003). Job satisfaction is a necessary component for any organization to measure

and take action to improving it (Chinnis, et al.; Ribelin; Cline, et al.; Kotter, 1990; Loke, 2001; Upenieks, 2003; Watson, 2002). A cross-sectional study was performed that found a significant relationship between leadership styles and subordinate satisfaction (Parkman, 2001).

Parkman (2001) found that transformational leadership positively correlated with subordinate satisfaction while transactional and laissez-faire leadership were negatively associated with subordinate satisfaction. Moss and Rowles (1997) examined the relationship between management styles of head nurses and staff nurse satisfaction by performing a non-experimental, descriptive study. This study was performed in three acute care Midwestern hospitals, utilizing Likert's management theory by grouping management styles into four categories.

The study had 250 registered nurses who participated in Moss & Rowles (1997) convenience sample by answering a twenty-six item questionnaire. The researchers' results found that as the head nurse management styles approached the participative style, simultaneously, the job satisfaction scoring increase (highest score M=1.97). In Moss and Rowles' variance analysis, they were able to show slight changes in job satisfaction as it related to head nurse participative management style ($p < .01$).

The researchers emphasized that as staff nursing roles change with managed care trends, that head nurses must be attentive of his/her leadership style and become vigorously involved in participative style management (Moss & Rowles, 1997). Dubrin (2001) found that transformational leaders must learn employee values in order to counter them while setting organizational goals. The key is for clinical leaders to know his/her staff in order to obtain a clear understanding of their values and motives so that attainable

organizational goals can be set and met (Dubrin; Kuokkanen et al., 2003; Shortell & Kaluzny, 2000; Thyer, 2003).

Empowerment

Research has shown correlations between nursing leadership job satisfaction and empowerment (Adams & Bond, 2000; Chinnis et al., 2001; Kuokkanen, et al., 2003; Laschinger et al., 2003; Manojlovich & Laschinger, 2002; Mrayyan, 2004). In recent years, the idea of empowerment has become popular in the nursing literature (Falk-Rafael, 2001; Kluska et al., 2004; Kuokkanen et al., 2000; Laschinger et al., 2003; Laschinger & Finegan, 2005). The review of the literature reveals empowerment being used in various contexts; such as, mental health, chronic care, and health promotion (Dahlgaard & Dahlgaard, 2003; Falk-Rafael; Kluska et al., 2004; Kuokkanen et al.2003; Laschinger et al., 2003; Laschinger & Finegan, 2005; Mrayyan; Paterson, 2001) .

In these contexts, the concept of empowerment incorporates positive and respectful relationships through constant dialog (Ellefsen & Hamilton, 2000; Falk-Rafael, 2001; Kluska et al., 2004; Laschinger, Almost & Tuer-Hodes, 2003; Laschinger & Finegan, 2005; Prybil, 2003). Morrison, Jones, and Fuller (1997) performed a non-experimental, descriptive study that explored the effects of leadership style and empowerment on nursing job satisfaction. The participants included various nursing personnel, such as nurse managers, nursing assistants, nursing clinical leaders, licensed practical nurses and staff nurses.

The researchers examined how staff nurses perceived management styles, what management styles were actually preferred; and if any relationship existed between the perceived management style of the nurse managers and staff nurses' job satisfaction. The

researchers results in their variance analysis indicated a statistically significant difference in empowerment among different job classifications within the organization ($F = 4.31$, $p < .05$). Empowerment accounted for more variance with job satisfaction for licensed personnel than for unlicensed personnel, as well as, for differing by type of satisfaction.

Morrison, Jones, and Fuller (1997) found that only TF leadership styles were positively related to empowerment ($r = .26$, $p < .05$) and empowerment was positively correlated to job satisfaction ($r = .41$, $p < .05$). The researchers' findings indicate the importance of empowerment to staff nurse job satisfaction. They also show the relative contribution of empowerment and leadership to job satisfaction and how they vary by personnel.

This study gives reason for performing this research study that examined the relationship of nurse manager leadership styles on nursing assistant job satisfaction. Nakata and Saylor (1994) examined the relationship between nursing management styles and job satisfaction levels of the nursing staff. The researchers performed a non-experimental, cross-sectional survey design and collected survey data from 239 nurses.

Nakata and Saylor (1994) examined how staff nurses perceived management styles, what management styles were actually preferred, and if any relationship existed between the perceived management style of the nurse managers and staff nurses' job satisfaction. The data results revealed a perceived management style of benevolent authoritative as most represented (mean overall score of 4.34 on a linear scale of 1 to 8). Further, the data revealed participative as most represented as a desired management style by the participants (mean overall score of 6.85 on a linear scale of 1 to 8).

The Pearson product correlation revealed a significant positive result of a relationship between the perceived management style of first-line managers and job satisfaction of hospital staff nurses ($r=.48, p<.0001$) (Nakata and Saylor, 1994). Nakata and Saylor (1994) found that the closer that perceived first-line manager style was to participative leadership style, the higher the level of job satisfaction would be. Further findings were that the staff nurses' responses felt control was high in the hospitals but they wanted control to be more widely shared among the entire nursing staff. Nakata and Saylor (1994) research findings concluded that a more trusting leader would demand less task structure and is often categorized as a highly transformational leader.

Nurses in management positions need a flexible structure that encourages autonomy, instills trust, promotes adherence to professional standards, and encourages participation in problem solving (Falk-Rafael, 2001; Konczak et al., 2000; Laschinger et al., 2003; Laschinger & Finegan, 2005; Mrayyan, 2004; Strachota et al., 2003). The literature suggests establishing a professional practice model for recruiting and retaining staff (Kluska et al., 2004; Kuokkanen & Leino-Kilpi, 2000; Laschinger & Sabiston; Mrayyan, 2004; Strachota et al.; Tang, 2003; Tansky, & Cohen, 2002). Professional practice models address accountability issues by identifying overlapping ranges of practice, which healthcare personnel often experience in their positions (Mrayyan, 2004; Strachota et al.).

The sixteen elements of an ideal professional practice model offer strategies for healthcare professionals to integrate in a healthcare organization. It is vital that hospital leaders address the challenges of creating a quality orientated work environment that fosters excellence (Kluska et al., 2004; Konczak et al., 2000; Mrayyan, 2004). By

implementing a professional model, the nurses in management positions can become empowered from the support of an organization's goals and mission statement (Mrayyan; Strachota et al., 2003).

Schmieding (1993) proposes three empowerment components; context, structure, and process. The contextual form is a shared vision that commits a group to action; while, structural components are needed to augment the empowerment, as obtained through the shared vision (Schmieding). Once empowerment becomes a realization, the group utilizes a reflective process of inquiry for all future actions (Schmieding).

Numerous strategies have been proposed to promote nurse empowerment (Ellefsen & Hamilton, 2000; Falk-Rafael, 2001; Kluska, Laschinger, & Kerr, 2004; Laschinger, Almost & Tuer-Hodes, 2003; Laschinger & Finegan, 2005; Mrayyan, 2004). Leadership styles have been discussed in the literature as a strategy to promote nurse empowerment (Arruda, 2005; Manion, 2004; Morrison, Jones, & Fuller, 1997; Prybil, 2003; Thyer, 2003; Wagner, 2006). This research study will further examine the relationship between leadership style and empowerment.

The numerous benefits of empowering employees has been linked to employee retention (Falk-Rafael, 2001; Kluska, Laschinger, & Kerr, 2004; Konczak, Stelly & Trusty, 2000; Mrayyan, 2004; Strachota, et al., 2003; Tang, 2003; Tansky & Cohen, 2002; Thyer, 2003). These benefits are improved morale and job satisfaction, less turnover, and improved job performance (Ellefsen & Hamilton, 2000; Dahlen, 2002; Falk-Rafael; Kluska, et al.; Mrayyan,; Morrison, Jones, & Fuller, 1997; Tansky & Cohen, 2002; Wagner, 2006). Numerous researchers have positively correlated transformational leadership with job satisfaction and retention (Chinnis, Summers, Doerr, Paulson, &

Davis, 2001; Kluska, et al., 2004; Prothero, Marshall, Fosbinder, & Hendrix, 2000; Mrayyan, 2005; Schein, 2004; Tansky & Cohen, 2002; Tzeng & Ketefian, 2002; Wagner).

Retention

In a hospital setting, low job satisfaction amongst nurses has been identified as one of the key reasons for high turnover (Dahlen, 2002; Tzeng & Ketefian, 2002). In support of transformational leadership in a hospital setting, Apker, Ford & Fox (2003) found that nurses often leave the profession entirely, due to lack of professional autonomy. Mrayyan (2005) used a descriptive design study using surveys of a convenience sample of 438 nurses and concluded nurse job satisfaction and retention are related concepts.

Boyle et al. (1999) found that the support of nurses' autonomy was necessary for job satisfaction and retention to occur. Reilly (2003) revealed that the main reason for high turnover is due to poor leader/subordinate relationships; where the subordinate feels not valued. Kalliath & Morris (2002) found that nurses who are satisfied in their jobs are likely to retain these jobs.

Numerous management professionals believe that the first step to turnover reduction plan is to increase job satisfaction (Wagner, 2006; Wallick, 2002). It has been chronicled that an increased level of worker job satisfaction negatively correlates to an employee's intention to leave their position (Altman, 2002; Laschinger & Finegan, 2005). Job satisfaction is tied to lower turnover, improved staff productivity, and increased patient satisfaction (Chinnis, Summers, Doerr, Paulson, & Davis, 2001; Dvir, Eden, Avolio, & Shamir, 2002; Wallick).

McNeese-Smith (2001) examined staff nurses views on productivity and non-productivity and what factors increased or decreased productivity and non-productivity. The researchers found two categories; quantity and quality of nurses' work. The quantity of work was key for nurses to feel productive, by finishing their tasks or doing extra work or staying late (McNeese-Smith, 2001).

The quality of work was measured by the reasons why a person chooses to be a nurse, by the outcomes of caring for their patients (McNeese-Smith, 2001). The more rewarding a nurse felt about their job; the higher level of productivity of work occurred. As to non-productivity, organizational and personal factors were key findings (McNeese-Smith, 2001). Most respondents believed the lack of organization (lack of teamwork, being overwhelmed) contributed greatly to feeling nonproductive (McNeese-Smith, 2001).

Loke (2001) found a significant correlation between leadership behaviors and employee outcomes. The regression results indicated that 29% of job satisfaction, 22% of organizational commitment and 9% of productivity were explained by the leadership behavior (Loke, 2001). Ingersall, et al., (2002), performed research to determine the nurses' level of job satisfaction and commitment to the work setting. Their investigation suggests the organizational environment, educational preparation and personal characteristics of the nursing sample group affect their current job satisfaction, organizational commitment and plans for staying on the job (Ingersall, Olsan, Drew-Cates, DeVinney, & Davies, 2002).

Fletcher (2001) investigated job satisfaction, dissatisfaction, patient satisfaction and safety, immediate supervisor role, extrinsic work values, and intent to stay in nursing.

Extrinsic work values such as, job security, salary, fringe benefits, and work schedules, were considered to be important in job satisfaction (Fletcher, 2001). Further results found restrictions in scheduling and limited availability of time off promoted frustration and dissatisfaction among the nurses (Fletcher, 2001).

In order to improve retention issues, Gifford et al. (2002) believed it is possible by improving managerial leadership, organizational culture, and the quality of work life. To help with retention problems, Tang (2003) suggested enhancing nurses' autonomy by providing a provision of support and assistance towards professional, educational, and career goals. By examining leadership and employee collaboration, Dahlgaard and Dahlgaard (2003) found a close relationship between employee job satisfaction, retention and organizational commitment.

Organizational Commitment

Much evidence suggest that job satisfaction influences organizational commitment when, for example, an employee possesses a high degree of autonomy, challenges and skill sets (Kuokkanen et al., 2003; Meyer & Herscovitch, 2001; Mowday, 1998; Tang, 2003). Becker (1992) examined employee's commitment to organizations or to their supervisor's were predictors of job satisfaction and intention to quit. He found that employees' commitment to supervisors was a higher predictor than commitment to an organization (Becker, 1992).

The literature reveals organizational commitment being an energy that binds an employee to his/her organization (Kuokkanen et al., 2003; Laschinger & Finegan, 2005; Lok, Westwood, & Crawford, 2005; Meyer & Herscovitch, 2001; Tang, 2003; Tansky &

Cohen, 2002). Employees are considered to be committed to their organizations if they show willingness to continue to be associated with their organization and make great efforts in achieving organizational objectives (Laschinger & Finegan, 2005; Lok, Westwood, & Crawford, 2005; Mowday, 1998; Tansky & Cohen). Meyer and Herscovitch (2001) found that employee commitment may be focused on numerous targets at various levels of an organization.

They give the example of an employee being committed to the whole organization, a work team, and/or a specific leader/supervisor (Meyer and Herscovitch, 2001). Buchanan (1974) defined organizational commitment as “a partisan, affective attachment to the goals and values of the organization, to one’s role in relation to the goals and values, and to the organization for its own sake, apart from its purely instrumental worth” (p.533). Porter, Steers, Mowday, and Boulian (1974) took Buchanan’s definition of organizational commitment one step further as “the strength of an individual’s identification with and involved in a particular organization” (p.533).

Rousseau (1998) gave organizations a vehicle to encourage employee commitment; by improving employee organizational perception thereby demonstrating their care and value of the employees. Tansky and Cohen (2002) found that encouraging employee development was positively correlated with organizational commitment. Bycio, et al., (1995) found positive correlations between leadership styles of charisma, individualized consideration, and contingent award; and organizational commitment.

Reichers (1986) reported a correlation between clinical level management goals and employee commitment. Lok, et al., (2005) took this correlation one step further by examining the roles of subculture and leadership on organizational commitment and

reported that these roles employee organizational commitment. After surveying 258 nurses from hospitals in Sydney, Australia, Lok, et al., revealed in their findings that supportive subcultures produced higher organizational commitment than bureaucratic work cultures (Lok, Westwood, & Crawford, 2005).

In a study with 239 participant nurses, Cohen (1996) found that employees who stayed in their jobs were more likely to exhibit higher levels of commitment to their work, position and career. Irving, Coleman, & Cooper (1997) examined the relationship between commitment and outcome measure of job satisfaction and retention. Their findings revealed that job satisfaction was positively related to commitment, while negatively related to intentions to leave.

Summary

The literature review has examined various leadership theories and how they correlate to nursing job satisfaction, empowerment, and organizational commitment. Further discussions include the impact of healthcare leadership, incorporating transformational leadership, and the need to improve job satisfaction, empowerment, and organizational commitment. The rationale for this research topic includes adding to today's body of research on the correlation between hospital clinical leadership styles (as perceived by nurses in management positions) and the job satisfaction, empowerment, and organizational commitment issues of nurses in management positions.

CHAPTER 3. METHODOLOGY

Methodology and Design

The research study was a quantitative, non-experimental, descriptive cross sectional research study design utilizing archival data. It was the most appropriate design to use for this study in order to determine if there is a relationship between the subordinate nurses' (in management positions) job satisfaction, perceived self-empowerment, organizational commitment, and their immediate supervisor's (a clinical leader) transformational, transactional, or laissez faire leadership styles. Also, this study has determined the differences in independent variables, based on the clinical leaders' transformational, transactional, or laissez faire leadership styles.

Leedy and Ormrod (2004) described the quantitative process as assigning consequential numerical values to qualitative data, by qualitatively analyzing and assigning significance to quantitative data. They described non-experimental design as an investigation of current status or relationships; which includes defining characteristics that are descriptive in nature. According to Leedy and Ormrod (2004) non-experimental studies do not use control groups, which are not needed for this research study.

In quantitative research, Sproull (2003) found quantitative research designs are either descriptive (subjects usually measured once) or experimental (subjects measured before and after a treatment). Leedy and Ormrod (2004) and Creswell (2003) revealed a descriptive study establishes only associations between variables, while an experiment establishes causality. In a descriptive study, Cooper & Schindler (2003) emphasized no attempt is made to change behavior or conditions; that a researcher measures the variables simply as found.

In an experimental study, Sproull (2003) emphasized taking measurements, possible intervening, than re-measure for possible new results. For the purpose of this study an experimental study was not used, but rather a form of descriptive study; cross-sectional design. In cross-sectional studies, Sproull and Neuman (2003) discussed that once finding variables of interest in a sample of subjects are examined, the researcher determines any the relationships at that moment of time.

In experimental designs, Creswell (2003) and Sproull (2003) emphasized that failure to randomize subjects to control and treatment groups will most likely produce bias. Creswell believed that the assessment of the relationship may be less likely biased if the study has a high participation rate (in a randomly selected sample). A type of non-experimental design is correlation (Creswell), which will establish the non-causal relationships between or among variables.

Sproull (2003) discussed some issues with correlation designs, such as the inability to manipulate an independent variable or control for extraneous variables. Also, a researcher cannot offer that a causal relationship exists because the observed relationship could have been the direct result of extraneous variables that were completely beyond the researcher's control (Neuman, 2003; Sproull). An experimental design was not chosen for this research study, because it is characterized by the random assignment of participants into equivalent test/treatment and control/comparison groups (Glickens, 2003; Sproull, 2003).

Creswell (2003) believed that a researcher should work with a sample of subjects, in order to generalize from the sample to the population. Creswell and Robson (2002) emphasized that the sample has to be representative of the population and to ensure this is

to use a random selection procedure. Sproull (2003) has found that if the sample is not representative of the population, selection bias is a possibility.

Random assignment is a means for removing bias by controlling for factors that the study is not looking for (Bernard, 2000; Creswell, 2003; Glicken, 2003). An experimental study was not chosen for this research study, even though it adheres to less random assignment but they do use test and control groups. Creswell and Neuman (2003) found that non-experimental designs can offer a detailed descriptive analysis, which will give confidence to this research study's findings.

By employing a quantitative methodology, non-experimental cross sectional design, the proposed research study has utilized an electronic mail survey instrument to retrieve information related to the study's research questions. When individuals are the units of analysis, surveys are scientifically most appropriate methods in collecting data of the targeted subjects (Bernard, 2000; Kerlinger, 1986; Leedy & Ormrod, 2004; Robson, 2002). The sample was taken from the American Organization of Nurse Executives (AONE) membership listing.

Creswell (2003) and Sproull (2003) found that for a precise estimate of the association between variables, a descriptive study usually needs a large sample, possibly into the hundreds; while an experiment study may need a small two-digit number sample. The precision with which a researcher measure the variables will have a large impact on sample size, i.e., the poorer the measurements, the more subjects that will be needed extrapolate solid statistics from the poor statistics (Bernard, 2000; Creswell; Robson, 2002). Precision is often expressed as validity and reliability (Bernard; Creswell; Mertens, 1998; Robson, 2002; Sproull, 2003).

Leedy and Ormrod (2004) described validity as it represents how well a variable measures what it is supposed to. Since validity is essential in descriptive studies, Leedy and Ormrod emphasized that if the researcher has poor validity of the variables; thousands rather than hundreds of subjects may be needed. Various statisticians described reliability as how reproducible the researcher's measures are on a retest; obviously, the more reliable a measure, the less subjects a researcher will need to for a minimal change in the measure (Creswell, 2003; Leedy & Ormrod; Neuman, 2003).

This non-experimental, descriptive cross-sectional research design has allowed a large sample population to be surveyed quickly (Creswell, 2003; Kerlinger, 1986; Neuman, 2003). In order to measure the effects of hospital clinical perceived leadership styles on the subordinate nurse manager's job satisfaction, organizational commitment, and job empowerment, the cross sectional study has established whether there is a relationship (positive or negative) between variables. Assuming the level of measurement for transactional and transformational leadership styles are interval and that each leader has a dependent score on both transactional and transformational leadership, a Pearson Product Moment Correlation was the appropriate correlation coefficient and an ANOVA was used to determine the differences in means between transformational and transactional type leaders by each of the independent variables.

A multiple regression analysis measured which of the independent variables were the most important in predicting the dependent variables. The study was utilized to examine the association between hospital clinical leadership styles (as perceived by the participants) and subordinate nurses (in management positions) job satisfaction (intrinsic, extrinsic), organizational commitment, and empowerment (reciprocity, synergy, and

ownership) gathered from participants who are members of the American Organization of Nurse Executives (AONE). The same has occurred with the demographic information of participant age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title.

Researchers have concluded that leadership styles of hospital clinical leaders play a vital role in nurse job satisfaction and empowerment (Acorn, Ratner, & Crawford, 1997; Keuter et al., 2000; Ma, Samuels, & Alexander, 2003; Mahoney, 2000; McNeese-Smith, 2001). Certain leadership styles have proven to result in employee job satisfaction, organizational commitment and empowerment (Laschinger, & Sabiston; Mrayyan, 2004; Sengin, 2003). Many researchers have concluded that transformational leadership is the most effective model of management in achieving the aforementioned constituents of job satisfaction, organizational commitment, and empowerment (Ellefsen & Hamilton, 2000; Falk-Rafael, 2001; Klakovich, 1995, Laschinger et al., 2001; Medley & LaRochelle, 1995).

Empowerment not only increases job satisfaction, but visionary transformational leadership encourages the highest level of staff efficiency and productivity (Keuter et al., 2000; Laschinger, et al.; Moss & Rowles, 1997). As it relates to this study, research has shown that transformational leadership works better than other leadership styles as part of the model for nurse retention (Breggren & Severinsson, 2003; Dahlen, 2002; Effken & Stetler, 1997; Fletcher, 2001; Laschinger, & Sabiston, 2000). This study's research design has examined and determined any relationships between the subordinate nurses' (in management positions) job satisfaction, perceived self-empowerment, organizational

commitment, and their immediate supervisor's (a clinical leader) transformational, transactional, or laissez faire leadership styles.

The independent variables in the study included transformational, transactional, and laissez-faire leadership styles of clinical leaders in a hospital setting. The dependent variables included subordinate nurses' (in management positions) job satisfaction (intrinsic, extrinsic), organizational commitment, and empowerment (reciprocity, synergy, and ownership). The intervening demographic data included the participant's age, gender, educational background, years in the field, years in current employment, salary range, current title, and state location of employment.

In this study, data was collected from survey information that the participants have filled out electronically. The data was measured the independent variable of hospital clinical leadership styles (as perceived by the participants, who are nurses in management positions) from the Multifactor Leadership Questionnaire (MLQ) Form 5x Short (rater) (Bass & Avolio, 1995). To measure the dependent variable of subordinate nurses' (in management positions) job satisfaction, the Mohrman-Cooke-Mohrman Job Scale survey (Mohrman, Cooke, & Mohrman, 1978) was given to any participating subordinate nurses (in management positions).

To measure the dependent variable of subordinate nurses' (in management position) empowerment, the Reciprocal Empowerment Scale (RES) (Klakovich, 1995) was given to any participating subordinate nurses (in management positions). To measure the dependent variable of subordinate nurses' (in management position) organizational commitment, the Organizational Commitment Questionnaire (OCQ) (Mowday, et al., 1979) was given to any participating subordinate nurses (in management

positions). To measure demographic variables, a demographic questionnaire was administered to the participants asking their age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title.

The independent variable is leadership style as perceived by subordinate nurses in management positions. The dependent variables are job satisfaction, organizational commitment, empowerment, and demographic variables. The following methods was used to determine the relationship between hospital clinical leadership styles (as measured by the MLQ) and nurses' (in management positions) job satisfaction (as measured by the MCMJSS), empowerment (as measured by the RES), organizational commitment (as measured by OCQ), and demographic variables (as measured by the demographic questionnaire).

The nurse (in a management position) job satisfaction variable was measured by the Mohrman Cooke Mohrman (MCMJS) job satisfaction survey. The nurse (in a management position) empowerment variable was measured by the Reciprocal Empowerment Scale (RES) survey; and the perceived leadership styles of the hospital clinical leaders was measured by the Multifactor Leadership Questionnaire (MLQ) Form 5x short (revised). The nurse (in a management position) organizational commitment variable was measured by the Organizational Commitment Questionnaire (OCQ). A demographic questionnaire was administered to address age, gender, educational background, years in the field, years at employment, salary range, state location of employment and current title.

On the MCMJSS, individual instruments were utilized in order to examine and establish an internal and external satisfaction score, as well as, an overall general satisfaction single score. An overall mean score was determined for internal, external and overall satisfaction. Frequency distributions and descriptive analysis of hospital clinical leaders' leadership styles (as measured by the MLQ) and nursing participant's job satisfaction (as measured by the MCMJSS) empowerment (as measured by the RES) organizational commitment (as measured by the OCQ), and demographic information (age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title.

Data was analyzed using the Statistical Package for Social Sciences (SPSS) 13.0 (Cronk, 2002). The linear regression analysis procedure was administered to determine if any significant relationship between the variables occurred. The level of significance used in this study was an alpha level of 0.05. Based on the results of the cross sectional study, this researcher was able to conclude whether there is a relationship between the variables in question.

Each instrument was selected because of its simplicity of use and being widely utilized in scholarly studies. The results of each instrument was analyzed and compared with the assistance of statistical instruments.

Population and Sampling

Creswell (2003) defined survey population as a finite number of units, such as individuals. The survey population is commonly known as the sampled population (Creswell). It is the actual population that is studied and surveyed (Creswell).

In any research study, Creswell (2003) & Sproull (2003) believe that the larger the sample size, the better the statistical process becomes and generalizability of the data findings. Leedy and Ormrod (2004) further give percentages based on large numbers, i.e., 1,500, 20% be the sample size (p. 22). Beyond this number, less than 10% is needed for very large populations (Leedy & Ormrod).

The researcher solicited all members of the American Organization of Nurse Executives (AONE), who hold the title of a nurse in a management position (Director, CNE, CNO, Manager, VP) and are employed at a hospital that is located in the United States. Currently, AONE has 6,432 members. At the time of the survey, it was an unknown how many members were categorized as nurses in a management position who are employed at hospitals located in the United States. The solicitation of the entire AONE membership gave the study equal representation to those members who were nurses in management positions in a hospital setting; which encouraged the validity of the study. Given the unpredictability of survey completion (Cooper & Schindler, 2003; Robson, 2002), any AONE member who was a nurse in a management position, who worked in a hospital in the U.S. was solicited. The sampling goal for this research study was 84 participants, which was predetermined by estimating an effect size of .3 with a 95% confidence interval.

There was one population studied, nurses in management positions, who were employed by a hospital in the U.S. In order for this study to yield valid results, it is essential that only hospital nurses in management positions (working in the U.S.) should take the surveys. If participants take the survey but do not fit the participant description, it will be difficult to draw statistical relationships.

Neuman (2003) and Glicken (2003) found that for a precise estimate of the association between variables, a descriptive study usually needs a large sample, possibly into the hundreds; while an experiment study may need a small two digit number sample. The precision with which a researcher measures the variables will have a large impact on sample size, i.e., the poorer the measurements, the more subjects that will be needed extrapolate solid statistics from the poor statistics (Creswell, 2003). Precision is often expressed as validity and reliability (Glicken; Sproull, 2003).

It is imperative that the research study examines the leadership styles of clinical leaders as perceived by subordinate nurses in management positions as they effect subordinate job satisfaction, perceived empowerment, organizational commitment, and demographic information. Consequently, each participant must be truthful in stating his/her position as a hospital nurse in a management position when taking the surveys.

A major extension of this research study is geographical area information. This study has examined participants of all states in the U.S. This study was meant to make some assumptions regarding the effect of the leadership styles of clinical leaders (as perceived by subordinate nurse managers) on a regional basis.

The study population was nurses in management positions, who were members of the American Organization of Nurse Executives, who worked in a hospital setting that is located in the U.S. A membership listing was obtained from AONE ($N= 6,200$). A participant was categorized as follows:

- 1) Nurses in management positions in a hospital setting located in the U. S.

The survey population was retrieved from a mailing list as authorized from

AONE. This list is constantly updated by AONE. At the time of the study, there were 6,200 members of AONE. The number of members who were nurses in management positions who worked in a hospital setting is unknown; due to the fact that some members do not give their job title to AONE for record keeping purposes.

The sample consisted of 373 nurses in management positions. Information that would personally identify individual participants was not asked nor transmitted with the survey data in this research study. It was not possible for the researcher to either see or identify the participants.

The data source came directly from the participants, as received from their answers that were retrieved from the survey collector, QuestionPro.com Web site. The participants' answers and mailing addresses were completely confidential. The data was represented in numerical form. The source of the data is the answers of the participants. The data retrieved from the survey collector (QuestionPro.com) was stored in the researcher's home computer, which was maintained by both firewalls and secure login to prevent unauthorized access to survey data that is received.

The data was collected by sampling any AONE members, who held a management position, in a hospital setting, located in the U.S. The participants were mailed an introductory letter to their address (as listed with AONE). The introductory letter asked the participant to participate in the research study by logging into QuestionPro.com and answering four surveys and one questionnaire, as follows. The first survey was the Multifactor Leadership Questionnaire (MLQ) Form 5x Short (revised) (Bass & Avolio, 1995), which measured the independent variables;

transformational, transactional, and laissez-faire leadership styles of clinical leaders in a hospital setting (Bass & Avolio, 1995).

The MLQ 5x Short (revised) that was used in this study is considered to have high construct and convergent validity (Bass & Avolio, 2000). The reliability of the MLQ has been measured and evaluated by many scholars in independent studies. Test reliability was measured in each of the twelve scales within the MLQ Form 5x-short.

The second survey was the Mohrman-Cooke-Mohrman Job Scale survey (Mohrman, A., Cooke, R., & Mohrman, S., 1978) which measured the dependent variable of subordinate nurse (in a management position) job satisfaction (intrinsic, extrinsic). Reliability on the intrinsic scale ranges from .81 to .87; while reliability on the extrinsic scale ranges from 0.77 to 0.82. The scale has been widely used and accepted by researchers (Creswell, 2003; Robson, 2002).

The third survey was the Reciprocal Empowerment Scale (RES) (Klakovich, 1995), which measured the dependent variable of subordinate nurse (in a management position) empowerment (reciprocity, synergy, and ownership). Convergent validity was established by comparing the RES to the Short Vincenz Empowerment Scale (SVES), which is an established instrument relevant to the construct of empowerment (Klakovich, 1995). The alpha coefficient for the total scale was .96 and ranged from .31 to .82 for the item-total correlations, with the end result having RES correlating positively to the SVES (Klakovich, 1995).

The fourth survey is the Organizational Commitment Questionnaire (OCQ) (Mowday, et al., 1979), which measured the dependent variable of subordinate nurse (in a management position) organizational commitment. Reliability and validity were tested

using six psychometric properties. The coefficient alpha remained consistently high, ranging from 0.82 to 0.93, with a 0.90 median.

For the OCQ, the test-retest method was used to test reliability over time. The levels of this method were from $r=0.53$ to $r=0.74$, which indicates the compatibility of the measurement. Convergent validity was tested across six various samples, ranging from 0.63 to 0.74, with a 0.70 median.

A demographic questionnaire was also given to the participants, measuring age, gender, educational background, years in the field, years in their current job, salary range, state location of employment and current title. The survey collector site (QuestionPro.com) contained a consent form, all four survey instruments and one demographic questionnaire.

The introductory cover letter was mailed to all participants, explaining the study, contact information, directions on where to go to complete the electronic surveys/questionnaires and their participant rights. The cover letter discussed information on issues of confidentiality of the participant responses and the general handling of the returned data information. The participant had the option to choose either to go to the web site and participate OR choose not to participate.

There was no further contact with the potential participant after he/she received the introductory letter. If the participant chose to participate, he/she could login to the web site and see a consent form. After reading the consent form, the participant had the option to continue on and fill out the surveys. At anytime, the participant was able to end their participation and close out their screen. Any incomplete surveys were not utilized in the research study.

Once the data is collected, this data was reflected in statistics related to the measurements of the variables in question. Based on the results of the cross sectional study, this researcher was able to conclude whether there was a relationship between the variables in question.

Instrumentation

The survey instrument that was used in this study consisted of four measures. To measure the independent variable of hospital leadership, the Multifactor Leadership Questionnaire (MLQ) Form 5x Short (revised) was given to all nurses in management positions who elect to participate (Bass & Avolio, 1995). To measure the dependent variable of subordinate nurses in management positions job satisfaction, the Mohrman-Cooke-Mohrman Job Scale survey (Mohrman, Cooke, & Mohrman, 1978) was given to all participating AONE members who are nurses in management positions in a hospital setting located in the U.S.

To measure the dependent variable of subordinate nurse empowerment, the Reciprocal Empowerment Scale (RES) (Klakovich, 1995) was given to all participating AONE members who are nurses in management positions in management positions in a hospital setting located in the U.S. To measure organizational commitment, the Organizational Commitment Questionnaire (OCQ) (Mowday, et al., 1979) was given to all AONE members who are nurses in management positions in a hospital setting located in the U.S. A demographic questionnaire was also given to the participants, measuring age, gender, educational background, years in the field, years in their current job, salary range, state location of employment and current title.

Based on the results of the surveys, this data was reflected in statistics related to the measurements of the variables in question. Based on the results of the cross sectional study, this researcher was able to conclude whether there is a relationship between the variables in question.

Multifactor Leadership Questionnaire (MLQ) Form 5x Short (revised)

The MLQ Form 5x Short (revised) was developed, by Bernard Bass and Bruce Avolio, as a tool for quantifying leadership (Bass & Avolio, 1995). The MLQ survey tool identifies a leader as being either transformational, transactional or laissez-faire in their leadership style (Bass & Avolio, 1995). After a survey is scored, the MLQ identifies which of the three styles is closely matched.

The MLQ utilizes 45 statements to assess a leader’s type of leadership tendencies. These statements ask the participant to respond using a 5 –point Likert scale (Bass & Avolio, 1995). The Likert scale (named after its developer) uses a rating scale containing five choices that are ordinarily arranged on a continuum.

The MLQ 5x that was used in this study is considered to have high construct and convergent validity (Bass & Avolio, 2000). The reliability of the MLQ has been measured and evaluated by many scholars in independent studies. Test reliability was measured in each of the twelve scales within the MLQ Form 5x-short.

The coefficient alpha (a) values of these scales are as follows in Table 1.

Scale	Coefficient Value
Attributed Idealized Influence	.86
Behavior Idealized Influence	.87

(continued)

Inspirational Motivation	.91
Intellectual Stimulation	.90
Individual Consideration	.90
Contingent Reward	.87
Active management by exception	.74
Passive management-by exception	.82
Laissez-faire Leadership	.83
Extra Effort	.91
Effectiveness	.91
Satisfaction	.94

These are high coefficient alpha (α) values and indicate that the MLQ is a reliable test for measuring leadership styles.

Mohrman-Cooke-Mohrman Job Satisfaction Scale

In 1977, Mohrman, Cooke, Duncan and Zaltman developed the Mohrman-Cooke-Mohrman Job Satisfaction Scale. This scale divided the study of job satisfaction into a two-factor (intrinsic/extrinsic) study of job satisfaction. It was developed in order to examine the two-factor theory of job satisfaction and closely follows Herzberg's theory (Mohrman, Cooke, Duncan & Zaltman, 1977).

This eight-question instrument is composed of four questions that address the motivators or job satisfaction elements; self-esteem, development opportunities, achievement, and job expectations. The second set of four questions addresses the hygiene's or job dissatisfaction elements; respect and fair treatment, feeling well or being

informed about what is happening in the workplace, the amount of supervision and the opportunity for worker participation. The response format for the instrument is a 1-point Likert type scale with a score of one (being the lowest) and a score of six (being the highest), as it relates to job satisfaction.

Job satisfaction of nurse manager's was examined by implementing the Mohrman-Cooke- Mohrman Job Satisfaction Scales (MCMJSS). The MCMJSS was designed to measure self-perceived intrinsic, extrinsic, and general satisfaction (Mohrman, Cooke, Mohrman, Duncan & Zaltman, 1977). The instrument consists of eight items divided into two sections of four items each and was a self-administered survey.

Each section has four items with a 6-point Likert type scale where the responses range from the score of one (lowest possible score) to the score of six (highest possible score). The MCMJSS measured the intrinsic and extrinsic perceptions of job satisfaction (Herzberg; 1969) as they relate to the motivation-hygiene theory of Herzberg (Mohrman et al., 1977).

Intrinsic satisfiers, also known as motivators, are those aspects of a person's job that convey feelings of self-esteem, achievement, personal growth, and accomplishments (Mohrman et al, 1977). Extrinsic satisfiers, also known as hygiene's, are those aspects of a person's job that convey feelings of fair treatment, being informed, respectfulness, purposeful participation opportunities, and obtainable goals achieved (Herzberg, 1969; Mohrman, et al.). Researchers of the MCMJSS scale established reliability ranges.

Reliability on the intrinsic scale ranges from .81 to .87 and reliability on the extrinsic scale ranges from 0.77 to 0.82. The scale has been widely used and accepted by researchers.

Reciprocal Empowerment Scale (RES)

The Reciprocal Empowerment Scale (RES) was developed by Dr. Klakovich to identify the dimensions of empowerment (Klakovich, 1995). Utilizing retroductive triangulation, Dr. Klakovich found that empowerment is a synergistic reciprocal process, where goals are reached and self-confidence is increased for both leaders and their followers (Klakovich, 1995). The end result was a 36-item survey tool with three subscales for reciprocity, synergy and ownership.

Convergent validity was established by comparing the RES to the Short Vincenz Empowerment Scale (SVES), which is an established instrument relevant to the construct of empowerment (Klakovich, 1995). The alpha coefficient for the total scale was .96 and ranged from .31 to .82 for the item-total correlations, with the end result having RES correlating positively to the SVES (Klakovich, 1995).

Organizational Commitment Questionnaire

Organizational commitment questionnaire, developed by Mowday, Steers, Porter, (1979), uses three factors that examines one's the belief system and acceptance of an organization's goals; an eagerness to exercise much effort for an organization; and a great desire to stay at an organization. This questionnaire consists of 15 items for measurement, using a 7-point Likert-type scale, in assessing one's level of organizational commitment and intent to stop one's commitment.

Reliability and validity were tested using six psychometric properties. The coefficient alpha remained consistently high, ranging from 0.82 to 0.93, with a 0.90 median. The test-retest method was used to test reliability over time. The levels of this method were from $r=0.53$ to $r=0.74$, which indicates the compatibility of the measurement. Convergent validity was tested across six various samples, ranging from 0.63 to 0.74, with a 0.70 median.

Demographics Questionnaire

A demographic questionnaire was administered to address age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title.

Data Collection

This study utilized self-reported survey procedures (Glicken, 2003) to collect the necessary data. In April 2008, members of AONE were mailed an introductory letter to participate in the research study. Since not all members list their job title and workplace with AONE; it was unknown which members are nurses in management positions in a hospital setting. To be a participant, it was required to be a nurse in a management position in a hospital setting, in the U.S. After receiving the introductory letter, the participant had the option to participate by logging into the survey collector web site on QuestionPro.com.

The introductory letter gave directions to enter the electronic surveys and contact information. The letter discussed information on issues of confidentiality of their responses and the general handling of the returned data information. At any time, the

participant may select not to participate and opt out by closing their screen. Before beginning the surveys, a consent form had to be clicked by the participant before entering the survey portal. After filling out the surveys, the participants were finished and participation completed.

No additional contact was made with the participants after the introductory letter is mailed. The introductory letter was the one and only form of contact between researcher and participants. The participants had approximately four weeks to go to the survey collector site and complete the surveys.

Ethical Issues

Researcher and Observer Disclosures

The surveys possibly discussed issues that may have been a source of potential stress at the participant's job. All possible measures were taken to assure participants of confidentiality of their responses. All participants were asked to candidly (with complete anonymity) to report their level of job satisfaction, organizational commitment, and the perceived leadership style of their immediate supervisor.

All participants were assured that they may withdraw from the study at any time or refuse to participate without any repercussions. They were also encouraged to contact the researcher directly (phone or email) to address any issues he/she may have about the study. If there was any emotional distress issue, the participant was reminded that participation was completely voluntary and confidential.

Consent Form and Confidentiality Agreement

Before answering any survey instruments, an informed consent document was prepared and approved by the Capella University Center for Social Sciences Research (CSSR). By understanding the research study, participants were able to make an informed decision to participate. Being a survey study, there were no face-to-face action between participant and researcher. The consent form was in a written format, as an introductory letter that solicits the participants, which provided a link to click for participating.

Since this research study contacted participants by their physical addresses, the researcher has held these addresses in confidence and has properly destroyed them. The participant answered the questions on a survey collector link, QuestionPro.com; which is a Web based software for collecting responses. By entering into the survey collector web site link, participants were giving consent to participate.

Assumptions & Limitations

The following assumptions and limitations were recognized as part of this study:

1. Only subordinate nurses in management positions, in hospital settings were surveyed in this study; therefore, results may only be applied to this group and not generalized for other groups in other healthcare settings. Surveys like the instruments being used in this study are highly fallible because the researcher may or may not be able to analyze the direction of causal relationships (Creswell, 2003; Leedy & Ormond, 2004).
2. Job satisfaction was measured by the Mohrman-Cooke-Mohrman Job Satisfaction (1978) survey. Eight questions on the questionnaire were developed to be used in various occupations, and the instrument was not specifically designed for nurses

in management positions. The results are self-reported, and therefore, may not correspond to what the participants actually experience. Response bias may also be an issue.

3. Empowerment was measured by the Reciprocal Empowerment Scale (Klakovich, 1995). Responding nurses in management positions may be more or less satisfied with their job regardless of the leadership style of their immediate supervisor. This is a commonly used survey and is often used in a cross-sectional design, which asks questions of its participants at one point in time. Such surveys are highly fallible because the researcher may or may not be able to analyze the direction of causal relationship (Leedy & Ormond, 2004; Neuman, 2003).
4. Organizational commitment was measured using the Organizational Commitment Questionnaire, developed by Mowday, Steers, Porter, (1979). Responding nurses in management positions may be more or less committed to their organization regardless of the leadership style of their immediate supervisor. This survey can be used in a cross-sectional design, which asks questions of its participants at one point in time. Such surveys are highly fallible because the researcher may or may not be able to analyze the direction of causal relationship (Creswell, 2003; Leedy & Ormond, 2004).

Estimated Timeline

Approval was received from AONE to commence the research study in April, 2008. This researcher mailed introduction letters to AONE members in April, 2008. This researcher had a four-week turnaround, with May 19, 2008, as the last day for data collection.

CHAPTER 4. DATA COLLECTION AND ANALYSIS RESULTS

Introduction

This chapter describes in detail the various results obtained for this research study. In this chapter, the findings are presented in accordance with the research questions and hypotheses. This chapter will discuss the following; the sample, the summary results, details of the analysis and results and conclusion.

Description of the Sample

The sample comprised of the membership list of the American Organization of Nurse Executives (AONE). At the time of the mailer, AONE had a membership list of 6,242 members. The exact number of AONE members who are nurses in management positions in a hospital setting was an unknown. An invitation to participate was mailed to the potential participants on April 3, 2008. A total number of sixty-five envelopes were returned non deliverable.

A total of 462 individuals viewed the surveys. A total of 41 individuals only viewed the survey. A total of 421 individuals started taking the survey. A total of 48 individuals did not complete the survey. A total of 373 individuals completed the survey (see Table 2).

It has been estimated that the power number of this study is $n=84$. This is based on the estimation of an effect size of 0.3, with a 95% confidence interval. With 373 completed surveys, this research study has clearly reached its participant goal.

Table 2 Response Rate Summary Report by Number of Respondents and Percentages

	Number	Percentage
Viewed Survey	462	
Started Survey	421	
Completed Survey	373	
Started/Completed Survey		88.84%
Viewed/Started Survey		91.13%

Participant Information

In order to maintain respondent anonymity, the participants were never asked identifying information. The assessments were of general questions in nature. For the purposes of the study, the participants were actively employed nurse managers in a hospital setting located in the United States.

Participants were current members of the American Organization of Nurse Executives. AONE provided this researcher their membership list with mailing addresses. Participants received a letter of participation in the mail the first week of April, 2008. In the participation letter, a link to QuestionPro.com, (<http://www.questionpro.com/akira/TakeSurvey?id=903364> or www.nancywood.org) gave the participant access to the research surveys. The participants had until May 19, 2008, to participate in the research study. By opting to participate, the participants had to log into the above internet address. On the web site, participants could opt-in/opt-out of the site at anytime and the consent form appeared on the screen.

After the study end date had passed, this researcher began reviewing and entering the data into the SPSS version 16.0 and an Excel spreadsheet (Cronk, 2002). All necessary instructions were followed for the surveys as directed by the authors. The level of significance was set at 0.05.

Age Category

The first demographic question was the age category. Table 3 summarizes the age category of the participants and the frequency distribution. The highest percentage of participants was in the 51-55 age range category (33.87%).

Table 3 Demographic Category Part 1 by Age, Percentages and Frequency Distribution of Mean, Standard Deviation and Variance

Age	%	
18 to 30 = 4	1.08%	
31 to 35 = 9	2.42%	
36 to 40 = 20	5.36%	
41 to 45 = 32	8.60%	
46 to 50 = 84	22.58%	
51 to 55 = 127	33.87%	
56 to 60 = 69	18.55%	
61 to 65 = 21	5.65%	
Over 65 = 7	1.88%	
Frequency Distribution		
Mean = 5.65	Standard Deviation = 1.47	Variance = 2.17

Gender

The second demographic question was gender. Table 4 summarizes the gender category of the participants and the frequency distribution. The majority of participants (93.22%) were female.

Table 4 Demographic Category Part 2 by Gender, Percentages and Frequency Distribution of Mean, Standard Deviation and Variance

Gender	%	
Female = 346	93.22%	
Male = 27	6.78%	
Frequency Distribution		
Mean = 1.07	Standard Dev. = 0.25	Variance = 0.06

Education Level

The next demographic question was highest level of education completed. Table 5 summarizes the highest level of education category as obtained by the participants and the frequency distribution. The majority of the participants (71.43%) have obtained a master degree.

Table 5 Demographic Category Part 3 by Highest Level of Education, Percentages and Frequency Distribution of Mean, Standard Deviation and Variance

Education Level	%
Associate = 5	1.35%
Bachelor = 39	10.51%
Master = 267	71.43%
Doctorate = 52	14.02%
Other = 10	2.70%

Frequency Distribution

Mean = 3.09 Standard Dev. = 0.73 Variance = 0.54

Salary Range

The next demographic question was salary range of the participant. Table 6 summarizes the salary range category of the participants and the frequency distribution. The majority of participants (88.20%) placed their salary in the \$85,000 and greater range.

Table 6 Demographic Category Part 4 by Salary Range, Percentages and Frequency Distribution of Mean, Standard Deviation and Variance

Salary	%
45,000 - \$49,999 = 1	0.27%
\$50,000 - \$54,999 = 1	0.27%
\$55,000 - \$59,999 = 1	0.27%
\$65,000 - \$69,999 = 5	1.34%
\$70,000 - \$74,999 = 3	0.80%
\$75,000 - \$79,999 = 13	3.49%
\$80,000 - \$84,999 = 20	5.36%
<u>\$85,000 and greater = 329</u>	<u>88.20%</u>

Frequency Distribution

Mean = 10.74 Standard Dev. = 0.90 Variance = 0.82

Job Title

The next demographic question was job title of the participant. Table 7 summarizes the job title category of the participants and the frequency distribution. The position of Director was the title for the majority of participants (41.02%).

Table 7 Demographic Category Part 5 by Job Title, Percentages and Frequency Distribution of Mean, Standard Deviation and Variance

Job	%
CNE = 12	3.22%
CNO = 67	17.96%
COO = 6	1.61%
President = 4	1.07%
Vice President = 43	11.53%
Director = 153	41.02%
Manager = 32	8.58%
Supervisor = 4	1.07%
Other = 52	13.94%

Frequency Distribution		
Mean = 5.46	Standard Dev. = 2.26	Variance = 5.09

Years in Current Position

The next question asked the participant of the years in current position. Table 8 summarizes the years in position category of the participants and the frequency distribution. The majority of participants (46.77%) have been in their position for 2-5 years.

Table 8 Demographic Category Part 6 by Years in Current Position, Percentages and Frequency Distribution of Mean, Standard Deviation and Variance

Years	%
One year or less = 61	16.40%
2 – 5 years = 175	46.77%
6 – 9 years = 70	18.82%
10 – 15 years = 34	9.14%
Over 15 years = 33	8.87%

Frequency Distribution		
Mean = 2.47	Standard Dev. = 1.14	Variance = 1.30

Years in Nursing

The final demographic question was the number of years in nursing.

Table 9 summarizes the years in the nursing field category of the participants and the frequency distribution. The majority of participants have been in nursing for over 30 years (45.31%).

Table 9 Demographic Data Part 7 by Years in the Nursing Field and Distribution Frequency

Years	Percentage
0 – 5 years = 0	0.00%
6 – 10 years = 8	2.14%
11 – 15 years = 25	6.70%
16 – 20 years = 29	7.77%
21 – 25 years = 50	13.40%

26 – 30 years = 92 24.66%

31 or greater = 169 45.31%

Frequency Distributions

Mean = 5.88

Standard Deviation = 1.35

Variance = 1.83

Region/State of Employment

The participants were asked what state he/she were currently employed. Table 10 summarizes the region with the highest participation and the state within the region with the highest participation. Table 22 (see Appendix J) further details the region and state participation.

Table 10 States by Region by Participation Percentage and State with Highest Participation in the Region, Demographic 8

	Percentage	State
New England	6.01	Massachusetts
Mid Atlantic	15.30	Pennsylvania
East North Central	17.21	Ohio
West North Central	11.75	Iowa
South Atlantic	20.49	Georgia
East South Central	5.74	Tennessee
West South Central	8.20	Texas
Mountain	7.10	Arizona
Pacific	8.20	California

Research Findings – Analyses and Results

The major findings of this research study are presented in this section. The Statistical Package for Social Sciences (SPSS) 16.0 was used to analyze the data. Descriptive statistics were retrieved and analyzed in order to identify any significant relationships in this research study.

A linear regression analysis was used to test the impact of the independent variables upon the dependent variables by using the coefficient of each variable. The larger the coefficient; the larger the effect upon the dependent variable. Mean scores, standard deviations and variances were computed for auxiliary findings and alpha level of 0.05 was set as the level of significance for the study.

The mean, standard deviation, and variance were calculated on the Multifactor Leadership Questionnaire (MLQ) found in Table 11 (p.77). Means were used to evaluate central tendency, while standard deviations were used to evaluate variance from the mean. The mean scores for transformational behaviors were calculated, resulting in the highest score of 2.98 for Inspirational Motivation (IM) and the weakest score of 2.37 for Intellectual Simulation (IS).

Inspirational Motivation is associated with a leader's ability to motivate his/her subordinates, while Intellectual Simulation is the leader's ability to encourage a subordinate to think "out of the box". The mean scores for the transactional behaviors were calculated, resulting in the highest score of 2.67 for Contingent Reward and the weakest score of 1.13 for Management-by-Exception (Passive). Contingent Reward is the leader rewarding the subordinate on predetermined organizational goals, while

Management-by-Exception (Passive) is the leader reacting to a subordinate's performance only when necessary.

Described as the most ineffective style (Bass & Avolio, 2000), Laissez Faire has the lowest score of 0.91 (a low mean score is desirable) and is defined as the leader avoiding being a leader at all times. In the MLQ analysis, nurses in management positions perceive the leadership style of their clinical leaders as mostly transformational, based on the mean transformational leadership behavior score of 2.684. The MLQ also measures and provides results in leadership outcomes as they relate to extra effort by subordinates, effectiveness of leading techniques, and subordinate satisfaction.

With a score of 2.75, job satisfaction was most closely linked to leadership styles. Even though the leadership outcomes are not in the scope of this research study, the results are listed in Table 11 (p.77) for analysis. Clearly the transformational scores are much higher, indicating the leadership styles of hospital clinical leaders (as perceived by nurses in management positions) are transformational.

Table 11 MLQ 5x Subscale and Scores of Mean Standard Deviation and Variance

Sub Scale	M	Scores SD	V
<u>Transformational</u>			
Idealized Influence (Attributed)	2.81	1.290	1.677
(continued)			
Idealized Influence (Behavioral)	2.84	1.192	1.507
Inspirational Motivation	2.98	1.165	1.375
Intellectual Stimulation	2.37	1.177	1.392
Individual Consideration	2.42	1.302	1.702

<u>Total</u>	2.684	1.225	1.530
<u>Transactional</u>			
Contingent Reward	2.67	1.192	1.437
Management-by-Exception (Active)	1.59	1.190	1.420
Management-by-Exception (Passive)	1.13	1.170	1.380
<u>Total</u>	1.796	1.184	1.412
<u>Non-Leadership</u>			
Laissez Faire	0.91	1.145	1.312
<u>Total</u>	0.91	1.145	1.312
<u>Outcomes</u>			
Extra Effort	2.53	1.366	1.870
Effectiveness	2.73	1.267	1.622
<u>Satisfaction</u>	2.75	1.285	1.660

After performing a national study, Drs. Bass and Avolio established Multifactor Leadership norm and/or baseline (Bass & Avolio, 2000). In Table 13, the results from the Bass & Avolio baseline and the results of this study are fairly close in approximation in the various scale (see Appendix C). From these calculations, this researcher can postulate that this study has a high level of reliability.

The mean, standard deviation and variance were calculated for the Mohrman-Cooke-Mohrman Job Satisfaction Scale (MCMJSS) Table 16 (see Appendix F). Internal

satisfaction received the highest score of 3.72. MCMJS measured the dependent variable of subordinate nurse (in a management position) job satisfaction (intrinsic, extrinsic).

Reliability on the intrinsic scale ranges from .81 to .87; while reliability on the extrinsic scale ranges from 0.77 to 0.82. The scale has been widely used and accepted by researchers (Creswell, 2003; Robson, 2002). Internal satisfaction received the highest score of 3.72.

The mean, standard deviation and variance were calculated for the Organizational Commitment Questionnaire as found in Table 17 (see Appendix F). OCQ measured the dependent variable of subordinate nurse (in a management position) organizational commitment. Reliability and validity were tested using six psychometric properties. The coefficient alpha remained consistently high, ranging from 0.82 to 0.93, with a 0.90 median.

For the OCQ, the test-retest method was used to test reliability over time. The levels of this method were from $r=0.53$ to $r=0.74$, which indicates the compatibility of the measurement. Convergent validity was tested across six various samples, ranging from 0.63 to 0.74, with a 0.70 median.

The OCQ contained 15 statements, using a seven-point Likert scale. Of the 15 statements, six statements negatively phrased (so the response values were reversed). The mean average of 4.59 reveals a slightly lower organizational commitment level of the participants. This analysis is based on the knowledge of Mowday, Porter, & Steer's previous OCQ reliability of measure testing in nine reported studies (Mowday, Porter, & Steers, 1979; Mowday, Porter, & Steers, 1982).

The mean, standard deviation and variance were calculated for the Reciprocal Empowerment Scale found in Table 18 (see Appendix F). RES measured the dependent variable of subordinate nurse (in a management position) empowerment (reciprocity, synergy, and ownership). Convergent validity was established by comparing the RES to the Short Vincenz Empowerment Scale (SVES), which is an established instrument relevant to the construct of empowerment (Klakovich, 1995).

The alpha coefficient for the total scale was .96 and ranged from .31 to .82 for the item-total correlations, with the end result having RES correlating positively to the SVES (Klakovich, 1995). The subscale ownership received the highest score of 3.70.

Research Question 1

The first research question guiding this study is:

Is there a relationship between the hospital's clinical leader leadership style (either transactional (TA), transformational (TF) or laissez-faire to subordinate hospital nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment in a hospital setting?

Data was collected using the MLQ to assess the leadership characteristics (independent variable) of hospital clinical as perceived by hospital nurses in management positions and what affects, if any, on their job satisfaction, organizational commitment and empowerment (dependent variables). Multiple regression analysis was performed and presented in Tables 19 – 21 (see Appendix G, H, I). Results of the multiple regression analysis replicated other studies (Bass & Avolio, 1990; Lowe, Kroeck, & Sivasubramaniam, 1996; Yammarino, Spangler, & Dubinsky, 1998).

The following summary identifies the percentage of variation for each independent MLQ factor and job satisfaction (Table 19, see Appendix G):

1. The Idealized Influence (Attributed) factor gave an explanation for 72% of the variation in the participants' job satisfaction scores.
2. The Idealized Influence (Behavioral) factor gave an explanation for 21% of the variation in the participants' job satisfaction scores.
3. The Inspirational Motivation factor gave an explanation for 1% of the variation in the participants' job satisfaction scores.
4. The Intellectual Stimulation factor gave an explanation for 62% of the variation in the participants' job satisfaction scores.
5. The Individual Consideration factor gave an explanation for 5% of the variation in the participants' job satisfaction scores.
6. The Contingent Reward factor gave an explanation for 38% of the variation in the participants' job satisfaction scores.
7. The Management-by-Exception (Active) factor gave an explanation for 46% of the variation in the participants' job satisfaction scores.
8. The Management-by-Exception (Passive) factor gave an explanation for 58% of the variation in the participants' job satisfaction scores.
9. The Laissez Faire factor gave an explanation for 98% of the variation in the participants' job satisfaction scores.
10. The following summary identifies the percentage of variation for each independent MLQ factor and organizational commitment (Table 20, see Appendix H).

11. The Idealized Influence (Attributed) factor gave an explanation for 20% of the variation in the participants' organizational commitment scores.
12. The Idealized Influence (Behavioral) factor gave an explanation for 90% of the variation in the participants' organizational commitment scores.
13. The Inspirational Motivation factor gave an explanation for 40% of the variation in the participants' organizational commitment scores.
14. The Intellectual Stimulation factor gave an explanation for 14% of the variation in the participants' organizational commitment scores.
15. The Individual Consideration factor gave an explanation for 0% of the variation in the participants' organizational commitment scores.
16. The Contingent Reward factor gave an explanation for 1% of the variation in the participants' organizational commitment scores.
17. The Management-by-Exception (Active) factor gave an explanation for 96% of the variation in the participants' organizational commitment scores.
18. The Management-by-Exception (Passive) factor gave an explanation for 50% of the variation in the participants' organizational commitment scores.
19. The Laissez Faire factor gave an explanation for 42% of the variation in the participants' organizational commitment scores.

The following summary identifies the percentage of variation for each independent MLQ factor and empowerment scores (Table 21, see Appendix I).

1. The Idealized Influence (Attributed) factor gave an explanation for 31% of the variation in the participants' empowerment scores.

2. The Idealized Influence (Behavioral) factor gave an explanation for 26% of the variation in the participants' empowerment scores.
3. The Inspirational Motivation factor gave an explanation for 61% of the variation in the participants' empowerment scores.
4. The Intellectual Stimulation factor gave an explanation for 41% of the variation in the participants' empowerment scores.
5. The Individual Consideration factor gave an explanation for 71% of the variation in the participants' empowerment scores.
6. The Contingent Reward factor gave an explanation for 20% of the variation in the participants' empowerment scores.
7. The Management-by-Exception (Active) factor gave an explanation for 0% of the variation in the participants' empowerment scores.
8. The Management-by-Exception (Passive) factor gave an explanation for 34% of the variation in the participants' empowerment scores.
9. The Laissez Faire factor gave an explanation for 0% of the variation in the participants' empowerment scores.

Hypothesis 1. Transactional (TA) and laissez-faire leadership styles of hospital clinical leaders will have lower positive correlations to subordinate nurses in a management position job satisfaction, organizational commitment, and perceived empowerment than Transformational leadership styles.

1. In all regions Inspirational Motivation is the highest scoring factor.

Inspirational Motivation is defined as the leader articulating him or herself as a visionary, which encourages followers to meet any new challenges with a

positive attitude, and talks with optimism, enthusiasm, and encouragement (Bass, 1997; Bass & Avolio, 1994).

Null Hypothesis. There is no difference between clinical leaders Transactional (TA), and Laissez Faire leadership styles and subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment.

In Table 14 (see Appendix D), the MLQ 5x Scale Leadership Styles are represented in summary by region. In Tables 16, 17, 18, 19, and 21, the MLQ 5x Scale Leadership Styles are represented in complete detail. The test results are presented in these Tables 16-21 found in Appendixes F – I.

Acceptance of the first Hypothesis is based on the regression analysis that provides empirical support. Rejection of the Null Hypothesis is based on the regression analysis that provides empirical support for the alternate hypothesis. Given these values, one must reject the null hypothesis and provide support for the alternate hypothesis.

These findings imply a lower positive correlation relationship between the leadership styles of clinical hospital leaders (as perceived by nurses in management positions) and job satisfaction, organizational commitment and empowerment of nurses in management position.

Research Question 2

The second research question guiding this study is:

Is there a relationship between leadership styles and job satisfaction, organizational commitment (job-longevity), perceived empowerment, in a hospital setting and the selected demographic variables? (Demographic variables included will measure

participant age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title).

A bivariate correlation matrix is found in Table 15, Appendix E. The following relationships were found to be significant between the demographic factors and leadership styles.

1. Age was significantly and positively related to gender, education, salary, position, years in position, years in nursing *and* significantly and negatively related to the leadership styles.
2. Gender was significantly and positively related to age, education, position, years in position, years in nursing.
3. Education was significantly and positively related to age, gender, salary, position, years in position, years in nursing, *and* significantly and negatively related to transactional leadership style.
4. Salary was significantly and positively related to age, education, position, years in position, years in nursing.
5. Position was significantly and positively related to age, gender, education, salary, years in position, years in nursing, *and* significantly and negatively related to transactional leadership style.
6. Years in position was significantly and positively related to age, gender, education, salary, position, and years in nursing.
7. Years in nursing was significantly and positively related to age, gender, education, salary, position, and years in position *and* significantly and negatively related to transactional leadership style.

Hypothesis 2. Transformational (TA) leadership styles of hospital management clinical leaders will have higher positive correlations to subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment, than Transactional leadership styles.

Null Hypothesis. There is no difference between Transactional (TA) leadership styles and Transformational leadership styles of hospital management clinical leaders as they correlate to subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment.

In Table 12 (see Appendix B), the MLQ 5x Scale Leadership Styles are represented in summary by region. In Tables 16, 17, 18, 19, and 21, the MLQ 5x Scale Leadership Styles are represented in complete detail. The test results are presented in Tables 16 – 21 found in Appendixes F-I.

Acceptance of the Hypothesis 2 is based on the regression analysis that provides empirical support. Rejection of the Null Hypothesis is based on the regression analysis that provides empirical support for the alternate hypothesis. Given these values, one must reject the null hypothesis and provide support for the alternate hypothesis.

These findings imply a relationship between the leadership styles of clinical hospital leaders (as perceived by nurses in management positions) and job satisfaction, organizational commitment and empowerment of nurses in management position. See Figure 1 for a conceptual model of the final results and outcomes of this research study.

CHAPTER 5. CONCLUSIONS & RECOMMENDATIONS

Summary

The purpose of this study was to produce a research model that examined any links between leadership styles (transformational, transactional, and laissez-faire) in order to determine which styles were most predictive of subordinate job satisfaction, organizational commitment and workplace empowerment. The assumption was made that transformational and transactional leadership styles would be more predictive of job satisfaction, organizational commitment and workplace empowerment. It was also assumed that laissez-faire would have a negative impact on the above stated variables.

The review of the literature raised the need to further examine the leadership arena as a place of interaction that occurs when leaders and employees come together to cooperate and work; the need to get beyond the ideas dominance and subordination to the idea of working in a cooperative relationship (Antonakis, Cianciolo & Sternberg, 2004; Goldsmith, Govindarajan, Kaye, & Vicere, 2003.; Kouzes & Posner, 2003; Northouse, 2004; Townsend & Gebhardt, 1997). The review of literature also raised some questions if new leadership practices are to be implemented in order to improve work collaboration in any organization (Antonakis, et. al, 2004; Bennis & Nanus; Goldsmith, et. al; Northouse; Townsend & Gebhardt). This research study examined the leadership practices in the healthcare arena, specifically, hospital clinical leadership.

Effective leadership is necessary in a complex organizational matrix such as a hospital setting (Gifford, Zammuto, Goodman, & Hill, 2002; Griffith & White, 2002; Mrayyan, 2004; Thyer, 2003). Hospital leaders must know how to motivate their staff;

employ performance management systems; and solve poor employee performance problems (Bryant, 2003; Leatt, Baker, Halverson, & Aird, 1997; Prothero, Marshall, Fosbinder, & Hendrix, 2000).

They must deal with their subordinate managers' perceptions of their work environment (job satisfaction and burnout); while, improving and promoting autonomy (Beckham, 2002; Leatt, et. al; Popper, 2004; Prybil, 2003). The literature review revealed how hospitals (in particular) are looking for strategies to retain all staff levels of nurses (Moss & Rowles, 1997), and one strategy for employee retention that research indicates is vital to organizational stability is increasing employee satisfaction and empowerment (Laschinger, Finegan, Shamian, & Wilk, 2001; Moss & Rowles). Research has defined job satisfaction encompassing various factors; opportunity for advancement, solid leadership, high work standards, and autonomy (Acorn, Ratner, & Crawford, 1997; Adams & Bond, 2000; Chinnis, et al.; Kalliath & Morris, 2002; Kuokkanen et al., 2003; Laschinger, Almost, & Tuer-Hodes, 2003; Laschinger & Finegan, 2005; Mrayyan, 2004; Popper, 2004).

Leadership styles have been discussed often in the literature as a strategy to promote nurse empowerment (Arruda, 2005; Manion, 2004; Morrison, Jones, & Fuller, 1997; Prybil, 2003; Thyer, 2003; Wagner, 2006). The purpose of this research study was to investigate the above stated relationships and what relationships (if any) were between the hospital clinical management leadership styles (as perceived by subordinate nurses in management positions) and subordinate nurse job satisfaction, organizational commitment and workplace empowerment. Other demographic variables were also

examined, such as participant age, gender, educational background, years in the field, years at current employment, salary, state location of employment and current title.

Specifically, this study examined three perceived leadership styles: transformational, transactional, and non-transactional (*laissez-faire*) to find an effect (if any) on the two aspects (intrinsic and extrinsic) of job satisfaction, three aspects (reciprocity, synergy, and ownership) of workplace empowerment, and organizational commitment. The independent variables in the study included transformational, transactional, and *laissez-faire* leadership styles of clinical leaders in a hospital setting. The dependent variables included subordinate nurses' (in management positions) job satisfaction (intrinsic, extrinsic), organizational commitment, and empowerment (reciprocity, synergy, and ownership). The intervening demographic data included the participant's age, gender, educational background, years in the field, years at current employment, salary range, current title, and state location of employment.

The first survey utilized in this study was the Multifactor Leadership Questionnaire (MLQ) Form 5x Short (revised) (Bass & Avolio, 1995), which measured the independent variables; transformational, transactional, and *laissez-faire* leadership styles of clinical leaders in a hospital setting (Bass & Avolio, 1995). The MLQ Form 5x Short (revised) was developed, by Bernard Bass and Bruce Avolio, as a tool for quantifying leadership (Bass & Avolio, 1995). The MLQ survey tool identifies a leader as being either transformational, transactional or *laissez-faire* in their leadership style (Bass & Avolio, 1995).

The second survey utilized in this research study was the Mohrman-Cooke-Mohrman Job Scale survey (Mohrman, Cooke, & Mohrman, 1978) which measured the dependent variable of subordinate nurse (in a management position) job satisfaction (intrinsic, extrinsic). Developed in 1977 by Mohrman, Cooke, Duncan and Zaltman, this scale divided the study of job satisfaction into a two-factor (intrinsic/extrinsic) study of job satisfaction. It was developed in order to examine the two-factor theory of job satisfaction and closely follows Herzberg's theory (Mohrman, Cooke, Duncan & Zaltman, 1977).

The third survey utilized in this research study was the Reciprocal Empowerment Scale (RES) (Klakovich, 1995) and was developed by Dr. Klakovich to identify the dimensions of empowerment (Klakovich, 1995). It measured the dependent variable of subordinate nurse (in a management position) empowerment (reciprocity, synergy, and ownership). Utilizing retroductive triangulation, Dr. Klakovich found that empowerment is a synergistic reciprocal process, where goals are reached and self-confidence is increased for both leaders and their followers (Klakovich, 1995). The end result was a 36-item survey tool with three subscales for reciprocity, synergy and ownership.

The fourth survey utilized in the Organizational Commitment Questionnaire (OCQ) (Mowday, et al., 1979), measured the dependent variable of subordinate nurse (in a management position) organizational commitment. Organizational commitment questionnaire, developed by Mowday, Steers, Porter, (1979), uses three factors that examines one's belief system and acceptance of an organization's goals; a willingness to exert great effort on behalf of an organization; and a great desire to stay at an

organization. A demographic questionnaire was also given to the participants, measuring age, gender, educational background, years in the field, years in their current job, salary range, state location of employment and current title.

This research study was a quantitative, non-experimental, descriptive cross sectional research study design utilizing archival data. It was the most appropriate design to use for this study in order to determine if there was a relationship between the subordinate nurses' (in management positions) job satisfaction, perceived self-empowerment, organizational commitment, and their immediate supervisor's (a clinical leader) transformational, transactional, or laissez faire leadership styles. Also, this study determined the differences in independent variables, based on the clinical leader's transformational, transactional, or laissez faire leadership styles.

For this research study, a sample comprised of the membership list of the American Organization of Nurse Executives (AONE). At the time of the mailer, AONE had a membership list of 6,242 members. The exact number of AONE members who are nurses in management positions in a hospital setting was an unknown.

An invitation to participate was mailed to the potential participants on April 3, 2008. A participant was categorized as any nurse in a management position, in a hospital setting located in the U.S. The number of members who are nurses in management positions who work in a hospital setting is unknown; due to the fact that some members do not give their job title to AONE for record keeping purposes.

A total of 41 individuals only viewed the survey. A total of 421 individuals started taking the survey. A total of 48 individuals did not complete the survey. A total of 373 individuals completed the survey.

In this study, data was collected from survey information that the participants had filled out electronically. The survey collector site (QuestionPro.com) contained a consent form, all four survey instruments and one demographic questionnaire. The MLQ Form 5x Short (rater) survey data measured the independent variable of hospital clinical leadership styles (as perceived by the participants, who are nurses in management positions) (Bass & Avolio, 1995).

The Mohrman-Cooke-Mohrman Job Scale survey data measured the dependent variable of subordinate nurses' (in management positions) job satisfaction, (Mohrman, Cooke, & Mohrman, 1978). The Reciprocal Empowerment Scale (RES) (Klakovich, 1995) measured the dependent variable of subordinate nurses' (in management positions) empowerment.

The Organizational Commitment Questionnaire (OCQ) (Mowday, et al., 1979) measured the dependent variable of subordinate nurses' (in management positions) organizational commitment. To measure demographic variables, a demographic questionnaire was administered to the participants asking their age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title. The survey collector site (QuestionPro.com) contained a consent form, all four survey instruments and one demographic questionnaire.

A multiple regression analysis was performed to measure which of the independent variables were the most important in predicting the dependent variables. A linear regression analysis was used to test the impact of the independent variable upon the dependent variable by using the coefficient of each variable. The larger the coefficient, then, the larger the effect upon the dependent variable.

The data clearly indicated a relationship between the leadership styles of hospital clinical leaders (as perceived by nurses in management positions) and subordinate hospital nurses (in management positions) job satisfaction, organizational commitment, and perceived empowerment in a hospital setting. The data clearly demonstrated that hospital clinical leaders display transformational leadership styles with a higher degree of frequency, as perceived and rated by their subordinate nurse managers. A good leader knows how to interact and communicate with followers by exchanging pertinent information and input; delegating authority appropriately; know how rise to the occasion when crises occur; and meeting necessary work expectations (Bass, 1997; Bass & Avolio; Beckham; Kouzes & Posner, 2003; Luthans & Avolio; Northouse).

Transformational leaders tend to embody the following attributes: (a) charisma, (b) a strong ethical base, (c) a motivational orientation (d) mentoring attributes and (e) creativity. In particular, hospital clinical leaders must exhibit a leadership style that communicates empathy, respect and trust; which are essential elements for the occurrence of positive team cohesion (Larrabee, Janney, & Ostrow, 2003). Bass and Avolio (2000) advocated transformational leadership as being most sensitive to developing a shared vision of a more desirable work culture; whereas, they found that transactional leadership

creates a less desirable work culture with little concern for working towards an organizational vision (Bass & Avolio). It would be presumed that these behaviors would be pertinent for hospital clinical leaders to project and exhibit in order to be successful as clinical leaders in a hospital setting.

In contrast, the data clearly demonstrated that hospital clinical leaders display transactional leadership styles with a moderate degree of frequency, as perceived and rated by their subordinate nurse managers. Transactional leaders are characterized by (a), contingent reward methods (b), reactive management approach and (c), passive management approach (Bass & Avolio, 2000). Burns recognized transactional leadership style focuses on motivating subordinates by offering rewards for services rendered.

Clearly, the hospital clinical leaders would provide motivation and offer various feedback to achieve the desired results. In any position, subordinates need a leader to outline performance expectations, perform yearly performance appraisals, and offer promises of rewards (raises, awards, promotions, etc.). Transactional leaders will closely watch the job performance of their subordinates by looking for mistakes and then quickly correcting them.

It is assumed that hospital clinical leaders would have very little time for close monitoring of his/her subordinates. Also, it would seem practically impossible for a hospital clinical leader to personally monitor the work patterns of his/her subordinates. It would be presumed that these behaviors would be less prudent for hospital clinical leaders to project and exhibit in order to be successful as clinical leaders in a hospital setting.

The data clearly demonstrated that hospital clinical leaders display laissez-faire leadership styles with the least degree of frequency, as perceived and rated by their subordinate nurse managers. Laissez-faire is most minimal in leadership functions and gives no direction and does not praise or punish subordinates. Clearly, hospital clinical leaders are very much 'hands on' and must make quick decisions on a daily basis.

Research Question 1

The first research question guiding this study is:

Is there a relationship between the hospital's clinical leader leadership style (either transactional (TA), transformational (TF) or laissez-faire to subordinate hospital nurses (in a management position) job satisfaction, organizational commitment, and perceived empowerment in a hospital setting?

The research findings of research question one suggests that the quantitative, non-experimental, descriptive cross sectional design (utilizing archival data) predicted job satisfaction, organizational commitment and empowerment among the subordinate nurses in management positions. Certain leadership styles have proven to result in employee job satisfaction, organizational commitment and empowerment (Laschinger, & Sabiston; Mrayyan, 2004; Sengin, 2003). Many researchers have concluded that transformational leadership is the most effective model of management in achieving the aforementioned constituents of job satisfaction, organizational commitment, and empowerment (Ellefsen & Hamilton, 2000; Falk-Rafael, 2001; Klakovich, 1995, Laschinger, Finegan, & Shamian, 2001; Medley & LaRochelle, 1995).

Job Satisfaction

This research study's findings support other researchers' conclusions that leadership styles of hospital clinical leaders play an important role in nursing management job satisfaction (Acorn, Ratner, & Crawford, 1997; Keuter et al., 2000).

Since the findings clearly show that hospital clinical leaders practiced transformational leadership styles, it is not surprising to see Inspirational Motivation factor giving an explanation for 1% of the variation in the participants' job satisfaction scores. Inspirational Motivation is defined as the leader articulating him or herself as a visionary, which encourages followers to meet any new challenges with a positive attitude, and talks with optimism, enthusiasm, and encouragement (Bass, 1997; Bass & Avolio, 1994).

Since the data clearly demonstrated that hospital clinical leaders display laissez-faire leadership styles with the least degree of frequency, it is not surprising to find the Laissez Faire factor gave an explanation for 98% of the variation in the participants' job satisfaction scores. Laissez-faire is most minimal in leadership functions and gives no direction and does not praise nor punish subordinates. These findings are not surprising since empirical evidence has confirmed that transformational leadership is more highly correlated to perceived employee job satisfaction than transactional leadership (Bass & Avolio, 1990; Dvir, et al., 2002; Ribelin, 2003; Wilmore, & Thomas, 2001); specifically with hospital nursing staff (Medley & Laroche, 1995; Tzeng & Ketefian, 2002; Upenieks, 2003; Watson, 2002).

Organizational Commitment

This research study's findings support other researchers' conclusions that leadership styles of hospital clinical leaders play an important role in nursing management organizational commitment (Irving, Coleman, & Cooper, 1997; Lok, Westwood, & Crawford, 2005). During the statistical process, the mean average of 4.59 revealed a slightly lower organizational commitment level of the participants. This analysis is based on the knowledge of Mowday, Porter, & Steer's previous OCQ reliability of measure testing in nine reported studies (Mowday, Porter, & Steers, 1979; Mowday, Porter, & Steers, 1982).

Individual Consideration factor gave an explanation for 0% of the variation in the participants' organizational commitment scores. This factor finds that the leader recognizes followers as individuals who have their own set of needs, abilities, and goals; listens attentively and furthers any followers' development; advises, teaches, and takes great care to treat everyone equally (Bass, 1997; Bass & Avolio, 1994). Bycio, Hackett, & Allen, (1995) found positive correlations between transformational leadership traits of charisma and individualized consideration; and organizational commitment.

The Management-by-Exception (Active) factor gave an explanation for 96% of the variation in the participants' organizational commitment scores. This factor finds that the leader is constantly reviewing and monitoring followers' job performance reviews, looking for problems and taking immediate corrective action (Bass, 1997). These findings clearly support other researchers' conclusions as to what leadership styles influence an employee's organizational commitment.

Tansky and Cohen (2002) found that encouraging employee development was positively correlated with organizational commitment. Much evidence suggests that job satisfaction influences organizational commitment when, for example, an employee possesses a high degree of autonomy, challenges and skill sets (Kuokkanen et al., 2003; Meyer & Herscovitch, 2001; Mowday, 1998; Tang, 2003).

Empowerment

This research study's findings supports other researchers' conclusions that leadership styles of hospital clinical leaders play an important role in nurses in management positions' workplace empowerment (Acorn, Ratner, & Crawford, 1997; Keuter et al., 2000). Individual Consideration factor gave an explanation for 71% of the variation in the participants' empowerment scores. This factor finds that the leader recognizes followers as individuals who have their own set of needs, abilities, and goals; listens attentively and furthers any followers' development; advises, teaches, and takes great care to treat everyone equally (Bass, 1997; Bass & Avolio, 1994).

Nurses in management positions need a flexible structure that encourages autonomy, instills trust, promotes adherence to professional standards, and encourages participation in problem solving (Falk-Rafael, 2001; Konczak, Stelly & Trusty, 2000; Laschinger, et al., 2003; Laschinger & Finegan, 2005; Mrayyan, 2004; Strachota, et al., 2003). Morrison, Jones, and Fuller (1997) found that only TF leadership styles were positively related to empowerment ($r=.26, p<.05$) and empowerment was positively correlated to job satisfaction ($r=.41, p<.05$). Nakata and Saylor (1994) examined how staff nurses perceived management styles, what management styles were actually

preferred, and if any relationship existed between the perceived management style of the nurse managers and staff nurses' job satisfaction and found the results revealed a perceived management style of benevolent authoritative as most represented (mean overall score of 4.34 on a linear scale of 1 to 8).

The Management-by-Exception (Active) factor gave an explanation for 0% of the variation in the participants' empowerment scores. This factor finds that the leader is constantly reviewing and monitoring followers' job performance reviews, looking for problems and taking immediate corrective action (Bass, 1997). These findings clearly support other researchers' conclusions as to what leadership styles influence an employee's workplace empowerment.

The Laissez Faire factor gave an explanation for 0% of the variation in the participants' empowerment scores. This factor finds that the leader is constantly reviewing and monitoring followers' job performance reviews, looking for problems and taking immediate corrective action (Bass, 1997). These findings clearly support other researchers' conclusions as to what leadership styles influence an employee's workplace empowerment.

The second research question guiding this study is:

Is there a relationship between leadership styles and job satisfaction, organizational commitment (job-longevity), perceived empowerment, in a hospital setting and the selected demographic variables? (Demographic variables included will measure participant age, gender, educational background, years in the field, years at current employment, salary range, state location of employment and current title)___

The following relationships were found to be significant between the demographic factors and leadership styles. Age was significantly and positively related to gender, education, salary, position, years in position, years in nursing *and* significantly and negatively related to the leadership styles. Gender was significantly and positively related to age, education, position, years in position, years in nursing.

Education was significantly and positively related to age, gender, salary, position, years in position, years in nursing, *and* significantly and negatively related to transactional leadership style. Salary was significantly and positively related to age, education, position, years in position, years in nursing. Position was significantly and positively related to age, gender, education, salary, years in position, years in nursing, *and* significantly and negatively related to transactional leadership style.

Years in position was significantly and positively related to age, gender, education, salary, position, and years in nursing. Years in nursing was significantly and positively related to age, gender, education, salary, position, and years in position *and* significantly and negatively related to transactional leadership style. Clearly, this study's data findings answered the hypotheses guiding this study by finding the hypotheses to be true and negating the null hypotheses.

Null Hypothesis. There is no difference between clinical leaders Transactional (TA), and Laissez Faire leadership styles and subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment

Hypothesis 1. Transactional (TA) and laissez-faire leadership styles of hospital clinical leaders will have lower positive correlations to subordinate nurse in a

management position job satisfaction, organizational commitment, and perceived empowerment than Transformational leadership styles.

Null Hypothesis. There is no difference between Transactional (TA) leadership styles and Transformational leadership styles of hospital management clinical leaders as they correlate to subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment.

Hypothesis 2. Transformational (TA) leadership styles of hospital management clinical leaders will have higher positive correlations to subordinate nurse (in a management position) job satisfaction, organizational commitment, and perceived empowerment, than Transactional leadership styles

Conclusions

As in any research study, it is imperative that caution be prevailing prior to the generalization of any study's results. Yet, this researcher is confident that this study's findings of this research study highlights how the hospital clinical leadership styles (as perceived by subordinate hospital nurses in management positions) is predictive of their subordinate hospital nurses' (in management positions) job satisfaction, subordinate hospital nurses' (in management positions) organizational commitment and subordinate hospital nurses' (in management positions) workplace empowerment.

Research has shown that transformational leadership works better than other alternatives and certain leadership traits are part of the model for nurse retention (Breggren & Severinsson, 2003; Dahlen, 2002; Effken & Stetler, 1997; Fletcher, 2001;

Laschinger, & Sabiston, 2000). Specifically, many researchers have concluded that transformational leadership is the most effective model of management in a healthcare setting to achieve the aforementioned constituents of job satisfaction, organizational commitment, and empowerment, in order to create the necessary positive relationship between leaders and workers (Ellefsen & Hamilton, 2000; Falk-Rafael, 2001; Klakovich, 1995, Laschinger, Finegan, & Shamian, 2001; Medley & LaRochelle, 1995).

More importantly, this study brings up the need to reexamine the leadership arena as a place of interaction that occurs when leaders and employees come together to cooperate and work; the need to get beyond the ideas dominance and subordination to the idea of working in a cooperative relationship (Antonakis, Cianciolo & Sternberg, 2004; Bennis & Nanus, 1997; Goldsmith, Govindarajan, Kaye, & Vicere, 2003; Northouse, 2004; Townsend & Gebhardt, 1997); specifically in a hospital setting.

Effective leadership is necessary in a complex organizational matrix such as a hospital setting (Mrayyan, 2004; Thyer, 2003). Evaluation of this study's data indicated that Idealized Influence (attributed), Idealized Influence (behavioral) and Inspirational Motivation were the primary predictors of job satisfaction, organizational commitment and workplace empowerment. Hospital leaders must know how to motivate their staff; employ performance management systems; and solve poor employee performance problems (Bryant, 2003; Prothero, Marshall, Fosbinder, & Hendrix, 2000; Mrayyan, 2004).

Empowerment not only increases job satisfaction, but inspirational and visionary transformational leadership encourages the highest level of staff efficiency and

productivity (Keuter, Byrne, Voell, & Larson, 2000; Laschinger, et al.; Moss & Rowles, 1997). Masi (2000) concludes that empowerment provides opportunities for choice and promotes autonomy, which allows subordinates to demonstrate their competencies.

Researchers have concluded that leadership styles of hospital clinical leaders play a vital role in nurse job satisfaction and empowerment (Acorn, Ratner, & Crawford, 1997; Keuter, Byrne, Voell, & Larson, 2000).

Bratt et al. (2000) performed a cross-sectional survey of 1,973 staff nurses working in a pediatric critical care in 65 health facilities. The results revealed that job stress and nursing leadership were the most influential variables (Bratt et al.) The researchers recommended that more research would be necessary to determine what managerial training programs would be necessary to support and empower the nursing staff (Bratt et al.).

Ribelin (2003) performed a convenience sample survey of 2,029 staff nurses, with a 70% return rate. The resulted findings demonstrated that leadership styles had a direct effect on job satisfaction and nurse retention (Ribelin). The participants preferred leaders who were involved, communicative, and gave recognition (Ribelin).

Masi (2000) believed that the key to transformational leadership is active listening through constant feedback (Bryant, 2003). This enhances avenues for meaningful nurse interaction and participation in formulating policies that remove barriers to success (Masi; Medley & LaRochelle, 1995; Kuokkanen, et al.; Laschinger, et al.; Laschinger, & Finegan).

Grossman & Valiga, 2000, found that this motivation gave individuals the ability to excel at their position, by giving them a sense of ownership and pride, while working towards a common goal (Jick & Peiperl, 2003; Kane-Urrabazo, 2006). By motivating through transformational leadership, employees become inspired and are willing to achieve organizational objectives and goals (Fletcher & Taplin, 2002; Grossman & Valiga; Schein, 2004).

Bass & Avolio (1995) found that the outcome of transformational leadership will enhance productivity, while encouraging job satisfaction. They believe that the innovative and proactive thinking, that transformational leadership provides, shapes the goals and values of its followers (Bass & Avolio; Bryant, 2003; Dvir, et al., 2002; Kouzes & Posner, 2003). This type of innovative leadership style has been observed as providing greater job satisfaction, improving team morale, and providing an atmosphere of empowerment (Bryant; Kouzes & Posner; Reinhardt, 2004; Whetstone, 2003).

Implications

This study has numerous pertinent implications. First, it contributes to the body of research regarding leadership, job satisfaction, organizational commitment and empowerment. Transformational leadership has been related to the long-standing literature on solid values, moral character and making ethical social choices (Bass, 1990; Bolman & Deal, 2003; Lowe, Kroeck, & Sivasubramaniam, 1996; Luthans & Avolio, 2003) and this study contributes to this body of work.

Researchers have often concluded that transformational leadership styles are preferred in this regard over transactional leadership styles (Bass & Avolio, 1990; Bolman & Deal, 2003; Leatt, Baker, Halverson, & Aird, 1997; Lowe, Kroeck, & Sivasubramaniam, 1996; Prothero, Marshall, Fosbinder, & Hendrix, 2000; Masi, 2000; Mrayyan, 2004; Warden, 1999). Much research has been performed to identify how leadership styles can be utilized to influence employee behavior that will lead to superior organizational outcomes (Adams & Bond; Arruda, 2005; Bennis & Nanus, 1997; Bryant, 2003; Dvir, et al., 2002; Houkes, Janssen, Jonge, & Arnold, 2003; Jick & Peiperl, 2003; Keuter, Byrne, Voell & Larson, 2000; Kouzes & Posner, 2003; Masi, 2000; Mohrman, Cohen, & Mohrman, 1995; Northouse, 2004; Townsend & Gebhardt, 1997; Wallick, 2002). Empirical evidence has found transformational leadership positively correlating to employee job satisfaction (Dumdum, Lowe, & Avolio, 2002; Walumbwa, et al., 2004), organizational commitment (Barling, Weber, & Kelloway, 1996; Gibson, et al., 2003; Lok, Westwood, & Crawford, 2005; Tansky & Cohen, 2002); and motivation and performance (Dvir, et al, 2002; Lowe & Barnes; 2002).

While clearly there is much research in leadership styles being related to job satisfaction, organizational commitment and empowerment, there are very few studies that combine the dependent variables of job satisfaction, organizational commitment and job empowerment, as this study has done. The knowledge that transformational leadership predicts job satisfaction, organizational commitment and job empowerment is important information for the field of leadership research.

Secondly, this study has notable implications for leaders in clinical settings, especially CEOs, Presidents, and other executive level staff in hospital settings. Knowing which leadership styles are predictive of their subordinate staffs' job satisfaction, organizational commitment and job empowerment, hospital leaders can maximize their efforts of retaining high performing staff and raise the perception of a highly effective organization. This is especially important in today's environment when healthcare is transitioning to a customer service business model.

Besides pointing out specific leadership styles that lead to job satisfaction, organizational commitment and job empowerment, this study determined which behaviors were predictive of which variables. Clearly the data points to leadership styles that are more worker satisfying, motivating, and effective in obtaining organizational goals and objectives. The participants in this study clearly established the preference for leaders who are energetic, gave them confidence, and offered a positive reward.

This research study provided empirical data to support the concept that a combination of the transformational leadership style factors (Idealized Influence (attributed), Idealized Influence (behavioral) and Inspirational Motivation) increased a subordinate's job satisfaction, organizational commitment and job empowerment. Clearly the transactional leadership style factor (Management-by-Exception (Passive) and laissez-faire leadership style were identified as a negative significant predictor of job satisfaction, organizational commitment and job empowerment. In today's chaotic healthcare work environments, it is vital that leaders take an active role in addressing problems, making critical decisions, and give overall direction.

It is pertinent that healthcare leaders create a structure of methods and processes that give guidance, offer support, and allow self-monitoring of subordinate performances. In turn, staff members will view their leaders as effective, which makes for an increase in loyalty and confidence. By creating such an organizational culture, all staff members can be proactive (versus reactive) in maintaining a healthy work environment that generates organizational commitment, job satisfaction and job empowerment.

Recommendations

The findings of this research study will be helpful to other students and researchers of healthcare administration. In furthering the field of leadership research, the following recommendations are given:

1. Further investigation is warranted on the leadership styles of hospital clinical leaders in other clinical settings (outside of hospital), to evaluate their impact on the job satisfaction, organizational commitment and empowerment of their subordinates.
2. Further analysis of Bass's constructs of transformational, transactional, laissez-faire can be explored to a higher degree.
3. By adding the gender of the clinical hospital leader to the study, it would warrant further analysis of what leadership styles are preferred by which gender.
4. Further investigation of geographic regions. One of the limitations of this study was low response rate of the participants per region.

5. Since these findings are specifically in relation to nurses in management positions (in a hospital setting), they may prove to be beneficial to nurses in management positions in other healthcare settings.
6. Leadership styles of other non-clinical leaders in a healthcare setting should be conducted to provide additional information on the impact of their leadership behaviors on their subordinates' job satisfaction, organizational commitment and empowerment.
7. Further investigations of hospital clinical leaders performing self-rating surveys and the perceived rating surveys of nurses in management positions, could provide further insights for further research.
8. Further research on whether higher levels of organizational commitment, job satisfaction and organizational commitment lead to higher levels of patient satisfaction (customer satisfaction).

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APPENDIX A. CONCEPTUAL FRAMEWORK

CONCEPTUAL MODEL

A STUDY ON THE RELATIONSHIP BETWEEN PERCEIVED LEADERSHIP STYLES OF HOSPITAL CLINICAL
AND PERCEIVED EMPOWERMENT, ORGANIZATIONAL COMMITMENT, AND JOB SATISFACTION OF
SUBORDINATE HOSPITAL NURSES IN A MANAGEMENT POSITION

INDEPENDENT VARIABLES

Hospital Clinical Leaders
Measuring

Perceived Leadership Styles
> Transformational
> Transactional
> Laissez-faire

*Multifactor Leadership Questionnaire
(MLQ) Form 5x Short (revised)*

INTERVENING VARIABLES

Personal Demographics
Measuring

Personal Demographics
of Nurse Managers
> age
> gender
> educational background
> years at current position
> state location of employment
> years in field
> salary range
> current title

Demographic Questionnaire

DEPENDENT VARIABLES

Nurse Managers
Measuring

Job Satisfaction
> intrinsic
> extrinsic
*Mohrman-Cooke-Mohrman Job Satisfaction Scale
(MCMJSS)*

Empowerment
> reciprocity
> synergy
> ownership
Reciprocal Empowerment Scale (RES)

Organizational Commitment
Organizational Commitment Questionnaire (OCQ)

APPENDIX B. MLQ 5x SCALE AND MEAN SCORE BY REGION SUMMARY

Table 12 MLQ 5x Scale and Mean Score by Region Summary									
	New England	Mid Atlantic	East North	West North	South Atlantic	East South	West South	Mountain	Pacific
		Central	Central	Central		Central	Central		
<i>Transformational</i>									
Inspirational Motivation	3.75	4.20	4.17	4.01	3.96	3.86	4.12	4.07	3.70
<i>Transactional</i>									
Contingent Reward	2.41	2.83	2.78	2.61	2.58	2.75	2.73	2.46	2.50
<i>Non-Leadership</i>									
Laissez Faire	1.37	0.71	0.65	1.06	1.09	0.83	0.85	0.68	1.04

APPENDIX C. MULTIFACTOR LEADERSHIP NORM AND/OR BASELINE

Table 13 Drs. Bass and Avolio established Multifactor Leadership norm and/or baseline		
<i>Scale</i>	<i>Nursing Leadership Mean</i>	<i>Bass-Avolio Norms Mean</i>
<i>Transformational</i>		
Idealized Influence (Attributed)	2.81	2.97
Idealized Influence (Behavioral)	2.84	2.75
Inspirational Motivation	2.98	2.97
Intellectual Stimulation	2.37	2.78
Individual Consideration	2.42	2.66
<i>Transactional</i>		
Contingent Reward	2.67	2.88
Management-by-Exception (Active)	1.59	1.62
Management-by-Exception (Passive)	1.13	1.00
<i>Non-Leadership</i>		
Laissez Faire	0.91	0.64
<i>Outcomes</i>		
Extra Effort	2.53	2.78
Effectiveness	2.73	3.06
Satisfaction	2.75	3.11

APPENDIX D. MLQ 5x SCALE AND MEAN SCORE BY REGION

Table 14	MLQ 5x Scale and Mean Score by Region								
	New England	Mid Atlantic Central	East North Central	West North Central	South Atlantic	East South Central	West South Central	Mountain	Pacific
<i>Transformational</i>									
Idealized Influence (Attributed)	2.48	1.64	2.01	2.09	1.79	2.02	2.33	2.02	1.11
Idealized Influence (Behavioral)	2.58	3.09	3.07	2.95	2.84	2.69	2.98	2.89	2.63
Inspirational Motivation	3.75	4.20	4.17	4.01	3.96	3.86	4.12	4.07	3.70
Intellectual Stimulation	2.25	2.53	2.46	2.41	2.34	2.41	2.71	2.61	2.13
Individual Consideration	2.31	2.68	2.67	2.40	2.38	2.02	2.47	2.58	2.26
<i>Transactional</i>									
Contingent Reward	2.41	2.83	2.78	2.61	2.58	2.75	2.73	2.46	2.50
Management-by-Exception (Active)	1.62	1.53	1.39	1.53	1.63	1.55	1.92	1.16	1.78
Management-by-Exception (Passive)	1.54	1.05	0.99	1.10	1.26	1.24	1.10	0.78	1.27
<i>Non-Leadership</i>									
Laissez Faire	1.37	0.71	0.65	1.06	1.09	0.83	0.85	0.68	1.04
<i>Outcomes</i>									
Extra Effort	2.33	2.75	2.91	2.70	2.40	2.44	2.89	2.50	2.23
Effectiveness	2.54	2.97	2.95	2.77	2.74	2.78	2.33	2.66	2.62
Satisfaction	2.53	2.72	2.97	2.97	2.65	2.75	2.95	2.85	2.61

APPENDIX E. BIVARIANTE CORRELATION GRAPH

Table 15 Bivariate Correlation Graph of Leadership Styles and Demographic Variables

	Age	Gender	Education	Salary	Position	Years in Position	Years in Nursing	Transformational	Transactional
Age									
Pearson Correlation	1	.474**	.846**	.652**	.912**	.862**	.903**	-.538*	-.888**
Sig, (2-tailed)		.000	.000	.000	.000	.000	.000	.014	.000
N	372	369	371	372	372	372	372	372	372
Gender									
Pearson Correlation		1	.551**	.077	.432**	.614**	.226**	.a	.a
Sig, (2-tailed)			.000	.138	.000	.000	.000	.000	.000
N		369	369	369	369	369	369	369	369
Education									
Pearson Correlation			1	.615**	.798**	.842**	.702**	-.148	-.873**
Sig, (2-tailed)				.000	.000	.000	.000	.534	.000
N			371	371	371	371	371	371	371
Salary									
Pearson Correlation				1	.508**	.370**	.673**	-.273	-.754**
Sig, (2-tailed)					.000	.000	.000	.244	.005
N				372	372	372	372	372	372
Position									
Pearson Correlation					1	.860**	.873**	-.713	.a
Sig, (2-tailed)						.000	.000	.000	.000
N					373	372	373	373	373
Years in Position									
Pearson Correlation						1	.738**	.a	.a
Sig, (2-tailed)							.000	.000	.000
N						372	372	372	372
Years in Nursing									
Pearson Correlation							1	-.347	-.677*
Sig, (2-tailed)								.134	.016
N							373	373	373
Transformational									
Pearson Correlation								1	-.328
Sig, (2-tailed)									.297
N								373	373
Transactional									
Pearson Correlation									1
Sig, (2-tailed)									
N									373

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

a. Cannot be computed because at least one of the variables is constant

APPENDIX F. MEAN, STANDARD DEVIATION AND VARIANCE FOR
MCMJSS, OC, & RES

Table 16 Mohrman-Cooke-Mohrman Job Satisfaction Scale by Mean, Standard Deviation and Variance

JSS	M	SD	V
Internal Satisfaction	3.720	1.414	2.000
External Satisfaction	3.715	1.914	3.667
Total Satisfaction	3.717	1.581	2.500

Table 17 Organizational Commitment Questionnaire Factors by Mean, Standard Deviation and Variance

	M	SD	V
Total	4.59	2.19	3.02

Table 18 Reciprocal Empowerment Scale by Mean, Standard Deviation and Variance

Subscale	M	SD	V
Reciprocity	3.694	1.806	3.263
Ownership	3.703	1.505	2.267
Synergy	3.698	1.328	1.764

APPENDIX G. REGRESSION MODEL OF THE MLQ FACTORS
AND JOB SATISFACTION SCALE

Table 19 Regression Model of the MLQ Factors & Job Satisfaction Scale
by Variation Analysis of R square, F Ratio and Beta

Factor	R Square	F	Beta
Idealized Influence (Attributed)	.719	5.128	-.848
Idealized Influence (Behavioral)	.211	.534	-.459
Inspirational Motivation	.009	.019	-.097
Intellectual Stimulation	.623	3.309	.789
Individual Consideration	.053	.113	-.231
Contingent Reward	.383	1.240	-.619
Management-by-Exception (Active)	.462	1.721	.680
Management-by-Exception (Passive)	.584	2.810	.764
Laissez Faire	.977	83.196	-.988

APPENDIX H. REGRESSION MODEL OF THE MLQ FACTORS
AND ORGANIZATIONAL COMMITMENT

Table 20 Regression Model of the MLQ Factors & Organizational Commitment
by Variation Analysis of R square, F Ratio and Beta

Factor	R Square	F	Beta
Idealized Influence (Attributed)	.197	.489	-.443
Idealized Influence (Behavioral)	.897	17.336	-.947
Inspirational Motivation	.394	1.302	.628
Intellectual Stimulation	.143	.333	.378
Individual Consideration	.003	.005	.051
Contingent Reward	.089	.196	.298
Management-by-Exception (Active)	.956	43.613	.978
Management-by-Exception (Passive)	.496	1.968	.704
Laissez Faire	.418	1.436	-.647

APPENDIX I. REGRESSION MODEL OF THE MLQ FACTORS
AND EMPOWERMENT

Table 21 Regression Model of the MLQ Factors & Empowerment
by Variation Analysis of R square, F Ratio and Beta

Factor	R Square	F	Beta
Idealized Influence (Attributed)	.310	.898	.557
Idealized Influence (Behavioral)	.259	.700	-.509
Inspirational Motivation	.614	3.187	.784
Intellectual Stimulation	.413	1.410	-.643
Individual Consideration	.707	4.833	-.841
Contingent Reward	.199	.498	.446
Management-by-Exception (Active)	.004	.007	.059
Management-by-Exception (Passive)	.336	1.013	.580
Laissez Faire	.004	.008	-.063

APPENDIX J. REGIONAL PARTICIPATION

Table 22 Regional Participation

New England

Connecticut	4	18.18%
Maine	2	9.09%
Massachusetts	9	36.36%
New Hampshire	4	18.18%
Rhode Island	1	4.55%
Vermont	3	13.64%
Total	23	

Regional 6.01%

Mid Atlantic

New Jersey	11	19.64%
New York	22	39.29%
Pennsylvania	23	41.07%
Total	56	

Regional 15.30%

East North Central

Indiana	7	11.11%
Illinois	18	28.57%
Michigan	9	14.29%
Ohio	22	33.33%
Wisconsin	8	12.70%
Total	64	

Regional 17.21%

West North Central

Iowa	14	32.56%
Kansas	5	11.63%
Minnesota	5	11.63%
Missouri	13	30.23%
Nebraska	4	9.30%
North Dakota	0	0.00%
South Dakota	2	4.65%
Total	43	

Regional 11.75%

South Atlantic

Delaware	3	4.00%
District of Columbia	4	5.33%
Florida	15	20.00%
Georgia	17	21.33%
Maryland	11	14.67%
North Carolina	14	18.67%
South Carolina	1	1.33%
Virginia	8	10.67%

East South Central

Alabama	0	0.00%
Kentucky	6	28.57%
Mississippi	4	19.05%
Tennessee	12	52.38%
Total	22	

Regional 5.74%

West South Central

Arkansas	3	10.00%
Louisiana	4	13.33%
Oklahoma	4	13.33%
Texas	19	63.33%
Total	30	

Regional 8.20%

Mountain

Arizona	8	30.77%
Colorado	6	23.08%
Idaho	3	11.54%
New Mexico	1	3.85%
Montana	1	3.85%
Utah	1	3.85%
Nevada	5	19.23%
Wyoming	1	3.85%
Total	26	

Regional 7.10%

Pacific

Alaska	3	10.00%
California	14	46.67%
Hawaii	0	0.00%
Oregon	4	13.33%
Washington	9	30.00%
Total	30	

Regional 8.20%

Total	West Virginia	3	4.00%
	Regional	76	20.49%