

LIBERTY UNIVERSITY
JOHN W. RAWLINGS SCHOOL OF DIVINITY

UNDERSTANDING CORRELATION BETWEEN CHRISTIAN AND NON-CHRISTIAN
SERVANT ORGANIZATIONAL LEADERSHIP AND PRE-LICENSURE
BACCALAUREATE NURSING STUDENT CARING DIMENSIONS

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by

Scott Jeffery Spiridigliozzi

Liberty University, Lynchburg, VA

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ABSTRACT

The purpose of this study was to understand if a relationship exists between Midwest baccalaureate Christian and Non-Christian nursing programs' organizational servant leadership characteristics and pre-licensure baccalaureate nursing students' caring dimensions. This study utilized a quantitative approach to a correlational design using survey methodology for data collection. The first sample consisted of four Christian pre-licensure baccalaureate nursing programs' Faculty/Staff, Supervisors, and the nursing program's Top Leadership, along with their pre-licensure baccalaureate nursing students. The second sample consisted of three Non-Christian pre-licensure baccalaureate nursing programs' Faculty/Staff, Supervisor, and nursing program Top Leadership and their pre-licensure baccalaureate nursing students. Many nursing studies reveal a persistent culture of incivility that begins in academia and continues into the graduate nurse's bedside practice, where nurses are known to "eat their young" (Palumbo, 2018, p. 144; Katz, 2014, p. 1-2). Incivility is a problem in nursing because a toxic environment can adversely affect patient care. This study sought to discern whether servant organizational leadership offered a means to resolve incivility in nursing by producing nursing students who care more. Therefore, this study measured whether servant organizational leadership theory explained the relationship between a Christian and Non-Christian servant leadership organization as measured by the servant Organizational Leadership Assessment - Standard Version (OLA-SV) instrument and the pre-licensure baccalaureate nursing student's caring dimensions as measured by the Caring Dimensions Inventory - 25 (CDI-25) instrument.

Keywords: Nurse educator, servant leadership, nursing student, caring, calling, incivility, theology of nursing

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Dedication

This dissertation is dedicated to my beautiful and loving wife, Gail, who has stuck with me on this journey through thick and thin. Your loving support has given me the strength to endure the hard times we faced. We faithfully stood our ground when the devil threw everything he had at us and emerged, triumphantly, closer to God and each other. Thank you for everything, Baby. I love you so much!

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Thank you, heavenly Father, for loving me unconditionally. Thank you for impressing upon my heart Your will to begin a teaching ministry in nursing. Thank you for your work on the Cross that wiped away my sins so I may live with you in heaven for eternity. In the meantime, though, we have work to do!

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Table of Contents

ABSTRACT	3
Dedication.....	5
Acknowledgments	6
List of Tables	13
List of Figures.....	14
List of Abbreviations	15
CHAPTER ONE: RESEARCH CONCERN.....	16
Introduction	16
Background to the Problem	17
Historical Perspective on Nursing	18
Theological Perspective on Nursing.....	19
Sociological Perspective on Nursing.....	20
Theoretical Perspective on Nursing.....	21
Statement of the Problem	22
Purpose Statement	23
Research Questions	24
Assumptions and Delimitations.....	24
Research Assumptions.....	25
Delimitations of the Research Design	25
Definition of Terms	26
Significance of the Study.....	27
Summary of the Design	29

CHAPTER TWO: LITERATURE REVIEW	31
Overview	31
Theological Framework for the Study.....	31
Theology of Servant Leadership	32
A Biblical Definition of Servant Leadership.....	33
Biblical Worldview of Servant Leadership	34
The Apostle Paul as Servant Leader.....	35
Jesus Christ as Servant Leader	36
Theology of Nurse as Servant Teacher	38
The Nurse Educator as Servant Teacher.....	39
Theology of Caring.....	40
A Caring Theology in Nursing	40
Made in the Image of God.....	41
Theology of Education in Nursing	42
Theoretical Framework for the Study.....	43
Theory of Servant Leadership	43
Perspectives on Leadership	45
An Abridged Evolution of Leadership Theory.....	46
Servant Leadership In Nursing Education.....	49
Definition of Caring in Nursing	51
Applications of Nursing Theory.....	51
Caring Aspects in Nursing.....	53
Ethical Considerations in Nursing.....	54

Related Literature	54
The Male Nursing Student.....	57
The Female Nursing Student	60
Nursing as a Vocation or Calling	63
Incivility in Nursing	64
Rationale for Study and Gap in the Literature.....	65
Rationale for Study.....	65
Gap in the Literature.....	68
Profile of the Current Study	70
CHAPTER THREE: RESEARCH METHODOLOGY	72
Research Design Synopsis.....	72
The Problem	72
Purpose Statement	75
Research Questions and Hypotheses	76
Research Design and Methodology.....	76
Population(s).....	78
Sampling Procedures	81
Limits of Generalization.....	86
Ethical Considerations.....	87
Instrumentation.....	89
Validity	92
Reliability	94
Research Procedures.....	94

Data Analysis and Statistical Procedures	96
Data Analysis.....	97
Statistical Procedures.....	103
Chapter Summary	104
CHAPTER FOUR: FINDINGS	105
Overview	105
Research Questions	106
Hypotheses	106
Compilation Protocol and Measures	106
Protocol.....	107
Descriptive Statistical Measures.....	108
Demographic and Sample Data	109
Data Analysis and Findings.....	118
Research Question One	119
Research Question Two.....	122
Research Question Three.....	125
Evaluation of the Research Design.....	132
CHAPTER FIVE: CONCLUSIONS	135
Overview	135
Research Purpose.....	135
Research Questions	135
Research Conclusions, Implications, and Applications	136
Research Conclusion One.....	137

Research Conclusion Two	139
Research Conclusion Three	140
Research Implications	143
Research Applications	145
Research Limitations	146
Further Research.....	146
Summary.....	148
REFERENCES	150
APPENDIX A -OLA ORGANIZATIONAL LEADERSHIP ASSESSMENT – STANDARD VERSION (OLA-SV)	161
APPENDIX B -REQUEST TO USE THE OLA INSTRUMENT.....	166
APPENDIX C-PERMISSION TO USE THE OLA INSTRUMENT	167
APPENDIX D-THE OLA SET UP	168
APPENDIX E-EMAIL WITH MICROSOFT EXCEL RAW DATA ATTACHMENT.....	171
APPENDIX F-CARING DIMENSIONS INVENTORY – 25 INSTRUMENT	172
APPENDIX G-PERMISSION TO CONDUCT RESEARCH EMAIL	174
APPENDIX H-LIBERTY UNIVERSITY IRB APPROVAL LETTER.....	175
APPENDIX I-UNIVERSITY D, IRB APPROVAL EMAIL	177
APPENDIX J-RECRUITMENT EMAIL	178
APPENDIX K-CONSENT FORM	180

List of Tables

Table 1. CDI-25 Participation Demographic Data.....	100
Table 2. OLA-SV Participant Demographic Data.....	101
Table 3. Demographic Characteristics of the OLA-SV Respondents by University.....	102
Table 4. Survey Response Data.....	113
Table 5. Completed Samples Returned vs. Bootstrap Datasets.....	118
Table 6. Nursing Student Perception of Caring Dimensions (CDI-25) by Nursing Program...	119
Table 7. Employee Perception of Servant Organizational Leadership (OLA-SV) by Nursing Program.....	119
Table 8. Christian vs. Non-Christian Nursing Program Measures of Central Tendencies.....	121
Table 9. Twelve Core CDI-25 Statements Constituting Nurse Caring.....	125
Table 10. Top-Ranking CDI-25 Caring Statements & Corresponding OLA-SV Construct Statements.....	126
Table 11. Christian, Non-Christian SOL Construct Means, and Nursing Student Caring Dimension Mean Scores.....	128
Table 12. Multiple Regression of the Six Top-Ranked OLA-SV Constructs & Corresponding Items in the CDI-25.....	130
Table 13. Correlation Between Christian Nursing Program OLA-SV Construct Items & Corresponding Christian Student Caring Dimensions.....	142
Table 14. Correlation Between Non-Christian Nursing Program OLA-SV Construct Items & Corresponding Non-Christian Student Caring Dimensions.....	143

List of Figures

Figure 1. Christian Universities Servant Organizational Leadership Nursing Student Performance on CDI-25.....	122
Figure 2. Non-Christian Universities Negative-Paternalistic Organizational Leadership Performance on CDI-25.....	124
Figure 3. Linear Regression Between OLA Constructs & CDI Caring Dimension Means at Christian Nursing Programs.....	127
Figure 4. Linear Regression Between OLA Constructs & CDI Caring Dimension Means at Non-Christian Nursing Programs.....	128
Figure 5. Christian & Non-Christian Nursing Programs' Servant OLA Construct Means and Nursing Student CDI-25 Caring Dimensions Means.....	129

List of Abbreviations

American Association of Colleges of Nursing (AACN)

Analysis of Variance (ANOVA)

Builds Community (BC)

Caring Dimensions Inventory – 25 (CDI-25)

Confidence Interval (CI)

Develops People (DP)

Displays Authenticity (DA)

Emotional Intelligence (EI)

Institutional Review Board (IRB)

Liberty University (LU)

Life Application Study Bible, New International Version (LASB, NIV)

Lower Extreme (LE)

Margin of Error (*E*)

National League of Nurses (NLN)

Organizational Leadership Assessment (OLA)

Provides Leadership (PL)

Shares Leadership (SL)

Servant Organizational Leadership (SOL)

Servant Organizational Leadership Assessment (SOLA)

Servant Organizational Leadership Assessment – Standard Version (OLA-SV)

Upper Extreme (UE)

Values People (VP)

CHAPTER ONE: RESEARCH CONCERN

Introduction

Educating nursing students about bedside care in today's healthcare environment is increasingly difficult (Joseph & Huber, 2015). Part of the problem is the leadership vision that has replaced nursing's Christian values, established by Florence Nightingale, over the past three to four decades with healthcare's new values – economic gains over patient outcomes (Paulson, 2004, p. 359). Under such leadership, Christian caring has become antithetical to the present austere and demanding culture where nurses and patients suffer under strain (Donley, 2005). Numerous studies have shown that this leadership model distracts nurses from their care at the patient's bedside (Paulson, 2004, p. 359; Ackerman, 2019, p. 572; Shelly & Miller, 2006, p. 23).

Therefore, nurses are experiencing burnout, and patient care is suffering to the point of causing adverse patient outcomes (Amadeo, 2008; Ackerman, 2019; Serber, 2014; Shelly & Miller, 2006). On a personal level, these inefficiencies and distractions cause nurses to question their calling to practice and the value of the service they provide for the patient. These problems are causing nurses to act out with uncivil behaviors (Sokol, 2004; Milesky et al., 2015; Emerson, 2017). Also, nursing leadership has adopted a Non-Christian medical model of leadership that emphasizes science and diagnoses over nursing's Christian values of selfless caring and commitment to the patient (Serber, 2014).

Due to nursing's leadership direction away from a civil leadership model toward the uncivil, this researcher sought to determine whether Servant Organizational Leadership in baccalaureate nursing programs could effectively improve their pre-licensure baccalaureate nursing students' caring dimensions. This research was vital because it showed that when exposed to the nursing program's servant leadership milieu, or lack thereof, as measured by

Laub's Servant Organizational Leadership – Standard Version (OLA-SV) instrument, the nursing students were more likely or less likely to agree or strongly agree with the caring dimensions, as measured on Watson and Lea's Caring Dimensions Inventory - 25 (CDI-25) instrument; the nursing students may or may not have embraced the servant leadership model of care to improve the quality of patient care; and as a result, the student nurse may or may not have been in a position to begin to change the uncivil nursing culture in their practice and beyond (White, 2015).

Chapter One discusses nursing's rich historical background, including its caring culture that stems from a Christian worldview. Scripture marked Jesus' servant leadership style with an emphasis on caring. This study examined how nursing, from a theological approach, can fulfill one's calling to care. This study investigated the sociological aspects of nurse educators' ability to influence their pre-licensure baccalaureate nursing students' identity as caring servants. Finally, the theoretical framework of servant leadership was used to investigate and understand servant organizational leadership in baccalaureate nursing schools and the relationship with the pre-licensure baccalaureate nursing students caring dimensions.

Background to the Problem

Since the "Lady with the Lamp" made rounds caring for wounded soldiers during the Crimean War (1853-1856), Florence Nightingale established modern nursing as a respectable vocation based on Christian values. Nursing has earned a place in history as a profession of caring individuals who selflessly serve their patients' needs above all else. With the advent of the medical business model of leadership, today's nursing culture is experiencing incivility between nurses and nurses and other healthcare professionals. The disrespect ultimately reaches the bedside and negatively affects patient care. This research attempted to understand whether

servant organizational leadership in the Midwestern pre-licensure baccalaureate nursing program can produce pre-licensure baccalaureate students who are more caring and desire to change the culture of incivility in their areas and beyond.

Historical Perspective on Nursing

With a long-established history of selfless care, the past 30 to 40 years have transformed the traditional nursing model into a more businesslike, customer-oriented medical model of care delivery (Donley, 2005; Paulson, 2004, p. 359; Ackerman, 2019, p. 572; Shelly & Miller, 2006, p. 23). Nurses complain that streamlining the business operation to enhance the bottom line overburdens them with tasks that have nothing to do with patient care, leaving the patients to suffer the consequences. Ackerman (2019) explains, “Nurses are torn between the economic direction of the organization and the needs of the patient and their family” (p. 572). As a result of being over-tasked, frustrated nurses are lashing out at one another and their patients with uncivil behaviors or leaving the profession altogether at a time when nurses are desperately needed (Hayne et al., 2020; Serber, 2014; Boychuk-Duchscher, 2008; Palumbo, 2018; Ackerman, 2019; Paulson, 2004).

Exposing students to the servant leadership model early in their education may foster a more caring approach to patient care by empowering nurses through shared leadership and knowledge creation, leading to an improved nursing culture (Sendjaya & Sarros, 2002, p. 57). Likewise, Rai and Prakash (2012) contend that there is a process through which “servant leadership influences knowledge creation where the importance of interactive influence process between servant leaders and followers and cultivating caring relationships as the principal mediating mechanism can influence knowledge creation” (p. 79).

Theological Perspective on Nursing

Nurses and doctors work hand in hand to care for the ill and infirm in all practice settings. However, they are two distinct disciplines with differing approaches to caring for the sick (Shelly & Miller, 2006, p. 16). So, for nursing to adopt the medical approach to care is a move away from what makes it fundamentally distinct and down a path of conflicting values.

Western medicine evolved from the Greek tradition that viewed the body as an object in a scientific dimension. On the other hand, the nursing profession was established from the Christian tradition viewing humankind as God's image-bearers. Nursing affirms each person's value while acknowledging that the body is the "temple of the Holy Spirit" (*Life Application Study Bible, New International Version, 1973/2005, 1 Corinthians 3:16*). Where medicine is more interested in curing an unhealthy, diseased body, nursing cares for the whole person, i.e., the body, psychosocial, and spiritual dimensions (Shelly & Miller, 2006). In other words, by nature, nursing is more of a *relational* and ministerial endeavor than medicine.

Indeed, nursing's strength lies in the fact that they minister to the needy, like Jesus did, in service to a community of God's image-bearers, for the glory of God. Shelly and Miller (2006) echo that strong Christian worldview sentiment when they write,

To be created in the image of God means that we must look to God for our meaning, purpose, and direction. It also makes us thinking, feeling, willing, relational creatures who reflect these attributes of our Creator. In order to understand ourselves in any depth, we must first look to God to know what he intended us to be. (p. 77)

One of nursing's main attributes is caring. Grigsby and Erickson-Megel (1995) acknowledged caring's centrality to the nursing profession by stating, "Central to nursing practice today is the theme of caring" (p. 411). This study investigated whether a servant organizational leadership baccalaureate nursing program can produce more caring pre-licensure baccalaureate nursing students through their exposure to servant leadership. Nursing

organizations, nursing students, entire communities, and patients stand to benefit from an improved nursing culture facilitated by servant-led nursing relationships.

Modern nursing education would be well served if it found itself rooted in its historical identity as a faith-based vocation that looks to the Lord for the strength and wisdom to train those who can help those suffering from an affliction. Christian nurses care for their patients from the Scripture-based theological directive, “You shall serve the Lord your God, and He will bless your bread and your water, and I will take sickness away from among you” (*LASB, NIV*, 1973/2005, Exodus 23:25).

Sociological Perspective on Nursing

Nursing’s roots run deep in religion and have been described by many over the years as a calling to ministry or religious pursuit. When questioned why they entered the profession, many nursing students will answer that they are answering the call to care for those less fortunate than they are (Widerquist, 1992; Prater & McEwen, 2006). Emerson (2017) asserts that “During the Protestant Reformation, the conceptualization of calling elevated all work to a divine offering of oneself to God” (p. 390). Emerson also discussed a modern, secularized version of calling in nursing today that exists in a societal context (Emerson, 2017). Prater and McEwen’s (2006) study found that “two-thirds of nursing students believe they were ‘called’ to nursing” (p. 63).

Building one’s nursing identity is a crucial development for the beginner nurse. This study investigated the nurse educator’s servant leadership influence on the student nurse’s indoctrination and identity development as caring servants. Walker et al. (2014) discussed five key elements that enabled “the development of the nursing student’s professional identity: positive role models, belonging, peer support, critical thinking abilities, and confidence” (p. 109).

Numerous studies have shown that the more caring the nurse is, the more beneficial the healthcare work environment and patient outcomes. Further, nursing needs these qualities to overcome the current incivility that exists in the profession. This study explored whether the organization utilizing the servant leader theory will develop pre-licensure baccalaureate student nurses who are more caring toward their fellow nurses and patients.

Theoretical Perspective on Nursing

This study intended to show how servant leadership in nursing education might be the key to overcoming the uncivil culture prevalent in nursing (Robinson, 2009, p. 1). A servant organizational leadership nursing program may directly influence the pre-licensure baccalaureate nursing students' caring behaviors through nurse educator servant behaviors. In that environment, the student begins to identify with those servant characteristics displayed by their nurse educators. In turn, they will exhibit the same attributes toward fellow nurses and patients in their practices (Robinson, 2009, p. 1; Patterson, 2003, p. 26). In her dissertation, Patterson (2003) noted this phenomenon when she observed, "The servant leader sets the organizational climate by showing others how to serve. Thus, they [servant teachers] model service through their behaviors and styles, so that they are leading by doing, which inspires and motivates followers" (p. 26).

Robert Greenleaf (1977) was the first to coin the phrase servant leadership. He described a servant leader as someone who "is servant first. It begins with the natural feeling that one wants to serve, to serve first" (p. 15). Greenleaf made some astute observations about how servant leadership can impact those following the servant leader. Greenleaf (1977), whose observations may be extrapolated to pre-licensure baccalaureate nursing students enrolled in servant organizational leadership programs, said,

The difference manifests itself in the care taken by the servant, first to make sure that other people's highest priority needs are being served. The best test, and difficult to administer, is: do those served grow as persons; do they, while being served, become healthier, wiser, freer, more autonomous, and more likely themselves to become servants? And, what is the effect on the least privileged in society; will they benefit, or, at least, will they not be further deprived? (p. 15)

Spears gleaned ten servant leadership characteristics from Greenleaf's work that can also be translated to the education context. Specifically, Hays' (2008) work introduced the "Servant Teacher" concept, based on Spear's ten servant leadership characteristics, when he identified the following ten servant leader attributes,

1. Listening
2. Empathy
3. Healing
4. Awareness
5. Persuasion
6. Conceptualizing
7. Foresight
8. Stewardship
9. Commitment to the growth of people
10. Building community (pp. 123-129)

Statement of the Problem

The problem with nursing today is a diminished level of care caused by an academic and healthcare system that abandoned the traditional Christian nursing values and adopted the business/medical model more geared toward profits than patients (Paulson, 2004, p. 359; Ackerman, 2019, p. 572; Shelly & Miller, 2006, p. 23). These non-nursing values being instilled into the students are thought by many to lead to uncaring and ill-prepared graduate nurses needing help to facilitate holistic healing (Shelly & Miller, 2006, p. 23). Katz (2014) noted that "65 percent of nurses surveyed by *American Nurse Today* have witnessed some form of nursing incivility (p. 1). Katz (2014) goes on to say that commonly, "nurse bullying is the result of ineffective communication and coping skills in a high stakes environment" where hazing and

uncivil behaviors are perpetrated upon young nurses by the seasoned nurses (p. 2). This phenomenon is known in the profession as older nurses “eating their young” (Palumbo, 2018, p. 144; Katz, 2014, p. 1-2). The literature shows that the nurses’ working environment becomes more civil when servant leadership is practiced. When a patient is cared for by a nurse who cares, patient outcomes are better (Dameron, 2011, p. 69).

Van Brummelen (2004) asserts that graduate nurses taught by Christian servant teachers move on into their professions with a greater sense of community and empathy while placing the common good ahead of their self-interests, stating, “They help build a school community united in passionately advancing teaching and learning based on, and that affirms a biblical worldview and lifestyle” (p. 20). Therefore, this study measured whether servant organizational leadership behaviors in Christian and Non-Christian baccalaureate nursing programs produced more caring nurses who fostered a more civil nursing environment. This author would assume that after graduation, the new nurses who move on into the clinical arena to practice those learned servant leader attributes will naturally create a more caring and civil work environment resulting in improved patient outcomes.

Purpose Statement

The purpose of this quantitative correlational study was to understand if a relationship exists between Christian and Non-Christian baccalaureate nursing programs’ servant organizational leadership characteristics in the Midwest region of the United States and the effect on their pre-licensure baccalaureate nursing students’ caring dimensions.

The principles of Christian servant leadership will be the guiding theory for this study. Kirkpatrick (1988) defined the Christian servant leader as,

A man or woman who has received a call from God to serve Him is cleansed and commissioned by God and is empowered and guided by the Holy Spirit. The marks of a

servant leader are humility, integrity, and faithfulness to the Word of God. Jesus Christ is the model for all servant leadership acts, attitudes, and attributes. (p. 11)

Leininger (1988) described caring as “the central and unifying domain for the body of knowledge and practice in nursing” (p. 3) and called for a better understanding of caring through evidence-based research to advance the profession and provide better outcomes for patients. This study investigated whether the relationship between servant leadership, introduced early in the nurse’s education, leads to nurses who care more for God and their communities. Shelly and Miller (1999) believe that,

Nursing cannot work toward the goal of health without including the clear proclamation of the gospel and providing physical care with a servant attitude. Nursing as a vocation, or *calling*, from God, must return to its roots in the church and Christian faith to work toward the goal of true health. Furthermore, if we hope to maintain a strong Christian worldview in nursing, our faith must be nurtured in a Christian community and informed by a clear theology. True nursing cannot be divorced from the Christian story. (pp. 24-25)

Research Questions

RQ1. What relationship, if any, exists between the Christian servant organizational leadership nursing program’s level of servant leadership and their pre-licensure baccalaureate nursing students caring dimensions?

RQ2. What relationship, if any, exists between the Non-Christian servant organizational leadership nursing program’s level of servant leadership and their pre-licensure baccalaureate nursing students caring dimensions?

RQ3. What relationship, if any, exists between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students caring dimensions?

Assumptions and Delimitations

Assumptions are statements about a research study that researchers will consider true, despite being untested scientifically. Usually, assumptions are “embedded in the philosophical base of the framework, study design, and interpretation of the findings” (Burns & Grove, 2005). Delimitations importantly describe what the researcher will not do in the study. They act as boundary lines, and the assumptions are the starting point (Leedy & Ormrod, 2019).

Research Assumptions

The following assumptions apply to this study,

1. All pre-licensure baccalaureate nursing students will have personal perceptions of the value and meaning of their caring dimensions.
2. Assume that the pre-licensure baccalaureate nursing students' clinical practicums may positively and negatively influence the student's caring dimensions and overall satisfaction with the nursing profession.
3. Assume that the pre-licensure baccalaureate nursing students' academic training may negatively and positively influence the student's caring dimensions and overall satisfaction with the nursing profession.
4. Assume that all pre-licensure baccalaureate nursing students know the concept of servant leadership.
5. Assume that not all nursing programs will utilize servant organizational leadership theory and methods.
6. Assume that servant organizational leadership has the potential to increase student nurse caring dimension scores.
7. Assume that a nursing program oriented on servant organizational leadership produces an educator oriented on servant leadership.
8. Assume that servant leadership leads to increased caring dimensions and improves patient outcomes.

Delimitations of the Research Design

The nature of this study among nursing students trained in servant leadership organizations by nurse educators who utilize servant leadership theory may influence its generalizability to other nursing settings and populations. The delimitations of this study are as follows,

1. The study is delimited to the nursing school's perception of and participation in a servant organizational leadership model.

2. The study is delimited to pre-licensure baccalaureate nursing students currently enrolled in resident “brick and mortar” Christian and Non-Christian university baccalaureate nursing programs in the Midwest region of the United States.
3. The study is delimited to the nursing program’s Faculty/Staff, Supervisor, and nursing school Top Leadership’s lack of perception of and participation in the servant organizational leadership model and servant leadership role.
4. The study is delimited to the Midwestern region of the United States baccalaureate nursing programs accredited by the Commission on Collegiate Nursing Education.

Definition of Terms

1. *Academic Incivility*: “Is defined as rude, discourteous speech or behavior that disrupts the teaching-learning environment (Feldman, 2001) and may range from misuse of cell phones and rude and sarcastic comments to threats for actual acts of physical harm” (Clark, 2007).
2. *Bootstrap*: “Bootstrap is a general technique for estimating unknown quantities associated with statistical models used to find standard errors for estimators, confidence intervals for unknown parameters, or p -values for test statistics under a null hypothesis. Thus, the bootstrap is typically used to estimate quantities associated with the sampling distribution of estimators and test statistics” (Boos, 2003).
3. *Calling*: “The terms vocation and calling are often used synonymously and generally refer to a spiritual or divine predisposition to undertake a certain work or occupation” (Prater & McEwen, 2006).
4. *Caring*: Caring is fundamental to quality nursing practice and is an expectation of nurses held by society, patients, and families. A caring nurse is often described as a “good” nurse. Caring is built on a foundation of kindness, empathetic accuracy (I understand), and empathetic concern (I care). Kindness is closely associated with caring” (Lyneham & Levett-Jones, 2016).
5. *Construct*: Refers to the six areas of servant leadership in the OLA model identified in Laub’s original research that developed the OLA Instrument. The six constructs are: Values People, Develops People, Builds Community, Displays Authenticity, Provides Leadership, and Shares Leadership. For this study, the six constructs were paired with a corresponding Caring Dimensions Inventory statement for statistical analysis.
6. *Incivility*: According to Milesky et al. (2015), “incivility is a widespread problem that negatively affects nursing students, faculty members, and clinical nurses. Conflictual behavior leads to toxic work environments that adversely affect patients” (p. 93).

7. *Nursing*: “The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or his recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible” (Henderson, 1966, in Shelley & Miller, 2006, p. 16-17).
8. *Servant leader (Christian)*: A servant leader is a man or woman who has received a call from God to serve Him, is cleansed and commissioned by God, and is empowered and guided by the Holy Spirit. The marks of a servant leader are humility, integrity, and faithfulness to the Word of God. Jesus Christ is the model for all acts, attitudes, and attributes of servant leadership (Kirkpatrick, 1988, p. 11).
9. *Servant leader (Non-Christian)*: According to Robert Greenleaf (2008), a “servant leader is servant first. It begins with the natural feeling that one wants to serve, to serve first” (p. 15).

Significance of the Study

Servant leadership is a timeless concept rooted in religious traditions that have been rediscovered and revealed over the past fifty years (Sendjaya et al., 2008; Robinson, 2009). There are numerous examples in Scripture of Jesus lovingly caring for and healing the people he encountered in His service to the Father. Florence Nightingale’s contribution to nursing was based on her conviction that, in the same way as Jesus, nurses can serve the Holy Father by caring for and healing His people. Therefore, nursing is viewed as a moral and caring profession where remarkable nurses compassionately care for patients physically and spiritually (Wagner & Whaite, 2010).

Nursing is a spiritual endeavor similar to when Moses stood before the burning bush, and God reminded him that he was standing on holy ground in the Lord’s presence. Sister O’Brien (2008) points out in her book *Spirituality in Nursing: Standing on Holy Ground*, “When the nurse clinician, nurse educator, nurse administrator, or nurse researcher stands before a patient, a student, a staff member, or a study participant, God is also present, and the ground on which the nurse is standing is holy” (p. 1). Conversely, Newham et al. (2019) think that when spirituality in

nursing care is devalued, “Failures in compassionate care may arise when caring is reduced to technical tasks; even if those tasks are performed competently, losing the moral, compassionate component of nursing” (p. 106). Due to the nursing profession’s difficult transition to a business economic model, a cultural problem fraught with uncivil behaviors can plague nurses from their formative years in academia through retirement (Luparell, 2011).

Nursing’s hope and challenge is to turn away from the culture of incivility and return to the fundamental [servant] tenets of nursing, i.e., showing love for people and caring for them in the manner Jesus and Florence Nightingale cared for people. The benefit Milesky et al. (2015) emphasized is that there is much to be gained in nursing from civil work cultures, like safer and just working environments and improved patient outcomes (p. 92).

Servant leadership in nursing education holds much promise for improving the nursing culture. Robinson (2009) remarked that the “application of the principles inherent in servant leadership to teaching/learning in nursing education is suggested as a way to produce professional nurses who are willing and able to transform the health care environment to achieve higher levels of quality and safety” (p. 1).

Servant teaching may be the change agent nursing needs to put the profession back on a proper footing. Servant teaching can profoundly transform and inspire student lives and relationships spanning their nursing education and professional practice. Reilly and Spears (2018) described the essence of servant teaching like this,

The essence of teaching and learning captures the noblest aspects of a person’s inner being. Its foundation rests on the conscious giving of self, the creative sharing of one’s knowledge and insights, and the contribution to the growth and development of others. Teaching can enrich the potential of others. The learning process has the energy to transform the capabilities of others so that the lives of all become better and more fulfilled. Teaching transcends the ordinary, empowering all. Through giving, caring, and sharing, effective teachers establish genuine relationships with their students, thereby enabling them to lead more capable and meaningful lives. (p. 57)

The promise of servant teaching lies in recognizing that all nurses are responsible for the continual growth of themselves and others through caring “human connections, compassion, and character development. To grow in the art of nursing, nurses must be willing to address the broken areas of their lives. Accountability for personal growth is achieved through faith, prayer, and healing resources that God makes available” (Moorman, 2015, p. E1).

Summary of the Design

This study utilized a quantitative method with a correlational design that investigated whether a relationship exists between the two variables of interest: the level of servant organizational leadership in four Christian and three Non-Christian baccalaureate nursing programs in the Midwest region of the United States and their pre-licensure baccalaureate students’ caring dimensions. This design will enable the researcher to measure how a difference in the level of servant leadership organization characteristics is correlated with differences in the level of pre-licensure baccalaureate nursing student caring dimensions.

The purposive sample involved a nonprobability sampling technique that permitted this researcher to select the sample from the larger population based on his knowledge and expertise in nursing. Purposive sampling is a data collection method that is only sometimes recommended in quantitative analysis but can be helpful in certain circumstances (Polit & Hungler, 1991, p. 260; Leedy & Ormrod, 2019, p. 178; Burns & Grove, 2005, pp. 354-355).

The two instruments used to gather the data for this study were well-established. The first instrument is Dr. Jim Laub’s (1999) Servant Organizational Leadership Assessment - Standard Version (OLA-SV) (Appendix A), which was designed to let “schools discover how their leadership practices and beliefs impact the different ways people function within the school” (p. 1). Laub has outlined an established process on the official OLA website (www.olagroup.com)

for those researchers desiring to use the OLA-SV instrument. The process aims to keep all the information gathered from studies using his instrument in one central location so he can update the instrument continuously to maintain its validity and reliability. When recruiting individual schools, this researcher asked the nursing programs to provide the subgroups of their employees, i.e., the demographics of their Faculty/Staff, Supervisors, and nursing school Top Leadership. After requesting to use Laub's instrument (Appendix B) and his approval to use the OLA-SV (Appendix C), this researcher then provided Laub, the proprietor of the copyrighted OLA instrument, with said information to set up the school-specific surveys (Appendix D). Once the participants completed the surveys, Dr. Laub received their raw data at his website, olagroup.com, assessed his instrument's performance and then passed along the anonymous raw data for this researcher to use in this study (Appendix E).

The second instrument is Watson and Lea's (1997) Caring Dimensions Inventory-25 (CDI-25) (Appendix F), which was used to understand the pre-licensure baccalaureate student nurses' perceptions of caring (p. 87). The *Qualtrics* web-based survey software gathered the caring dimensions raw data online.

CHAPTER TWO: LITERATURE REVIEW

Overview

Historically, at the core of the nurse-patient relationship, “fidelity is the duty of the nurse to place the patient’s interests above self-interest or the interests of others” (Beauchamp & Childress, 2001, p. 149), and in the foundation of that relationship lies the value of caring (Brilowski & Wendler, 2005, p. 641). It has been this way since Florence Nightingale transformed nursing into a “respected profession combining both ‘art and science’ as well as an opportunity to serve God by serving mankind” (Dossey, 2001, p. 300).

Over the past 30 to 40 years, however, nursing has adopted a business and economic care delivery model that has led to a culture change in the profession (Serber, 2014, p. 15). This culture change has forced the nurse to put the organization’s needs ahead of their patient’s, adversely affecting patient care (Kalb et al., 2012; Meyer & O'Brien-Pallas, 2010).

Because of the present customer-oriented care delivery model, too many nursing students are entering the profession not to serve God and care for the sick, as Nightingale envisioned, but only to earn a decent wage (Shelly & Miller, 2009, pp. 23-24). More specifically, studies show that “academic incivility negatively impacts faculty and student well-being, weakens professional relationships, and impedes effective teaching and learning” beyond the university and into the nursing workforce (Clark & Kenaley, 2011, p. 158). Therefore, this study investigated whether applying servant leadership in the nurse’s training will move the present uncivil culture in a more civil, patient-focused, and caring direction.

Theological Framework for the Study

Jesus’ primary purpose in everything is to serve the Father. He came to this earth totally man and God to serve and care for His people while serving the mission God the Father called

him to do. Wilkes (1998) stated that Jesus “was never self-serving. We see that everything he did was in service to this mission. His mission was to serve not his own will but the will of his Father” (p. 10). The apostle John tells us that Jesus said, “For I have come down from heaven not to do my will but to do the will of him who sent me” (LASB, NIV, 1973/2005, John 6:38). Jesus has been known throughout the ages as the consummate servant leader and Teacher.

This section focuses on the theology of servant leadership and includes a biblical definition. The servant leadership styles of the apostle Paul and Jesus are explored. Also, this section addresses the biblical worldview of servant leadership based on the example of the relationships between an ever-loving and Almighty Triune God. Finally, the implications of Christian servant leadership’s application to servant teaching in nursing and the nurse educator as a servant are presented here.

Theology of Servant Leadership

Christian nursing education combines faith and learning in serving. Esqueda (2014) reports that “Professors who believe in Christ and allow him to become the center of their lives would naturally express their faith in their teaching and academic activities” (p. 93). A biblical worldview is the only way to bridge the gap between faith and learning.

Florence Nightingale, the archetype of modern nursing, defined nursing as being in “charge of the personal health of somebody... [knowing] how to put the constitution in such a state as it will have no disease, or that it will recover from disease” (Shelly & Miller, 1999, p. 240). She saw the people of her era turning away from God and the ethics of being Christian. Nightingale saw it as her mission to elevate nursing from the disreputable and shady occupation that enlisted alcoholics and prostitutes for the service into a respectable profession by demanding

strict adherence to a moral code and formal education. She regarded herself as a Christian called to a nursing ministry by God (Beck, 2010, p. 291).

Her approach to care was groundbreaking. Nightingale's vision for elevating nursing to a profession meant nurses were providing patient-centered nursing care that enriches the patient's spiritual needs while manipulating the patient's environment to optimize the body's ability to heal. Wagner and Whaite (2010) point out that Nightingale perceived the nurse's role and work as,

Having a threefold interest in her work – an intellectual interest in the case, a (much higher) hearty interest in the patient, and a technical (practical) interest in the patient's care and cure. She must look not upon patients as made for nurses but upon nurses as made for patients. (p. 233)

Nursing has abandoned Nightingale's Christian values that have served the profession and patients well since the mid-1800s. Shelly and Miller (2006) said, "The spirit of service and compassion that once motivated nurses have evolved into the professionalism that demands power, status, and appropriate compensation. We see the effects in a health care system controlled by the bottom line" (pp. 15-16).

A Biblical Definition of Servant Leadership

Kirkpatrick's definition of servant leadership is the definition that will guide this study. His definition should be commended for emphasizing the power and intimacy of the caring relationship between God and the servant leader. Kirkpatrick's (1988) definition of Christian servant leadership declares,

A servant is a man or woman who has received a call from God to serve Him, is cleansed and commissioned by God, and is empowered and guided by the Holy Spirit. The marks of a servant leader are humility, integrity, and faithfulness to the Word of God. Jesus Christ is the model for all acts, attitudes, and attributes of servant leadership. (p. 11)

Biblical Worldview of Servant Leadership

The basis of nursing with a biblical worldview begins with the understanding and acknowledgment of an ever-loving and Almighty Triune God consisting of the Father, Son, and Holy Spirit. The Almighty reveals Himself as the incarnate Word of God and the second member of the Godhead, Jesus, through the written Word of Scripture and the creation made in His image – humankind (Esqueda, 2014, p. 94). John’s Gospel declared the authority of God and Scripture when he confirmed,

In the beginning was the Word, and the Word was with God, and the Word was God. He was in the beginning with God. All things came into being through Him, and apart from Him, nothing came into being that has come into being. (LASB, NIV, 1973/2005, John 1:1-3)

The Triune God is the Christian’s example of caring faith in the community. Jesus, the exemplar servant leader, told His followers to share the Gospel and educate others so they might come to faith through the Holy Spirit (LASB, NIV, 1973/2005, Matthew 28:16-20). Therefore, Christian servant teachers are instrumental in telling the story of Jesus’ healing grace and redemption so that others may come to worship Him (Esqueda, 2014, pp. 93-95).

The biblical foundations of leadership throughout the Bible show that Christ led with humility and grace. Guided by the Holy Spirit, Jesus’ followers are called to servant leadership with characteristic humility and love (Patterson, 2016, p. 78). Paul said to the Philippians of Jesus, “Who, being in very nature God, did not consider equality with God something to be used to his advantage; rather, he made himself nothing by taking the very nature of a servant” (LASB, NIV, 1973/2005, Philippians 2:6-7).

Patterson (2017) described the relationship between Jesus and the Christian leader as a stewardship that prioritizes caring service for followers through personal example (p. 81). Matthew recorded the depth of Jesus’ sacrifice for humankind when he wrote, “Just as the Son of

Man did not come to be served, but to serve, and to give his life as a ransom for many” (LASB, NIV, 1973/2005, Matthew 20:28).

Moore (2012) defined servant leadership as “characterized by concepts of servanthood exhibited through service to others as explicated in Jesus’ teachings on greatness through service. It carries no servant-first imperative and doesn’t rely on a conscious decision to lead. Biblical servant leadership evolves from one’s obedience to God and humble service to others” (p. 8).

The Apostle Paul as Servant Leader

The apostle Paul embodied Kirkpatrick’s definition of a servant leader through his work to establish the fledgling church. Paul, the Pharisee, and leader in the Jewish faith, was a persecutor of the early church until his conversion, in dramatic fashion, on the road to Damascus, where he was confronted by Jesus (LASB, NIV, 1973/2005, Acts 9:3-31). Scripture described Paul as a notorious “blasphemer, persecutor, and insolent opponent” of the faith (LASB, NIV, 1973/2005, 1 Timothy 1:12-13). After the encounter on the road to Damascus, he answered Jesus’ call to ministry to “Go into all the world and preach the gospel to all creation” (LASB, NIV, 1973/2005, Mark 16:15).

Paul’s example as a servant leader is set apart by his encounter on the road to Damascus and his willingness to sacrifice his worldly comforts to obey his call, serve others, and build the church. His leadership style was that of the servant who, having received God’s great mercies, and being led by the Holy Spirit, strove to bring out the best in others for the kingdom of God (Howell, 2003, p. 277; Myung, 2015, p. 65). Paul wrote Timothy, “But for that very reason, I was shown mercy so that in me, the worst of sinners, Christ Jesus might display his immense patience as an example for those who would believe in him and receive eternal life” (LASB, NIV, 1973/2005, 1 Timothy 1:16).

Jesus Christ as Servant Leader

To adopt the Christian servant-teacher style in nursing education means to place God's interests and others ahead of self and the organization. Jesus' kind of leadership means serving others' needs through service and, more importantly, serving God (Roach, 2016, pp. ix-x). As the apostle John tells it, Jesus said, "Whoever serves me must follow me; and where I am, my servant also will be. My Father will honor the one who serves me" (LASB, NIV, 1973/2005, John 12:26).

According to Wilkes (1998), the fulfillment of the mission handed down to Jesus was meant to bring glory to God the Father, "For I have come down from heaven not to do my will but to do the will of him who sent me" (LASB, NIV, 1973/2005, John 6:38). In his attempts to discern the elements of Jesus' servant leadership style, Wilkes (1998) outlined the seven timeless principles he had discovered as a result of his study,

1. Jesus *humbled* himself and allowed God to exalt him.
2. Jesus *followed* his Father's will rather than seek a position.
3. Jesus defined greatness as being a servant and being first as becoming a *slave*.
4. Jesus *risked* serving others because he trusted that he was God's Son.
5. Jesus *left his place at the head of the table* to serve the needs of others.
6. Jesus *shared responsibility* and authority with those he was called to lead.
7. Jesus built a team to carry out a *worldwide vision*. (pp. 11-12)

Scripture teaches the seven servant leadership principles Wilkes discussed, and Jesus portrayed. For example, Wilkes asserts that servant leaders will *humble* themselves by not seeking honor but by waiting for the One in authority to exalt them. Luke's gospel teaches, "When someone invites you to a wedding feast, do not take the place of honor, for a person more distinguished than you may have been invited" (LASB, NIV, 1973/2005, Luke 14:8). They will faithfully *follow* Jesus and do His will as opposed to jockeying for a position of leadership like the apostles James and John did who asked Him, "Teacher, Let one of us sit at your right and the

other at your left in your glory” (LASB, NIV, 1973/2005, Mark 10:37). In direct contrast to James and John, Jesus lived a life of humility as a *slave* to the Father. Jesus saw the conflict their hubris caused among the twelve and intervened by teaching that whoever desires greatness will humble themselves as a servant to become great, “For even the Son of man did not come to be served, but to serve, and to give his life as a ransom for many” (LASB, NIV, 1973/2005, Mark 10:45).

Servant leaders take *risks serving* their followers because they know that losing their lives in service of others will bring them closer to God. John’s gospel teaches that “Jesus knew that the Father had put all things under his power and that he had come from God and was returning to God,” so he proceeded to wash the disciples’ feet (LASB, NIV, 1973/2005, John 13:3-6). Jesus taught the disciples that in order to meet the needs of others, a servant leader will *step down from a position of authority*, wrap a towel around their waist and wash the feet of those whom they serve (LASB, NIV, 1973/2005, John 13:4-5).

Wilkes pointed out that Scripture teaches that a servant leader will fellowship and *share leadership* with others for the greater good of the church and to spread the gospel (LASB, NIV, 1973/2005, Acts 6:1-6). Recognizing that *spreading the gospel* requires teamwork, Jesus “sent the twelve out two by two and gave them authority over evil spirits” (LASB, NIV, 1973/2005, Mark 6:7).

As followers of Christ and servants of men, Christian servant leaders must live by the principles set forward by the Teacher. Christian nurse educators, therefore, must freely apply their God-given gift of teaching to building the church. Wilkes (1996) acknowledged, “Developing servant leaders is what the church has been about since Jesus affirmed Peter’s

confession of faith and established His church on that rock. Training servant leaders will be a task of the church until Christ returns” (p. 5).

Theology of Nurse as Servant Teacher

No one in nursing has captured the spirit of the nurse’s call to duty to provide patient care based on Scripture more than Sister Mary Elizabeth O’Brien. In her book, *Spirituality in Nursing: Standing on Holy Ground*, she starts off the book with the passage in Exodus where Moses stands before the burning bush, and God tells him, “Remove the sandals from your feet, for the place on which you are standing is holy ground” (LASB, NIV, 1973/2005, Exodus 3:4-5). Then, O’Brien goes on to capture the essence and beauty, the humility and gravitas, embodied by the servant nurse educator when she writes,

When the nurse clinician, nurse educator, nurse administrator, or nurse researcher stands before a patient, a student, a staff member, or a study participant, God is also present. The ground on which the nurse is standing is holy. For it is here, in the act of serving a brother or sister in need, that the nurse truly encounters God. (O’Brien, 2008, p. 1)

However, the reality of the practice environment in today’s healthcare delivery has led to a diminished role for the type of care described by Sister O’Brien in academia and at the patient’s bedside. Leininger (1981) identified the problem in the early 1980s when she warned, “Given the relative powerlessness of nurses *vis-à-vis* physicians and administrators and the problem of insurance company control over health care expenditures, nursing has been unable to sustain its caring ideology” (p. 28).

The modern nursing model of care should be kept separate from the medical model (Ackerman, 2019; Amendolair, 2012). Medicine developed from Greek and Cartesian schools of thought that regarded the human body as an object capable of being manipulated into an improved state of wellness (Shelly & Miller, 1999, p. 16). In contrast, Shelly and Miller (1999) emphasized the Scriptural basis for nursing care, “Nursing grew out of a Christian understanding

of the human person as created in the image of God and viewed the body as a living unity and the “temple of the Holy Spirit” (p. 16).

O’Brien (2006) proposes in her book, *The Nurse with an Alabaster Jar: A Biblical Approach to Nursing*, that much of the spiritual care and servant leadership nurses provide is never recognized and needs to be recovered to history. For example, O’Brien noted the loving gesture of the woman who anointed Jesus with a precious perfume called nard to prepare his body for his impending death on the Cross (pp. 32-33). When the others who were present criticized her actions as frivolous, Jesus spoke out in support of her tender loving care when he said, “She has performed a good service for me,” and then forgave her sins (LASB, NIV, 1973/2005, Matthew 26:10). The name of the woman whose selfless tender mercies brought Jesus’ comfort in his final hours will never be known, much like the selfless servant teacher whose care touches a nursing student’s heart without lasting recognition.

The Nurse Educator as Servant Teacher

The Christian servant nurse educator recognizes that they teach in an organization of believers with Jesus Christ as the church’s head. The individual members are the parts that make up the whole (LASB, NIV, 1973/2005, 1 Corinthians 12:12-31). Within the church, the members encourage one another and raise them up to share their burdens (Erickson & Hustad, 2015, p. 395).

Nursing servant teachers are accountable to their calling and stewardship through this relationship with God. Laniak (2006) put it this way, “A good shepherd sees what the Owner sees and does what the Owner does. He is a follower *before* he is a leader. He is a leader *because* he is a follower” (p. 22). Harris (1999) noted, “What motivates [the slave of Christ’s] service is

not fear of punishment or even principally the prospect of reward, but the desire to please their Master” (p. 97).

Theology of Caring

Christianity has a rich history of caring for the sick, the outcasts, and the needy through Christian servant nurses in the early hospitals. O’Brien (1999) cited Nurse historians Lavinia Dock and Isabel Stewart, who stated,

The age-old custom of hospitality...was practiced with religious fervor by the early Christians... Their houses were opened wide to every afflicted applicant and, not satisfied with receiving needy ones, the deacons, men, and women alike went out to search and bring them in. (p. 19)

The impetus of their servant’s heart came directly from Scripture. For example, Jesus’ brother James implored Christians to “look after orphans and widows in their distress and to keep oneself from being polluted by the world” (LASB, NIV, 1973/2005, James 1:27). The author of Hebrews encouraged Christ’s followers to “keep on loving one another as brothers and sisters. Do not forget to show hospitality to strangers, for by so doing, some people have shown hospitality to angels without knowing it. Continue to remember those in prison as if you were together with them in prison and those who are mistreated as if you yourselves were suffering” (LASB, NIV, 1973/2005, Hebrews 13:1-3). The apostle Matthew gave Christians the most transparent insight into whom they as servants are intended to serve when he recalled Jesus’ words, “Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me” (LASB, NIV, 1973/2005, Matthew 25:40).

A Caring Theology in Nursing

The definition of Christian nursing, according to Shelly and Miller (1999), is “a ministry of compassionate care for the whole person, in response to God’s grace toward a sinful world, which aims to foster optimum health (*Shalom*) and bring comfort in suffering and death for

anyone in need” (p. 244). They further describe that Christian caring demands the nurse to serve the individual in their care faithfully, “[it] is not just an emotional tug, an intellectual concept, or a metaphysical event. It is a hands-on, patient-centered, physical, psychosocial, and spiritual intervention to meet a patient’s needs *regardless of how the nurse feels*” (p. 250).

During the Last Supper, Jesus gave the disciples an example of what a caring servant should be by washing their feet and telling them to follow his example (LASB, NIV, 1973/2005, John 13:1-17). Therefore, in obedience to God, nurses do the work of servants. Shelly and Miller (2006) explained that “these servant nurses remain unheralded and invisible. But nurses must not lose sight of whom they serve – Jesus” (p. 213).

Made in the Image of God

Christian servant teachers in nursing education are responsible for teaching and modeling compassionate care because their students and patients are made in the image of God (Cusveller, 2013, p. 765). Kilner (2015) said, “Humanity’s creation in God’s image, then, has inspired initiatives to meet the needs of those who are neediest” (p. 9). God’s beauty is evident throughout His creation, and God’s character is unmistakable in the caring for the patients nurses are in charge of (Petersen-Finch, 2007, p. 206).

Depending on the type, degree, and depth, human suffering will often require the care of a nurse. Stott (2006) assures, “According to the Bible, suffering is an alien intrusion into God’s good world and will have no part in his new universe. It is a satanic and destructive onslaught against the creator. The book of Job makes that clear” (pp. 304-305). Christian nurse educators can help their students understand Jesus’ suffering on the Cross and the implications for their practice. Stott (2006) believes suffering is the “path to mature holiness” (p. 307). This

perspective would benefit the servant teacher who desires to help their nursing students accept their suffering and mature holiness.

God has graced human beings with the responsibility to care for one another in the community. For nurses to assume responsibility for each other's well-being is to be faithful to Christ's example and teachings, acknowledge his work on the Cross, and promote the hope that faith in Christ will lead to salvation (Cusveller, 2013, pp. 765-766).

Theology of Education in Nursing

Bredfeldt (2006) discussed Christian teaching theology as "an enormous responsibility because it is an extremely powerful method of leadership. When it comes to leading the people of God, it is the most powerful means of bringing genuine and lasting change" (p. 47). Likewise, when discussing Scripture's place in Christian education, Wilhoit (1991) said, "The task of Christian education is not to teach theology, but to use theology as the basic tool for bringing learners into the right relationship with God" (p. 6). Therefore, regarding the Christian nurse educator, "Scripture is the primary lens through which the Christian [nurse] educator perceives and prescribes the character of education in the church" (Estep et al., 2008, p. 44).

The parable of the Good Samaritan in Luke's Gospel captures and aligns the Christian nurse educators' enormous responsibility to serve the needs of their students and patients as if they were their neighbors. Jesus told this story of the Good Samaritan to a lawyer,

When a man went down from Jerusalem to Jericho and fell among robbers who beat and left him for dead, a Priest and a Levite did not want to get involved, so they passed him by. The Good Samaritan took compassion and mercy on him, cared for his wounds, and transported him to the Inn. He handed him off to the innkeeper, who would take care of him until he returned, and assured the innkeeper that he would pay him for what he owed him for his service. Jesus asked the lawyer which of the three he thought was the man's neighbor. The lawyer replied, "The one who had mercy on him." Then Jesus told him, "Go and do likewise" (LASB, NIV, 1973/2005, Luke 10:25-37).

Like the Good Samaritan, Christian nurse educators recognize their students as “neighbors” who need mercy, kindness, and care because God has called them to do that.

Theoretical Framework for the Study

Servant leadership is a theory where servant-leaders establish relationships with their followers based on mutual understanding and respect. The servant leader places the needs of the followers above their own needs and empowers them to be their very best (Greenleaf, 2008; van Dierendonck, 2011; Noland & Richards, 2015; Patterson, 2003; Northouse, 2013). Therefore, servant teachers can create a learning environment, whether in a classroom, online, or in the hospital, that promotes comfort for the student nurse to blossom and develop to their fullest. Robinson (2009) thinks, “These students, in turn, are likely to become precisely the types of professionals who are not content with the status quo and who will emerge to transform health care to address current quality and safety crises” (p. 4).

The following section will concentrate on the servant leadership theory and perspectives on effective leadership. An abridged evolution of leadership theory will give the reader a sense of leadership styles developed and utilized during the industrial revolution in America until today, including servant leadership in nursing education. Caring in nursing will be defined along with the applications of nursing theories and caring aspects in nursing education. This section will conclude with the ethical considerations in nursing.

Theory of Servant Leadership

The workplace consists of diverse, interdependent groups who must realize a common objective. Leading interdependent groups is not easy, and meeting their common goals come down to the leader’s ability to “guide a group or organization in designing the kind of community they intend to become” (De Pree, 1990, pp. viii-xii). De Pree (1990) defined the art

of leadership as “liberating people to do what is required of them most effectively and humanely possible” (p. 1).

Northouse (2013) described leadership as “a process whereby an individual influences a group of individuals to achieve a common goal” (p. 5). Northouse (2013) goes on to say that the components that make up leadership, as he described, are that leadership is a process, involves influence, occurs in groups, and involves common goals. (p. 5). Northouse (2013) defined servant leadership as follows,

Servant leadership is an approach focusing on leadership from the point of view of the leader and their behaviors. Servant leadership emphasizes that leaders be attentive to the concern of the followers, empathize with them, and nurture them. Servant leaders put followers *first*, empower them, and help them develop their full personal capacities. Furthermore, servant leaders are ethical and lead in ways that serve the greater good of the organization, community, and society at large. (p. 219)

Robert Greenleaf’s inspiration that formed the basis of his servant leadership principles of leadership came during his undergraduate education. Greenleaf (2002) relates that his life changed when during a lecture, the sociology professor spoke these words to the class,

There is a new problem in our country. We are becoming a nation dominated by large institutions – churches, businesses, governments, labor unions, and universities – and these big institutions are not serving us well. I hope that all of you will be concerned about this. Now you can do as I do, stand outside, and criticize, bring pressure if you can, write and argue about it. All of this may do some good. But nothing of substance will happen unless there are people inside these institutions who are able to (and want to) lead them to better performance for the public good. Some of you ought to make careers inside these big institutions and become a force for good – from the inside. (pp. 15-16)

From that time on, Greenleaf’s approach to leadership would be from the principles of the servant and the follower. Eventually, this point of view would lead to the creation of the contemporary servant leadership approach to leadership in organizations.

Laub (2004) recognized the need for an instrument that enables researchers to quantify the characteristics of servant leadership and answers the call for a “deeper study of the meaning and application of the emerging sub-field of leadership study” (p. 1). Consequently, he

developed the servant Organizational Leadership Assessment (OLA) instrument to facilitate quantitative analysis of the constructs of servant leadership. Laub's OLA instrument gives researchers the means to quantify and measure an organization's health level while identifying the following six areas, or constructs, of servant leadership: values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership.

Laub's contribution to clarifying servant leadership for scholarship's sake has been significant. After much inquiry into leadership, Laub (2004) offers the following definition of servant leadership,

an understanding and practice of leadership that places the good of those led over the self-interest of the leader. Further, servant leadership promotes the valuing and development of people, the building of community, the practice of authenticity, the providing of leadership for the good of those led, and the sharing of power and status for the common good of each individual, the entire organization and those served by the organization. (p. 9)

Perspectives on Leadership

Considering the problems systemic incivility has caused on the nursing profession's academic and clinical sites, perhaps these are symptoms indicative of nursing at a crossroads (Eka & Chambers, 2019; Clark, 2011; AbuAlRub, 2004; Boychuk-Duchscher & Myrick, 2008; Schneider, 2016). This literature review intended to shed light on whether the servant leadership model's implementation can positively affect nursing student caring dimensions to "improve both the ethical climate and the internal work environment of an organization" or the profession overall (McMahon, 2012, p. 339).

As an alternative to the business, customer-oriented, managed care model of care delivery in healthcare today, the servant leadership model supports a community culture through positive leader-follower relationships based on mutual understanding and respect. In this model, the servant-leader places the followers' needs above their own and empowers them to be their best

(Greenleaf, 2008; van Dierendonck, 2011; Noland & Richards, 2015; Patterson, 2003; Northouse, 2013). The relationship principles of servant leadership have gained momentum and a substantial following in organizations over the past thirty to forty years.

In the preface to his book, *Leadership is an Art*, Max De Pree outlined the three themes that emerged from those who read his book and provided feedback. What the readers mentioned most were areas of the leader's integrity. He said integrity is a principle that serves society and never changes. He mentioned the leader's importance of "building and nurturing relationships" (De Pree, 1990, pp. viii-xii).

A thriving organization is one whose success relies upon a civil community that promotes and values the integrity of both its leaders and followers. De Pree remarked that the last theme concerns the leader's ability to "guide a group or organization in designing the kind of community they intend to become" (De Pree, 1990, pp. viii-xii). De Pree (1990) explained that the art of leadership ultimately comes down to "liberating people to do what is required of them most effectively and humanely possible" (p. 1). These principles that DePree speaks of are consistent with the servant leadership model.

An Abridged Evolution of Leadership Theory

At the time of the industrial revolution, most workers working in the factories were craftsmen employed as independent subcontractors. These subcontractors would negotiate their rate with the company, and the job usually went to the contractor with the lowest bid. After getting the job, these craftsmen were responsible for organizing how they would meet the production requirements set by the company. They often employed apprentices and artisans to help them meet their goals. Depending on the craftsman, the production could have been more uniform, efficient, and lacking quality. Therefore, in the interest of uniformity, efficiency, and

improved quality, the industry began to look for ways to enhance productivity through “Elaborate systems of management control, like Taylorism” (Knotter, 2016, pp. 415-416).

Taylor devised the Scientific Management theory in response to a common delay tactic called “soldiering” some craftsmen would employ to help gain the upper hand in their company relations. Taylor’s principles helped overcome problems in the organization, such as organizational problems, inefficiencies, and poor labor relations. Taylor’s way of conducting business was based on the scientific method and critical analysis of the received data through close observation (Knotter, 2016; Taneja et al., 2011; Grachev & Rakitsky, 2013; Shima & Lemak, 2010; Taylor, 1914).

Using the Scientific Management theory, workers were observed doing their jobs using stopwatches to develop the fastest, most efficient way of performing a specific operation. This type of work became overly repetitive, and the workers needed help dealing with the boredom. They complained that scientific management made them feel like another machine on the production line. Interestingly, Taylor (1914) personally answered the harsh criticisms Mr. Cadbury directed at his book, the *Principles of Scientific Management*, when he retorted,

To itemize: Mr. Cadbury fears that ‘the assignment of daily tasks to workmen may lead to a great nervous and physical strain,’ ‘the reduction of the workman to a living tool,’ and may ‘induce him to spend his last ounce of energy while initiative and judgment and freedom of movement are eliminated.’ (p. 267)

Elton Mayo’s Human Relations Theory and People Management followed Taylor’s Scientific Management Theory and was considered an improvement in human relations. Mayo was a philosopher psychologist, and his Hawthorne Studies were among the first to apply psychology to managerial and organizational contexts (McCambridge et al., 2013; O’Connor, 1999; Adair, 1984; Sonnenfeld, 1985; Rose, 2005).

The Hawthorne Studies were conducted in Chicago's Western Electric Company's Hawthorne plants. According to Adair (1984), the studies claimed to have demonstrated that "increased personal attention by supervisors led to improved productivities [and] found measurements of behavior were altered by the subjects' knowledge that they were in an experiment, later to be called the Hawthorne effect" (p. 334). These studies recognized the "human factor" in the workplace. Rose (2005) explains, "That meant that workers were now recognized as having social needs and interests such that they could no longer be regarded as the economically motivated automatons envisaged by Taylorism" (pp. 43-44).

An applied psychology scientist, McGregor, developed the organization behavior movement in response to Alfred Sloan's question on whether business managers are "born or made." McGregor observed two categories of managers based on their presumptions regarding their employees (Head, 2011; Schein, 2011; McGregor, 2006).

In McGregor's book, *The Human Side of Enterprise*, he described two categories of managers: "Theory X" and "Theory Y." The Theory X manager believed the workers to be "generally lazy, uninspired, unimaginative, and only react to reward and punishments." Contrarily, the Theory Y manager felt the followers wanted to excel, to be desirous and capable of independent thought and action, and responded well to 'higher order' tasks" (McGregor, 2006, pp. 43-76; Head, 2011, p. 202-203). Schein (2011) notes that McGregor believed the "Theory X manager will always lean toward command and control as the sole solution, while the Theory Y manager will manage in terms of the requirements of the task, being more autocratic or participative as the situation may require" (p. 158).

For Robert Greenleaf (1970), the goal of servant leadership involved a committed servant relationship between followers and leaders that created a more just and caring organization to

ensure “other people’s highest priority needs are being served, and the best test is do those served grow as persons; do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants?” (p. 15).

Servant Leadership In Nursing Education

In Florence Nightingale’s book (1969), *Notes on Nursing: What it is and What it is not*, she made it clear that to be a nurse was to *be* a servant. She insisted the intention of her book was “to give hints for thought to women who have personal charge of the health of others. The work of the ‘nurse’ was not different from that of the ordinary housemaid except that, in addition, she ‘attended’ the sick” (pp. xi-xii). Dunbar commented in the Forward to *Notes on Nursing* that the human element of care that Florence built a profession on remained constant over the generations, “But human beings have remained human beings, and for this reason, the fundamental needs of the sick, weak, helpless human being which are recorded here remain surprisingly as they were then” (p. xiii). In other words, Nightingale established that a nurse, by definition, needs to *serve* the needs of others.

Hays (2008) noted that “The servant teacher is focused on education as relational, empowering, and liberating instead of on teaching as a one-way, top-down, authoritarian enterprise” (p. 114). Noland and Richards (2015) found in their study investigating teacher servant leadership on student outcomes that “Servant teaching is well-positioned to provide teachers with a set of tools to improve student indicators of learning and engagement” (p. 26-27). Robinson (2009) observed that when the tools of servant teaching are employed in nursing education, they will “produce professionals who can participate in eradicating health disparities and developing compassionate public health policy. Natural outcomes of serving may be patient-centeredness, quality, and safety” (p. 4). Hall (2015), in her dissertation, cited Huber (2014), who

said, “The servant leadership model requires nurse leaders to be attentive to the needs of others and enhances personal growth of nurses, improves the quality of care, values teamwork, and promotes personal involvement and caring behavior” (p. 10).

The servant leadership concept can be attributed to Robert Greenleaf’s essay, *The Servant as Leader*, back in 1970. Since the publication of Greenleaf’s (2003) refined observations presented in the book, *The Servant-Leader Within: A Transformative Path*, there has been a growing interest in implementing the model in organizations to “stimulate thought and action for building a better, more caring society” based on the ten characteristics set forth by Greenleaf’s protégé, Larry Spears,

1. Listening
2. Empathy
3. Healing
4. Awareness
5. Persuasion
6. Conceptualization
7. Foresight
8. Stewardship
9. Commitment to the growth of people
10. Building community (pp. 14-19)

Listening involves the servant leader identifying and clarifying the follower(s) will. The *empathetic* servant leader makes it their goal to understand and empathize with others. Servant leaders have the potential to *heal* themselves and their followers to help make them whole. *Awareness* of self and others allows the servant leader to understand the ethics and values of successfully leading others. The effective servant leader will rely on *persuasion* instead of authority to build consensus among the team. *Conceptualization* is the visionary process where the servant leader thinks out of the box to lead the organization into the future without losing sight of the day-to-day operations. *Foresight* is the servant leadership characteristic that enables

leadership based on past and present knowledge that informs future decisions. The servant leader is committed to serving the needs of others with a spirit of *stewardship* for the greater good of society. A servant leader is *committed to the growth of each follower* to empower them to be their absolute best. Finally, the servant leader is dedicated to *building community* among followers and the communities in which they live (Spears & Lawrence, 2002, pp. 5-8).

Definition of Caring in Nursing

Bevis defined caring in Leininger's (1981) book, *Caring: An Essential Human Need*, this way,

[Caring is] one of life's essential ingredients; it may be its most essential ingredient. Caring helps to ensure that life goes on by producing primary groups and a positive environment for children and adults. Caring helps to prevent disease, promote health, heal, or help the vulnerable, educate the population, and raise human relationships to satisfying experiences of pleasure, security, trust, growth, and positive activity. Love, hate, fear, happiness, anger, pleasure, or any other human emotion may have the growth-producing, energy-generating, motivating, and consistently positive effects of caring. All other human feelings have potentially negative and positive effects, but caring, by its nature and definition, is only and always positive. (p. 49)

Role modeling is an effective method in nursing to introduce and teach new caring knowledge. Leininger established caring as "the essence of and unifying intellectual and practical dimension of professional nursing" (Nelms et al., 1993, p. 18). Many nurse educators believe caring cannot be taught through the usual education channels, such as lecturing students. Nelms et al. (1993) discovered through their research that nursing students could learn to care for their teachers through the teacher's role-modeling and caring faculty-student interaction in the classroom and clinical practice (p. 18-23). In other words, caring relationships begets further caring relationships (Liedtka, 1996; Luthans & Youssef, 2007; May et al., 2003).

Applications of Nursing Theory

According to Jarvis (2019), Swanson's definition of caring is "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p.

266). Swanson's Theory of Caring (1991) determined how relating was expressed through five caring processes: knowing, being with; doing for; enabling; and maintaining belief.

The concept of caring in nursing has proven challenging despite a growing bank of knowledge through research over the past decades. Bilowski and Wendler (2005) found in their study, *An Evolutionary Concept Analysis of Caring*, that Rodgers' work was vital to identifying what she described as the five attributes of caring within nursing: relationship; action; attitude; acceptance; and variability (pp. 641-643).

McCance et al. (1999) described four modern nurse theorists' theoretical perspectives of relevance to nurse caring, including Leininger, Watson, Roach, Boykin and Schoenhofer.

- Leininger's theoretical perspective on care consisted of "caring actions and activities directed towards assisting, supporting, or enabling another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway, or to face death."
- Jean Watson's theoretical perspective on care consisted of "A value and an attitude that has to become a will, an intention, or a commitment, that manifests itself in concrete acts."
- Roach's theoretical perspective on care purports, "Caring is the human mode of being."
- Boykin & Schoenhofer's perspective on care consisted of "the intentional and authentic presence of the nurse with another who is recognized as a person living caring and growing in caring" (p. 1390).

Roger Watson and Amandah Lea (1997) created the Caring Dimensions Inventory (CDI) to enable nurse researchers to quantitatively measure the "elusive phenomenon" of the perceptions of caring in nursing (p. 87). Lea et al. (1998) study reported that the items contained within the CDI-25 "span a range of nursing actions including instrumental actions, affective actions, and professional actions to derive general categories of care" (p. 663). They found four latent dimensions contained within the CDI instrument's data.

Lea et al. (1988) described the latent dimensions found in the CDI as having two significant dimensions to caring and two lesser ones linked to self-giving. Lea et al. (1998) study revealed that self-giving could be further broken down into appropriate and inappropriate self-giving in nursing. There was a strong correlation between the first three dimensions, i.e., psychosocial, professional, technical, and appropriate self-giving. The fourth factor, inappropriate self-giving, did not correlate as well as the first three, meaning it does not reflect caring in nursing (p. 669).

Caring Aspects in Nursing

Brown (2011) has identified “caring in nursing education [as] a multidimensional concept expressed through interactions among the nursing faculty, between the faculty and nursing students, among nursing students, and between nursing students and patients (p. 360). The current nursing curriculum focuses more on skills development and command of nursing knowledge than on caring and humanitarian aspects of the caring profession (Brown, 2011, p. 363). Incorporating a caring curriculum into the nursing program that “provides a holistic approach to learning about care and caring is needed” (McEnroe-Petitte, 2011, p. 82).

As Ackerman (2019) cites Watson (2006), in the current era of healthcare, big business is merged with health systems leading to healing-caring environments to be replaced with business models that have “moved from caring healing-environments to business or economic models of caring institutions that focus on census instead of patients and, technology instead of touch or human connection” (p. 572). A critical aspect of nursing education the literature shows might be to develop a curriculum that fosters caring environments where students may have more confidence in their expressions of their caring role leading to positive job satisfaction (Amendolair, 2012).

Ethical Considerations in Nursing

The nursing profession's hallmark is ethical care for individuals who cannot care for themselves. The rich history of caring is what sets nursing apart from medicine. However, nursing's caring practice is downplayed in healthcare due to "sociopolitical forces" and beyond (Woods, 2011, p. 1-2).

Nurses must be educated to understand the power imbalance in the nurse-patient relationship to address the patient's concerns and suffering sincerely to promote healing. Listening to the patient's descriptions of their suffering has been shown to reinforce a therapeutic caring attitude. In an authentic desire for what is best for the patient, the nurse can engage the patient in a caring conversation that enlists the patient in self-expression with the power to heal. Fredriksson and Eriksson (2003) assert that the nurse's gift is the giving of his or herself, where the giving is understood as being available and at the other person's disposal with the nurse's self. Ultimately, the nurse wholeheartedly makes room to care for the other person. If the patient accepts this gift, an invitation to share the patient's world of suffering is possible (pp. 146-147).

Related Literature

Many studies show that patients appreciate and even do better when their care is provided by a nurse who is genuinely interested in their well-being and is attentive to their needs. White (2002) reports, "Evidence suggests that patients value the kind of care given to them by nurses who are sensitive and responsive to their needs, not care in the professional sense of providing competent treatment, but care in the personal, vocational sense" (p. 280). The following is a discussion of the impact and influence gender, the nurse's calling or lack of calling, and nursing's uncivil culture have on nursing organizational leadership and nursing student caring dimensions.

Men have been an integral part of nursing, the caring profession, from ancient times, i.e., up until about 150 years ago, when Florence Nightingale changed nursing into today's profession. Unfortunately for men, Nightingale's vision of nursing as a vocation with empathy, gentleness, nurturance, compassion, tenderness, and unselfishness did not include them (DeVito, 2015, p. 246). Consequently, Nightingale refused entry of men into her schools, and other nursing schools opened at the time followed her lead. In the times before Florence's, there was no formal training for a nurse.

Much has been written about Nightingale's contributions to the nursing profession. Still, at the same time, some historians blame her for why men do not consider nursing their occupation of choice (DeVito, 2015, p. 246). Despite the negative stereotyping over the past 150 years, males increasingly select nursing as their chosen career. The National Council of State Boards of Nursing's (2020) research shows that male Registered Nurses comprised 9.4% of the workforce in 2020, compared to 9.1% in 2017, 8.0% in 2015, and 6.6% in the 2013 study.

McMillian et al. (2006) say, "Women choose to nurse because the social, political, and economic systems continue to perpetuate the image of nursing as a female-dominated profession" (p. 100). Considering these strong cultural influences, women may believe entering nursing is natural. Boughn and Lentini (1999) found that women enter the profession because they desire to care for people and the power and empowerment present in the nursing role (p. 156).

Both men and women come to the nursing profession for various reasons. Some enter because they follow in the footsteps of a family member or someone they look upon favorably. Others may have cared for a loved one who was sick or injured or a patient. Still, others will

come to the profession to answer their “calling” from God to care for the ill and injured (Prater & McEwen, 2006, pp. 63-64).

Whatever the reason a person chooses nursing as their career, their integration and adaptation to the training they receive will be critical to their success. Developing their nursing identity, particularly in their clinical practice, will be essential to becoming a nurse. Walker et al. (2014) conducted a study that revealed the five elements that build a nursing identity. The five elements are good role models, acceptance, critical thinking abilities, peer support, and confidence (p. 106).

The challenges nursing programs face in educating the next generation of nurses are teaching the required psychomotor skill set, developing a patient-centered attitude, and performing patient care utilizing best practices for optimal results. Therefore, educators must be welcoming so students feel a ‘part’ of [to identify with] the nursing profession (Walker et al., 2014, p. 103). Further, the Walker et al. study showed that “good roles models were identified as a key support for participants [students] in the construction of their nursing identity [and] poor roles models during the clinical learning experience impacted not only the participant’s ability to learn but also their morale and perception of nursing” (p. 106).

The image of the nurse continues to evolve with each new generation. The nurse’s primary role, i.e., caring and empathy, has endured. However, each new generation will have its unique set of ideals they believe constitutes nursing. Cowin and Johnson (2011) researched to examine “student nurses’ perceptions of qualities of professional nurses and how they differ with age, gender, country of birth, healthcare experiences and mode of entry to the nursing program” (p. 414). The study showed that older individuals might be more aware and happier with their

nursing choice with increasing age and more exposure to healthcare. The study found that males are more likely to leave nursing than their female counterparts once accepted into a program.

Further, whether their birth country considered nursing a skilled or unskilled occupation influenced their approach to nursing. Interestingly, the student's backgrounds played a role in their understanding of nursing. For example, after high school, students entering their training would have a different point-of-view on nursing than the older person who has experienced the profession from a personal point of view. And lastly, this study found that caring and compassion scored somewhat lower than being more oriented toward professional issues (Cowin & Johnson, 2011, pp. 415-417).

The nursing profession is currently experiencing a shortage that calls for new and diverse talent to enter the field (Boughn, 2001, p. 14). There are various reasons why a person will choose nursing as a profession. Boughn reports,

Male and female subjects did not differ in their desire to care for others, but both women and men were motivated by the desire to care for others. Less anticipated was the finding that both sexes also had a strong interest in power and empowerment for themselves. Differences were detected in the desire to use power on behalf of others. (p. 16)

Boughn (2001) discovered that women desired to use their power to empower other people, e.g., to "make [patients] feel independent like they're taking care of themselves. A good nurse isn't going to do everything for the patient... make them do [it]" (p. 17). However, male students seek to empower the profession. They are interested in demanding respect for their work from other healthcare professionals. Also, males were more interested in making a good wage than women in the study (Boughn, 2001, p. 17).

The Male Nursing Student

One distinction of the male nurse that sets him apart from the female nurse is his maleness (Loughrey, 2008). Despite the perception that nursing is a female profession, males are

entering the practice in increasing numbers (Grady et al., 2006, Abushaikha et al., 2014, Dyck et al., 2009; DeVito, 2015; Stott, 2003; Bartfay et al., 2010; Loughrey 2008). Males are entering despite the cultural perceptions and negative stereotypes that “male nurses are gay, effeminate, less compassionate and caring than female nurses,” which may inhibit recruitment and retention in nursing schools (Bartfay et al., 2010; Clow, 2015). Sasa (2019) said, “The term *male nurse* is often problematic to those referred to, as the label carries stereotypes that further marginalize this extreme minority in the nursing profession” (p. 593).

The male gender has a rich history of caring for others. Strong-Anthony (2004) states, “Caregiving in ancient civilizations were often closely tied to religious worship and a role assumed by priests and their assistants. The Mosaic Laws of the Bible provide an example of the relationship between religious worship and health practices. During the Middle Ages, the caregiver’s role was open to both males and females. [Finally], they comprise 30% of military nurses” (p. 121-122).

Nightingale opened the Nightingale Training School for Nursing in 1860, becoming the archetype for nursing schools in England and America. Men were not permitted entry into the program, and their contributions to caring were destined to be forgotten as nursing became perceived as exclusively for females (Strong-Anthony, 2004).

Today, nursing is seen as homogeneous and predominantly a woman’s profession, where sex stereotypes and stigma are common throughout nursing. Sasa (2019) described seven defining attributes of the male nurse:

1. Perceived as male – Specifically, this attribute is defined in biological terms
2. Credentialed as a nurse – Being credentialed makes a male or female a nurse
3. Increased visibility – People tend to focus on someone different, given a homogeneous group

4. Stereotyped/stigmatized – these critical characteristics of individuals who are an extreme minority in the workplace include,
 - Being a doctor wannabe
 - Being gay or effeminate
 - Emasculated
 - A heterosexual deviant or sexual predator
5. Nonconformists as to career choice
6. Cautious caregivers
7. Increased role strain (p. 595)

Loughrey (2008) conducted a quantitative study that examined the gender role perceptions of male nurses. His analysis found that male nurses possess stereotypical male and female gender role attributes, but they recognize the need to maintain their masculinity. Loughrey cited Holyoake (2002), who concluded that the way these men resolved the gender-based identity issue was to develop a sort of hybrid gender role that he described as a “soft masculinity” that blends both the male and female roles into a socially acceptable hybrid (p. 36).

Loughery’s study also discovered evidence for the “male nurses’ struggle for power,” as evidenced by their drive to move up the chain of command and seek more excellent educational opportunities to help them advance. Therefore, men enter the profession emphasizing the caring role, but as they gain experience and confidence, “on the whole, they seem to follow traditional masculine paths” (pp. 1329-1330). Interestingly, MacDougall (1996) found that “a profession that consists overwhelmingly of women is being dominated by men in power positions. If these men occupy the traditional masculine standpoint, then this may have a negative impact on care” (pp. 811-812).

Grady et al. (2008) report that “studies about caring in nursing education assume that caring can be taught or enhanced through formal education, experience, and role modeling. The faculty-student caring relationship is a prerequisite ‘to the students’ acquisition of caring attitudes and behaviors” (p. 315). The Grady et al. study would support this study’s premise that the nursing program’s servant leadership model will enhance nursing students caring behaviors. Male nursing students also experience other positive benefits during nursing school and beyond, such as “personal growth, attaining a sense of accomplishment, gaining friendships, acquiring new knowledge and skills, helpful faculty and teaching styles, developing a nursing professional identity and stable employment associated with nursing” (Abushaikha et al., 2014, p. 264).

The Female Nursing Student

Nursing is a female-dominated profession with a super-majority composition of about 87.0% females and 13.0% males (NLN, 2020). Cho et al. (2010) point out that “understanding who enters nursing schools and why they choose nursing is essential for the nursing profession to recruit and retain their successors in nursing” (p. 180). This information is critical considering the current nursing shortage in the United States and worldwide.

The reasons for entering the nursing profession are multifactorial. Cho et al. (2010) contend there are five influences for choosing to nurse: lower household income, biology subject pursued, previous academic achievement, mother’s occupation, and their perception of nursing (p. 180). Typically, students entering a nursing program will more commonly come from a family that had “relatively lower household income than non-nursing students. The lower household income of nursing students may link to the finding that 55% of nursing students chose the nursing major because of employability” (p. 184). Cho et al. (2010) cite several studies in their research on female nurses that show,

The reasons for choosing nursing or influential factors for considering nursing as a career choice are a desire to help and care for others, the chance to work with people and in a variety of work settings, job opportunities, and security, income potential, the impact of family and friends in the nursing profession, positive images of nurses and quality of work environment. (p. 180)

Like male nurses, female nurses are concerned with the power and empowerment of their patients. They also come into the profession with a strong desire to care for others. However, in Boughn and Lentini's (1999) phenomenological study, they found that "it was power and empowerment that emerged from the interviews as the most resounding and fully developed construct of the study" (p. 156). Boughn and Lentini also declared that, with a healthcare sector in utter disarray, "more than ever, the needs and expectations of women choosing nursing must be compatible with the needs and expectations of the profession for its very survival" (p. 157).

Horne and Holzemer (1991) did a study that compared the characteristics of female nursing students to women studying education and engineering. The study looked at the demographic characteristics, vocational personality, and sex-role orientation of female nursing students compared to women who studied education and engineering (p. 411). What the authors point out is that "people who work in these two fields [nursing and education] have a strong "social" element in their personality as well as in the environment they work in" (p. 417). They also noted that "nursing students differed from education students by the fact that almost half of them majored in chemistry and biology in high school" (p. 417).

Horne and Holzemer (1991) also studied how female nursing students compared to female engineering students regarding masculine qualities required for their occupations, such as mathematics and science, technical talent, and a nontraditional attitude. While nursing demands a life sciences background, nurses' work requires a high level of autonomy associated with masculine traits: "independent decision-making, excellence in technical skills, and extensive knowledge base for practice" (p. 418).

Female nursing students appear more in tune with their patients' needs through emotional intelligence (EI) than male nurses. Horn and Holzemer (1991) found that "while female nursing students scored higher on the EI scale than male nursing students, there was no statistical difference" (p. 418). According to a study by Stiglic et al. (2018), EI is "The ability to monitor one's and others' emotions, discriminate among them, and use the information to guide one's thinking and actions" (p. 37). EI correlates strongly with "care, compassion, and empathy" (p. 36). Therefore, considering a nurse's time with the patient and their family, EI is an essential quality for nursing schools to develop within their students.

The female nursing student's self-confidence and self-reported competence are areas that nursing schools can focus on to improve individual nurses' and their patients' lives and practice. Kukulu et al. (2013) did a study that defined self-confidence as "an individual's recognition of their abilities, love him or herself, and being aware of their own emotions. Self-confidence may also be described as feelings of well-being because of deepening positive emotions" (p. 330). Kukulu et al. (2013) declared, "Self-confidence is an important psychological construct that affects a student's academic performance. Self-confident people trust their abilities, have a general sense of control, and believe they can accomplish what they expect, wish, and plan for" (p. 331).

Carlsson (2019) compared female versus male nursing students' self-reported competence, where "female students estimated their competence in giving value-based nursing care as higher than males. Male students estimated their competence in development and leadership higher than females" (p. 191). This finding would suggest an imbalance of power between female and male nursing students.

Nursing as a Vocation or Calling

Humans are created in God's image as partners who are made to be in covenant with Him. Further, humans were created, body and soul, to be in a relationship with God and others. Lundmark (2007) states, "As a creation of God, humans are both material (as created) and spiritual (as covenant partners). The human spiritual dimension is people's capacity to meet God, to be persons for God and in a relationship with God" (p. 773). In that realm of the human relationship with God, where He exerts His will, i.e., the potential nurse beckons His call to serve Him through nursing and, thus, becomes a nurse. In a social sense, White (2002) described the nursing vocation like this,

The nurses responded not in their interests but *for the patient's and the patient's sake*. The personal identification with and, indeed, the claim of ownership of the social meaning of nursing helps to structure the nurse's identity and thus creates the 'moral pull' those nurses feel towards tasks involved in caring for patients. The personal meaning of a vocation requires a commitment to act in the appropriate ways, and insofar as the commitment is conceived to be a moral one, the personal meaning passes over into a moral one. (p. 284)

In an ever-changing world, the reasons for entering the nursing profession today vary from person to person. Shelly and Miller (2006) write critically about Christian nursing abdication in today's field. They relate the story of nurses coming into the profession without a calling, earning a steady check, gaining power or prestige, or with other motivations that take precedence over serving God. Shelly and Miller (2006) remind Christian nurses of the servant nature of their work based on Scripture's description of Jesus Christ in their book, *Called to Care: A Christian Worldview for Nursing*,

Jesus Christ has called us to a different vision for nursing. He touched lepers (Luke 5). He applied mud compresses (John 9:6). He washed feet (John 13). Jesus proclaimed, Whoever wishes to become great among you must be your servant, and whoever wishes to be first among you must be slave of all. For the Son of Man came not to be served but to serve, and to give his life as a ransom for many (Mark 10:43-45). (p. 24)

Scripture states that healing the body would help your neighbor resume their relationship with God and the community. Therefore, Christian nurses cannot help their patients fully without using the gospel in their ministry. Shelly and Miller (2006) suggest,

Nursing as a vocation, or calling, from God must return to its roots in the church and Christian faith to work toward the goal of true health. Furthermore, if we hope to maintain a strong Christian worldview in nursing, our faith must be nurtured in a Christian community and informed by clear theology. (pp. 24-25)

Incivility in Nursing

The incivility that exists in the nursing profession and nursing academia has been well documented. Luparell (2011) declares that “Because today’s students are tomorrow’s colleagues, conversations regarding how to address incivility and bullying should include specific aspects of nursing academia and the preparation of new nurses” (p. 92). Incivility in the classroom is defined as any behaviors or actions that impede learning (Feldman, 2001). It can manifest itself as speech or activity that is discourteous, insulting, or violent behavior (Tiberius & Flak, 1999).

Those student behaviors that are frequently considered uncivil include conversations that distract others, computer usage at inappropriate times, and demand that the teacher change a grade or provide a make-up test. The most frequent uncivil student behaviors that occur the most include late arrivals to class, engaging in distracting conversations, and not being prepared for class. The most often cited faculty behaviors considered uncivil are condescending comments, rude comments or gestures, and looking down on others. The uncivil faculty behaviors that happened the most included poor teaching techniques, not being on time, and lack of adherence to the course schedule (Clark, 2008, p. 458).

The outcome of academic incivility can lead to problems of diminished self-esteem that leads to dysfunctional and stressful student-faculty relationships. The maladaptive relationships may carry over from academia into the nurse’s practice setting. Clarke (2008) cited Randle

(2003), who said, “Bullying as a form of incivility is commonplace in the transition from nursing student to practicing nurse” (p. 459). The author noted that strong-arm tactics and other humiliating behaviors significantly create a negative culture of incivility where “self-worth is diminished, and nursing care is compromised” (Clark, 2008, p. 459). Milesky et al. (2014) said, “Students who experience incivility in the academic setting feel anxiety and suffer poor performance” (p. 91). Their work cited Peter Pronovost, whose “research has demonstrated repeatedly that safe and just work cultures in healthcare improve patient outcomes” (p. 92).

Incivility is a dynamic relationship between two individuals with a back-and-forth of inappropriate behaviors. Clarke described the interaction this way, “Incivility is like a dance – one dancer leads, and the other follows – and sometimes the dancers do both” (p. 2011). Many nursing schools and healthcare systems feel the heat of incivility due to a change from care-centered values to business values where making money preempts patient care. Nurses feel the weight of increased demands on their time caring for patients. Donley (2005) explains that,

Nurses face long shifts, mandatory overtime, short staffing, and inadequate professional staff ratios to patients. Patients and healthcare providers feel rushed in all settings. They miss the rapport that they once enjoyed with patients. Patients believe their doctors and nurses are very busy and do not give them the time and attention they need. (p. 317)

Rationale for Study and Gap in the Literature

Rationale for Study

This study’s rationale stemmed from a deep concern for the future of nursing and the patients nurses care for. The present leadership model in nursing academia and at the patient’s bedside is a business/economic model focusing on profits over patients (Ackerman, 2019; Shelly & Miller, 2006; Paulson, 2004; Boychuk-Duchscher & Myrick, 2008; Serber, 2014). The literature shows that the current practice environment is diminished because of the business model’s focus away from patient care (Ackerman, 2019). From a caring perspective, it becomes

apparent that the system is broken (Shelly & Miller, 2006). This author desired to study whether the servant leadership model in nursing education can produce a more suitable environment conducive to caring for the nursing profession, nurses, and patients.

Much has been written about servant leadership for over 30 to 40 years. Servant leadership can be approached from secular principles such as Greenleaf's essay, *The Servant as Leader*. It can also come from Christian principles based on Scripture, such as those outlined by Wilkes in his book, *Jesus on Leadership: Timeless Wisdom on Servant Leadership*. Servant leadership depends upon the leader to choose the principles by which they will be guided and choose to lead.

Wilkes (1998) said of servant leadership, "You will never become a servant leader until you first become a servant to the leader" (p. 23). By accepting God's Word as the Truth that guides their leadership, servant nurse educators and their students can find particular utility and inspiration from Wilkes' (1998) seven Christian servant leadership principles based on Scripture,

1. Humble your heart: "Servant leaders humble themselves and wait for God to exalt them" (based on Luke 14:7-11).
2. First, be a follower: "Servant leaders give up personal rights to find greatness in service to others" (based on Mark 10:32-40).
3. Find greatness in service: "Servant leaders give up personal rights to find greatness in service to others" (based on Mark 10:45).
4. Take risks: "Servant leaders can risk serving others because they trust that God is in control of their lives" (based on John 13:3).
5. Take up the towel: "Servant leaders take up Jesus' towel of servanthood to meet the needs of others" (based on John 13:4-11).
6. Share responsibility and authority: "Servant leaders share their responsibility and authority with others to meet the greater need" (based on Acts 6:1-6).
7. Build a team: "Servant leaders multiply their leadership by empowering others to lead" (based on Mark 6:7). (pp. 23-27)

Greenleaf (2008) defined the Non-Christian servant leader as someone who “is servant first. It begins with the natural feeling that one wants to serve, to serve first” (p. 15). Larry Spears, a close associate of Greenleaf, studied Greenleaf’s original writings and derived the servant leader’s ten characteristics. The ten characteristics were: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community (Greenleaf, 2003, pp. 17-19). Nursing program administrators might be wise to look for these characteristics in the nurse educators they recruit to ensure a civil atmosphere for faculty and students in their programs and beyond (Hays, 2008, p. 113).

Robinson (2009) found that servant teaching can motivate nursing students to transform healthcare’s culture of incivility. He discussed a culture that prioritizes safety and quality through the following principles, judicious use of power, listening and empathy, willingness to change, reflection and contemplation, collaboration and consensus, service learning, healing, conceptualization, stewardship, building community, and commitment to the growth of people (p. 5-11).

Noland and Richards (2015) studied servant-teacher behaviors and whether they impacted student outcomes (p. 17). This study measured servant teaching and student outcomes and found a positive correlation between servant leadership and student learning and engagement (pp. 18-19). Their research provided vital information for the process of changing the uncivil culture that currently exists where nurses learn and work.

Today, there is a shift from a Christian basis of caring to a more alternative approach to caring. The bottom-line economics resulting in staffing cuts makes it difficult for nurses to care safely for their patients. Shelly and Miller (1999) cited Stocker, who pointed out,

I'm seeing an increasing number of students not entering nursing for the same reasons you and I did. They don't have a caring attitude. They have a goal, and that goal is to get a job that pays a decent wage. The end. What impact will that have on the professional organization and the profession? (p. 23)

The nursing profession has been set adrift because it has lost its Christian identity, and nursing's core principle of caring has never been so challenging to implement. Incivility toward students is well documented (Hayne et al., 2020; Clark & Springer, 2010; Clark & Springer, 2007; Feldman, 2001; Luparell, 2007). Instead of the Christian values nursing was founded on, nursing has adopted alternative approaches along the way. It has adopted a business model that does not attend to patients or their families (Ackerman, 2019, p. 572). Amendola (2012) contends that "Nurse leaders must develop creative programs and strategies that support and value a caring environment for patients and staff so that nurses will be fulfilled in their work, ensure retention, and improve organizational outcomes" (p. 42).

A good literature review must also offer a clear rationale for the research study, suggesting a gap in the existing literature, which the study will seek to address. This will be a short section that identifies the place of your study as a contributor to the literature in the field. The reader should be left comprehending what this study will add to that literature base.

Gap in the Literature

The literature is replete with information on servant leadership and caring. However, after a thorough search, a gap in the literature failed to examine the relationship between Christian and Non-Christian servant organizational leadership and pre-licensure baccalaureate nursing student caring dimensions in the Midwest region of the United States.

Robert Greenleaf is well known for his principles of servant leadership. He professed that the leader becomes the servant who serves the follower first while placing the follower's needs above the leader's or organization's needs. Hays' (2008) study discovered that the application of

Greenleaf's principles of servant leadership made "a profound impact on learning and in the learning experience of both students and teachers" (p. 113). However, his study did not link servant organizational leadership with increased nursing student caring dimensions.

Robinson (2009) conducted a comprehensive study that elucidated the environment servant leadership can create and its effect on an individual's values and beliefs that improve nurse educators and their student's relationships. However, Robinson's research did not directly address servant leadership's impact on the student nurse's caring dimensions.

Noland and Richards (2015) researched whether servant-teacher behaviors impacted student outcomes (p. 17). This study measured servant teaching and student outcomes and found a positive correlation between servant leadership and student learning and engagement (pp. 18-19). Again, this is another example of an excellent study designed to understand better the impact servant teaching can have on students; however, it should have considered whether student caring dimensions were enhanced.

Numerous studies have documented the impact of incivility in nursing on the profession's overall culture. Shelly and Miller's book, *Called to Care: A Christian Theology of Nursing* (1999), describes a profession adrift with no rudder. Their book details the fundamental principles of traditional nursing, including Christian caring. While their book gives an excellent examination of caring in nursing from a Christian nursing perspective, Shelly and Miller do not discuss caring in a servant organizational leadership milieu.

The Labrague et al. (2015) study was an international study that attempted to identify a correlation between the instructors' and nursing students' caring behaviors and to understand the instructors' caring behaviors' impact on the students' internalized caring behaviors. Their study found that the instructor's caring behaviors positively influenced the nursing students' caring

behaviors. Therefore, their study concluded that “through positive faculty modeling and role modeling, nursing students can be professionally trained to develop the competence of caring” (p. 338).

In Amendola’s (1998) dissertation, *Toward a Caring Nursing Curriculum*, he examined “the development of a caring curriculum within nursing education, with a particular focus on nursing and caring as a feminine-based cognate” (p. ii). His study does explore the nursing teacher-pupil relationship based on love and caring. He does not declare a servant teacher role; however, the characteristics he describes would qualify. Amendola cited Huebner (1984), who said, “This caring relationship between the teacher and the student will conquer the fear of the unknown”. Again, as the Bible states, “Love conquers all” (p. 48). Therefore, although Amendola’s study discusses servant leadership and caring, he did not quantitatively explore and measure their relationship.

Profile of the Current Study

The above studies identify that servant leadership and caring are essential aspects of nursing academia and the profession. This study also recognized the promise and the hope servant leadership holds for molding and shaping the next generation of nurses into more caring colleagues and practitioners. Therefore, this study is worthwhile for understanding the relationship between the servant organizational leadership nursing program and the pre-licensure baccalaureate nursing students’ caring dimensions within a Christian and Non-Christian worldview.

After careful deliberation, this researcher decided that the appropriate research design for understanding the relationship between the servant organizational leadership baccalaureate nursing program and the pre-licensure baccalaureate nursing students’ caring dimensions would

be a quantitative correlational method with a nonexperimental purposive sample. The instruments to be used in this study, the OLA-SV and CDI-25, are well-established, valid, and reliable for measuring servant organizational leadership and the caring dimensions of nurses, respectively. The instruments are well suited for confidential online, web-based surveys using the *Qualtrics* survey software and Microsoft Excel for organization and data calculations.

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter described the research methodology used to examine whether servant organizational leadership in Christian and Non-Christian baccalaureate nursing education enhances nursing student caring. A thorough discussion of the research design was conducted, including the problem, purpose statement, research questions and hypotheses, research design, and research methodology. The author detailed the population and explained the sampling procedures. The limitations of generalization were outlined to establish clear parameters for how this research can and cannot be applied. The ethical considerations of confidentiality and anonymity were presented. A description of the instruments used in this study included their validity and reliability. A step-by-step, chronological recount of the research procedures used in this study was presented in sufficient detail to enable future researchers to replicate this study if desired. Finally, data analysis and statistical methods were provided to understand how the data was managed.

Research Design Synopsis

The Problem

Is a caring servant nurse a relic of the past? Nursing history has demonstrated that “fidelity is the nurse’s duty to place the patient’s interests above self-interest or the interests of others” (Beauchamp & Childress, 2001). The impetus of that well-established therapeutic relationship lies in the heart of a nurse that cares for and about their patient (Bilowski & Wendler, 2005, p. 641).

Florence Nightingale put it this way, “Let whoever is in charge keep this simple question in her head [not, how can I always do this right thing myself, but] how can I provide for this right thing to be always done” (White, 2014, p. 27). Nightingale established the modern nursing

profession on her Christian value system of caring through serving, i.e., Christian servant leadership and Christian values in service to her patients, students, and God (Nightingale, 1969; Gill & Gill, 2005; Rakoczy, 2018; Hegge, 2011; McDonald, 2012).

The fundamental basis of the nursing profession remains the caring relationship between nurse and patient (Nightingale, 1969; O'Brien, 2011; O'Brien, 2001, Shelly & Miller, 1999; Shelly & Miller, 2006; Leininger, 1988; White, 2002; Wagner & Whaite, 2010; Serber, 2014; Paulson, 2004; Labrague, 2015; Fouch, 2016; Beckett, 2013; Ackerman, 2019). Furthermore, Fahlberg and Toomey (2016) explain that some of the best nursing leadership characteristics involve serving first and fostering caring relationships (p. 49). Therefore, the servant nurse leader can influence the group through those nursing relationships to effect cultural change (Northhouse, 2007, p. 5). These nurse leaders who model servant traits build cohesive organizational citizenship behaviors, such as compassion and altruism, to instill a sense of “cohesiveness, collaboration, and sustainable relationships” (Ebener & O'Connell, 2010, p. 315; Jit et al., 2017, p. 61).

Over the past 30 to 40 years, nursing and nursing education has seen a cultural shift that pits a Nightingale value system that calls for nurses to care for patients and students in service to God against the healthcare organization's pursuit of economic health (Shelly & Miller, 2009, pp. 23-24). To compete for viability in this new healthcare landscape, hospitals have moved from caring-healing environments to business or economic-based caring institutions focusing on census instead of patients, and technology instead of touch or human connection” (Ackerman, 2019, p. 572). This has led to stress, burnout, incivility, and worse – adverse patient outcomes (Palumbo, 2018, p. 144). Palumbo says that in this new healthcare environment where the

economic ‘bottom line’ takes precedence, “caring and administrative practices are often in conflict” (p. 144).

It used to be that nursing values and beliefs were for serving their fellow human beings. Around the mid-20th century, when nursing education moved from hospitals to universities, the nursing paradigm of care shifted from traditional nursing service to nurses viewing their role as “psychodynamic care provider(s) rather than nurturer(s). Nurses learned to view the nurse-patient relationship objectively and use a problem-solving process to provide nursing care” (Prater & McEwen, 2006, p. 64). The nurse educator can be a crucial mentor for indoctrinating nursing students into cultural, social, and political nuances (Newton et al., 2009; Walker et al., 2014).

If the dominant ‘bottom line’ economic culture in nursing is ever to become more caring and kinder, the servant teaching model may be the catalyst that produces nursing students who care more. When servant teachers see each student, and when students see each patient as being made in the image of God with innate value, their desire to share the love of God will have the power to change the healthcare and nurse education cultures in a positive way (Shelly & Miller, 2006; Kilner, 2015).

Because today’s nursing students are tomorrow’s nursing leaders, the servant teacher must model and nurture caring and serving relationships between teacher and student to effect positive cultural change in nursing for the benefit of the students, profession, and patients (Luparell, 2011, p. 92). Therefore, examining the relationship between Christian and Non-Christian servant organizational leadership in nursing education and pre-licensure baccalaureate nursing students’ caring dimensions is worthwhile because it may provide valuable insights into

how nursing can reconnect with its fundamental Christian calling – caring for patients in service to God.

Purpose Statement

The purpose of this quantitative correlational study was to understand if a relationship exists between Midwest Christian baccalaureate nursing programs and Non-Christian baccalaureate nursing programs' organizational servant leadership characteristics and their pre-licensure baccalaureate nursing students' caring dimensions. The principles of Christian servant leadership were the guiding theory for this study. Kirkpatrick (1988) defined the servant leader as,

A man or woman who has received a call from God to serve Him is cleansed and commissioned by God and is empowered and guided by the Holy Spirit. The marks of a servant leader are humility, integrity, and faithfulness to the Word of God. Jesus Christ is the model for all acts, attitudes, and attributes of servant leadership. (p. 11)

Leininger (1988) described caring as “the central and unifying domain for the body of knowledge and practice in nursing” and called for a better understanding of caring through evidence-based research to advance the profession and provide better outcomes for patients (p. 3). This study investigated whether the relationship between servant leadership, introduced early in the nurse's education, will lead to nurses who care more for God and their communities.

Shelly and Miller (1999) believe,

Nursing cannot work toward the goal of health without including the clear proclamation of the gospel and providing physical care with a servant attitude. Nursing as a vocation, or *calling*, from God, must return to its roots in the church and Christian faith to work toward the goal of true health. Furthermore, if we hope to maintain a strong Christian worldview in nursing, our faith must be nurtured in a Christian community and informed by a clear theology. True nursing cannot be divorced from the Christian story. (pp. 24-25)

Research Questions and Hypotheses

Research Questions

RQ1. What relationship, if any, exists between the Christian servant organizational leadership nursing program's level of servant leadership and their pre-licensure baccalaureate nursing students caring dimensions?

RQ2. What relationship, if any, exists between the Non-Christian servant organizational leadership nursing program's level of servant leadership and their pre-licensure baccalaureate nursing students caring dimensions?

RQ3. What relationship, if any, exists between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students caring dimensions?

Research Hypotheses

H₀₁. There is no statistical correlation between the Christian nursing program's servant organizational leadership characteristics level and their pre-licensure baccalaureate nursing students caring dimensions.

H₀₂. There is no statistical correlation between the Non-Christian nursing program's servant organizational leadership characteristics level and their pre-licensure baccalaureate nursing student caring dimensions.

H₀₃. There is no statistical correlation between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students' caring dimensions.

Research Design and Methodology

This study utilized the quantitative method with a correlational design to determine whether a relationship exists between the two variables of interest: the level of servant organizational leadership characteristics in four Christian and three Non-Christian baccalaureate nursing programs in the Midwestern region of the United States and the level of caring possessed by the pre-licensure baccalaureate nursing students in each school. Because the author is an expert, advanced practice registered nurse with more than 25 years in the nursing profession, a nonprobability purposive sampling process was used "based on the researcher's knowledge

about the population and its elements,” he judged to be typical of the larger, and homogeneous, population (Polit & Hungler, 1991, p. 260).

Polit and Hungler (1991) defined quantitative analysis as “the manipulation of numerical data through statistical procedures to describe phenomena or assess the magnitude and reliability of relationships among them” (pp. 652-653). A quantitative method was chosen for this research because of the specific nature of the instruments’ processes and their demonstrated reliability in measuring the relationship’s correlation that may be generalized to other organizations and nursing students (Leedy & Ormrod, 2019, p. 89). This study did not use the qualitative methodology because they “rarely try to simplify or quantify what they observe” (Leedy & Ormrod, 2019, p. 228). Also, the “*iterative and recursive process* methodology in which the researcher moves back and forth between data collection and data analysis” is not the straightforward method this study demands (Leedy & Ormrod, 2019, p. 229).

The correlational design was utilized for this research because it enabled the relationships of interest to be investigated to the degree that a difference in the level of servant organizational leadership characteristics correlates with differences in the level of pre-licensure baccalaureate nursing student caring characteristics (Leedy & Ormrod, 2019, p. 89). The purposive samples were chosen using nonprobability methods based on the researcher’s experience and expert knowledge of the population to discern whether a relationship exists between organizational servant leadership characteristics and pre-licensure baccalaureate student nurse caring dimensions in Christian and Non-Christian baccalaureate nursing programs.

Two well-established instruments were used to gather the data using the *Qualtrics* surveys web-based software via the internet. The first instrument is Laub’s (1999) Servant Organizational Leadership Assessment – Standard Version (OLA-SV) (Appendix A), which was

used to enable the researcher “to discover how [the nursing program’s] leadership practices and beliefs impact the different ways people function within the school” (p. 1). The second instrument is Watson and Lea’s (1997) Caring Dimensions Inventory-25 (CDI-25) instrument (Appendix F) which was used to establish the pre-licensure baccalaureate student nurses’ perceptions of caring (p. 87).

Population(s)

Inferential statistics allow researchers to draw inferences about large populations by gathering data from smaller samples of that population and then estimating the characteristics of the larger population. Therefore, population refers to “the entire set of individuals (or objects) having a common characteristic” (Polit & Hungler, 1991, p. 191). Whereas Leedy and Ormrod (2019) defined a sample as the “subset of a population of people, another biological species, or inanimate objects [where] data collected from this subset is used to conclude the population from which it has come” (p. 419).

As previously mentioned, the overall population of Midwest baccalaureate nursing programs and their pre-licensure baccalaureate students would be nearly impossible to reach individually. And even if it were possible to reach every individual population member, it would be too expensive and impractical to conduct a study of that size. With studies that utilize nonprobability samples, it is understood that said sample will only partially represent the larger population. Therefore, it is an accepted practice for researchers to resort to less-than-perfect nonprobability sampling techniques to obtain data that will be void of some members or elements of the population (Leedy & Ormrod, 2019, p. 177).

To that end, this study investigated two nonprobability selected populations of interest using purposive sampling. Purposive sampling is only sometimes a recommended quantitative

data collection method but can be helpful in certain circumstances (Polit & Hungler, 1991, p. 260). The fundamental basis for utilizing the purposive method in this research is that a “researcher’s knowledge about the [homogeneous nursing] population and its elements can be used to handpick the cases to be included in the sample” (Polit & Hungler, 1991, p. 260).

Within the Midwestern Region of the United States, there is an extensive enough baccalaureate nursing program base and student population from which a sufficient sample was drawn. It is noted that most schools of nursing reflect the population of the university’s location. O’Callaghan (2020) cited Robinia in her article, who said of nursing education, “Most college students tend to stick closer to their hometowns, and the more homogeneous the population in the university’s surrounding areas makes it difficult to attract more diverse nursing students” (p. 1). Green (2020) described the homogeneity, i.e., lack of variability, within the nursing population in the United States overall as improving but hardly representative of “cultural, linguistic, gender, and racial diversity” (p. 280). Green (2020) noted that the diversity in nursing academia is approximately the same as in the clinical side of nursing but remains low (p. 280).

The researcher’s experience and reason permit him to assert that, by and large, larger nursing programs admit larger and more diverse cohorts that reflect larger population centers, and smaller nursing programs admit smaller and lesser diverse cohorts that reflect their smaller population centers. This researcher purposively cast a wide net when requesting permission to research to match the variability of the overall Midwest baccalaureate nursing program population.

With that understanding, the researcher emailed *Permission to Conduct Research* emails to the Deans of Nursing at 101 baccalaureate nursing programs across the Midwestern United States (Appendix G). Only eight Deans of Nursing agreed to participate in this study. And of

those eight nursing programs, only seven schools participated in this research. Therefore, the overall nursing program participation rate was $7/101 = .07$. In the researcher's judgment, these respondent nursing schools accurately represented the general populations of the Midwestern baccalaureate nursing programs and pre-licensure baccalaureate students. Each nursing program provided two samples for this study.

The samples comprised a study population of four Christian and three Non-Christian baccalaureate nursing programs with typical enrollment sizes. The first sample consisted of four Midwestern Christian baccalaureate nursing programs, including the Faculty/Staff, Supervisors, and nursing program Top Leadership and the pre-licensure baccalaureate nursing students, Christian and Non-Christian, enrolled in those programs. The second sample consisted of three Midwestern Non-Christian baccalaureate nursing programs that included the Faculty/Staff, Supervisors, nursing program Top Leadership, and the pre-licensure baccalaureate nursing students, Christian and Non-Christian, enrolled in those programs.

The author deduced that the purposively derived samples of pre-licensure baccalaureate nursing students were the ideal choice for the study because they closely resembled the average of the larger nursing population, thereby avoiding the upper extreme (UE) values and the lower extreme (LE) values of the samples. At the UE of the sample population, baccalaureate nursing programs had enrollment greater than 1,800 pre-licensure baccalaureate nursing students. At the LE of the sample population, baccalaureate nursing programs had an enrollment of fewer than 75 students. The Non-Christian baccalaureate nursing programs tended to be State Universities with larger enrollment numbers, and the Christian baccalaureate nursing programs tended to be private Universities with fewer enrollment numbers. Using the purposive sample method, the

researcher had to reassess the sample distributions to ensure that samples were large enough to evaluate the data at a 95% Confidence Interval (CI).

RQ1 and RQ2 compared, in a rather straightforward fashion, the independent and dependent variables for each question using the derived measures of central tendencies and standard deviations. RQ3 compared the population independent variables Christian versus Non-Christian servant organizational leadership characteristics at baccalaureate nursing programs with the dependent variable population pre-licensure baccalaureate nursing student caring dimensions using two entirely different survey instruments. The OLA-SV instrument had 60 questions, and the CDI-25 instrument had 25 questions, respectively. This introduced complexity to performing inferential statistical methodology because the datasets were inherently unequal. Therefore, the researcher strategically employed the statistical bootstrap methods to ensure the necessary population characteristics could be compared using equal datasets and the results potentially generalized to the larger nursing population.

Sampling Procedures

The advantage of nonprobability sampling lies in its economy and practicality (Polit & Hungler, 1991, p. 260). Researchers can select from three nonprobability sampling techniques that they can use to gather data from their sample populations, i.e., convenience, quota, and purposive.

Convenience sampling is a method that investigates the subjects as they become available to the researcher (Leedy & Ormrod, 2019, p. 177). Quota sampling is a form of nonprobability sampling like the convenience sampling method. According to Polit and Hungler (1991), quota sampling is “the nonrandom selection of subjects in which the researcher pre-specifies characteristics of the sample to increase its representativeness” (p. 653). Purposive sampling is

the method of nonprobability sampling that best suits this research study. Polit and Hungler (1991) defined purposive sampling as “a type of nonprobability sampling method in which the researcher selects subjects for the study based on a personal judgment about which ones will be most representative or productive” (p. 652). It is commonly known as judgmental sampling; therefore, this researcher will use his advanced practice nursing experience and expert nursing judgment to select an appropriate sample.

Using a purposive sample is less likely to achieve accurate and reliable samples than probability sampling methods. With nonprobability sampling methods, “the researcher has no way of predicting or guaranteeing that each element of the population will be represented in the sample” (Leedy & Ormrod, 2019, p. 177). Most research, including nursing, utilizes nonprobability sampling methods (Polit & Hungler, 1991, pp. 256-257). Researchers justify using this method based on the belief that any errors of judgment over time will even out (Polit & Hungler, 1991, pp. 260).

Leedy and Ormrod (2019) suggest, “regardless of research methodology, purposive sampling involves choosing participants or other units of study, as the name implies, for a particular purpose” (p. 178). Upon admission to a nursing program, the diversity of the baccalaureate nursing student population typically reflects their home communities, and from there, students become acculturated into the nursing population (Milesky et al., 2015; Moorman, 2015; Nolan & Richards, 2015; Robinson, 2009; Paulson, 2004). In the researcher’s expert judgment and based on the Policy Brief for the American Association of Colleges of Nursing (AACN), the characteristics of the Faculty/Staff, Supervisors, and nursing program Top Leadership, and the pre-licensure baccalaureate nursing students enrolled in those programs in

the purposively selected test schools were representative of the population because of the homogeneous nature of the Midwest region's nursing population (AACN, 2019).

The sample population of four Christian and three Non-Christian baccalaureate nursing programs and the pre-licensure baccalaureate nursing students attending their programs was selected for this research. The samples were further divided into two different groups; one group measured Laub's (1999) six organizational health levels that included input by the Faculty/Staff, Supervisors, and nursing program Top Leadership, and the other group measured Watson and Lea's (1997) caring dimensions inventory of the pre-licensure baccalaureate nursing student participants.

Laub's (1999) OLA-SV instrument shows high reliability with a Cronbach's alpha score of 0.98 with similar populations. The OLA instrument is significant, exhibiting consistent validity with both test and retest at $p < .01$. The CDI-25 also exhibited an acceptable level of reliability at 0.91, showing a high level of internal consistency. The CDI-25 is significant with consistent validity at $p < .05$.

In research, the larger the sample, the better, which is the typical approach to identifying a sufficient sample size. To assist the researcher in selecting a sample size, Leedy and Ormrod (2019) suggested, "if the population size is beyond a certain point (about $N = 5,000$), the population size is almost irrelevant, and a sample size of 400 will be adequate" (p. 179).

This study's population sample is described here for statistical purposes. They will be referred to as University A, University B, University C, University D, University E, University F, University G, and University H.

University A is a Christian baccalaureate nursing program with 17 Faculty/Staff, Supervisors, and nursing program Top Leadership employed, and 108 pre-licensure

baccalaureate nursing students enrolled. University B is a Christian baccalaureate nursing program with eight Faculty/Staff, Supervisors, and nursing program Top Leadership employed and 79 pre-licensure baccalaureate nursing students. University C is a Christian baccalaureate nursing program with thirty-three Faculty/Staff, Supervisors, and nursing program Top Leadership employed, and 520 pre-licensure baccalaureate nursing students. University D is a Christian baccalaureate nursing program with ten Faculty/Staff, Supervisors, and nursing program Top Leadership employed and 65 pre-licensure baccalaureate nursing students enrolled. University E is a Christian baccalaureate nursing program with 17 Faculty/Staff, Supervisors, and nursing program Top Leadership employed and 62 pre-licensure baccalaureate nursing students. After this program committed to participating, they dropped out of the study due to an unforeseen transition the administration began to undergo. University F is a Non-Christian baccalaureate nursing program with 125 Faculty/Staff, Supervisors, and nursing program Top Leadership employed and 1,800 pre-licensure baccalaureate nursing students enrolled. University G is a Non-Christian baccalaureate nursing program with 103 Faculty/Staff, Supervisors, and nursing program Top Leadership employed and 384 pre-licensure baccalaureate nursing students. Finally, University H is a Non-Christian baccalaureate nursing program with 81 Faculty/Staff, Supervisors, and nursing program Top Leadership and 1,100 pre-licensure baccalaureate nursing students.

Therefore, this study had a population of 85 ($17 + 8 + 33 + 10 + 17 = 85$) Christian University Faculty/Staff, Supervisors, and nursing program Top Leadership participants, along with a population of 834 ($108 + 79 + 520 + 65 + 62 = 834$) Christian University pre-licensure baccalaureate nursing student participants. The information presented on the Christian university

websites affirming their Christian heritage, values, and missions led the researcher to believe they could model Christian servant organizational leadership.

Further, this study had a population of 309 ($125 + 103 + 81 = 309$) Non-Christian University Faculty/Staff, Supervisors, and nursing program Top Leadership employed participants along with a population of 3,284 ($1,800 + 384 + 1,100 = 3,284$) Non-Christian university pre-licensure baccalaureate nursing student participants. The information posted on the Non-Christian university websites did not lead the researcher to think these schools could model Christian servant organizational leadership. Finally, there was a total sample population of 394 Faculty/Staff, Supervisors, and nursing program Top Leadership participants and 4,118 pre-licensure baccalaureate nursing student participants equaling 4,512 participants in this study.

With a combined population size of about $N = 5,000$, Leedy and Ormrod's (2019) guidelines for an adequate sample size for this study would be approximately 400 participants. However, the precedent literature discussing nursing demographics describes the homogeneity of the overall nursing population (O'Callaghan, 2020; Green, 2020, AACN, 2019).

The *American Association of Colleges of Nursing* (AACN) (2019) Policy Brief indicates that while some progress has been made to increase diversity, work still needs “to be done nationwide and on state levels to increase diverse student representation in the nursing field” (p. 2). According to the National Academies of Sciences, Engineering, and Medicine (2021), *The Future of Nursing* report, “Although the composition of the nursing student body is more racially and ethnically diverse than that of the current workforce, diversity continues to be a challenge within the profession” (p. 31). The National League of Nursing, in a statement on diversity published on their website, noted that while the United States is historically culturally rich, diversity continues to be an issue for nurse educators and nursing students” (Green, 2020, p.

281). Leedy and Ormrod (2019) concluded that a homogeneous population [like nursing] does not require as large a sample as a population that is markedly heterogeneous (p. 180). Polit and Hungler (1991) explained, “If the population is homogeneous on the critical attributes, then systematic biases may be negligible” (p. 260).

Mostly, people’s lives are full of demands that keep them extremely busy. The life of a baccalaureate nursing program employee and a pre-licensure baccalaureate nursing student, the subjects of this study, is no different. It is not unusual for pre-licensure baccalaureate nursing students’ email boxes to be overburdened with surveys asking to be completed (Nulty, 2008). Corner and Lemonde (2019) understand the demands placed on pre-licensure baccalaureate nursing students and explain that “obtaining adequate survey response rates from registered nurses can, at times, seem like an uphill battle” (p. 58). Because of this, the author reasonably assumed that the rate of surveys returned would be lower than the sample size of 400 recommended by Leedy and Ormrod.

The researcher believed a sample rate of return of 20% would represent the larger population. He thought this rate of return was acceptable because only seven baccalaureate nursing programs had agreed to participate and because he used purposive sampling methods on a homogeneous population.

Limits of Generalization

This study’s nature pertains to pre-licensure baccalaureate nursing students at Christian and Non-Christian university nursing programs in the Midwest region of the United States who may or may not attend servant organizational leadership nursing programs. A limitation of the study was the lack of statistical power due to the small sample size of $n \sim 225$. The study investigated only a tiny facet of what could influence nursing students’ caring attitudes.

Nevertheless, this study was vital despite not establishing the relationship between servant organizational leadership in baccalaureate nursing programs and their pre-licensure baccalaureate nursing students' caring dimensions.

This study was limited because it is not easily generalized to nursing students outside the Midwest attending Christian and Non-Christian university baccalaureate nursing programs. Further, this study limited the generalization of the research findings on nursing student caring behaviors outside the Midwest attending Christian and Non-Christian baccalaureate nursing programs. This study only measured the CDI-25 instrument's 25 caring dimension statements and the OLA-SV 60-point servant organizational leadership questions.

Finally, registered nurse education spans several educational levels, from the associate degree to the doctoral degree, with many tracks leading to a number of advanced clinical or research specialties. This research had limited generalization to associate degrees, graduate degrees, and advanced specialty clinical and research degree programs.

Ethical Considerations

The use of human subjects in research must be carefully planned to comply with all ethical considerations. The researcher must remain vigilant in four areas of ethics to protect their subject's human rights. The four areas of ethics are protection from harm, voluntary and informed participation, right to privacy, and honesty with professional colleagues (Leedy & Ormrod, 2019, p. 111).

With protection from harm, researchers should not cause their subjects to experience any unnecessary physical or mental harm exceeding anything greater than the normal daily risks in their lives. When subjects are recruited for a research study, it is their right to be informed of the nature and goals of the study, what participation involves, to be informed that participation is

strictly voluntary, the benefits of the study, confidentiality and anonymity will be maintained, and that the subject will be able to contact the researcher about detailed information. The participant can sign and date an agreement to participate. The subject can expect the researcher will ensure their right to privacy. Finally, researchers should present any conflicts of interest that risk introducing bias into the study.

The research plan was reviewed and approved by the Liberty University (LU) Institutional Review Board (IRB) (Appendix H) as well as University A through H's nursing program's top leadership to ensure compliance with federal regulations protecting against human rights violations before proceeding (Leedy & Ormrod, 2019, p. 115). At University D, this study had to go through its IRB processes to obtain its approval to conduct this research there (Appendix I). This research investigated nursing students and nursing program employees who were presumed to be over the age of consent. Approval from the Deans of the Nursing programs was obtained by outlining a *Permission Request to Conduct Research* in their nursing program (Appendix G).

Once permission was granted to conduct research, a *Recruitment* email was sent to each participant via a third party. The emails contained a link to each survey (Appendix J). The Dean of the nursing program, or the Dean's designee, acted as a third party who distributed the email to the participants to ensure anonymity. The first page of the survey was the *Consent to Participate* in the study (Appendix K). The consent form contained the standard elements protecting the subject's human dignity. The consent also included the researcher's identification and the study's purpose. The benefits and risks were explained clearly. The participants were given a choice to participate, whereby clicking "no" closed the survey, and clicking "yes" confirmed their intent and willingness to participate and allowed them to proceed. The

participants' privacy and confidentiality were guaranteed. The participants were instructed that the data and other materials would be securely maintained for over five years (Creswell, 2014, pp. 92-101).

Instrumentation

The topic of teamwork in organizations worldwide in the first quarter of the 21st century has garnered much attention. Organizational leaders are challenged to improve their operations and to determine what leadership style best suits their needs. Many organizational leaders believe that servant leadership may be the answer to the traditional leadership power structures.

Laub (1999) said new leadership is what is needed for the 21st-century organization that “is not trendy and transient, but a leadership that is rooted in our most ethical and moral teaching; leadership that works because it is based on how people need to be treated, motivated and led” (p. 4). He set about to develop an instrument that researchers can use for “assessing the level at which leaders and workers perceive that these [servant leader] characteristics are displayed in their organizations” (Laub, 1999, p. 4).

The OLA-SV instrument is an instrument that can be effectively utilized to establish to what degree servant leadership exists in an academic organization (Attachment G). It is a 60-question questionnaire divided into three sections. It is “designed to be taken by people at all levels of the organization including Faculty/Staff, Supervisors, and nursing school Top Leadership” (Laub, 1999). Through his research, and as previously discussed, Laub (1999) discovered that the OLA instrument displayed high-reliability scores with a high correlation for the following six constructs: values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership (p. 67).

The OLA-SV is a trusted and reliable instrument for measuring the health of servant-minded organizations (Laub, 2003). Laub (1999) comprised an expert panel who “were experts in the servant leadership field or who taught about it at the university level,” and they determined that the OLA-SV had the “necessary and essential” characteristics of servant leadership within the 60-question instrument (p. 42). Laub (1999) utilized a Delphi process to reach a consensus on the instrument’s constructs. The OLA-SV has a high-reliability score of .98 using Cronbach’s alpha coefficient (Laub, 2003). The test-retest study on the instrument showed “the means and standard deviations between the Test and the Retest for this study remained consistent at $p < .01$ (Laub, 2003).

This researcher employed the assistance of a third party to email links to electronic surveys to participants to collect quantitative data describing their nursing program’s servant organizational leadership characteristics. OLA-SV uses a five-point Likert scale ranging from Strongly Agree to Strongly Disagree. Responses will be as follows: Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2, and Strongly Disagree = 1. According to Laub (2005), the average score on the OLA-SV is 3.64 (p. 161). Likert responses were combined into a composite inventory score that ranges from 60 to 300 points (Leedy & Ormrod, 2019, pp. 155-156). A score of 60 will be the lowest possible score on this 60-question inventory, and a score of 300 will be the highest. The information derived from the Likert responses was part of the raw data used to calculate the mean Organizational Health Level.

Laub’s research (2005) further determined that the breakpoint for identifying an organization as a servant leadership organization was a score of 4.0 (p. 161). Laub’s (2005) Six Organizational Health Levels are as follows:

- 1.0 to 1.99 = Org 1 = Autocratic (Toxic Health)
- 2.0 to 2.99 = Org 2 = Autocratic (Poor Health)

3.0 to 3.49 = Org 3 = Negative Paternalistic (Limited Health)
3.5 to 3.99 = Org 4 = Positive Paternalistic (Moderate Health)
4.0 to 4.49 = Org 5 = Servant (Excellent Health)
4.5 to 5.00 = Org 6 = Servant (Optimal Health) (p. 161)

The OLA-SV instrument has been used in numerous studies in the United States and abroad, such as Henning's (2016) research, "The relationship between servant leadership and employee job satisfaction in a Colorado nonprofit organization" (pp. 1-152); Azadfada's (2014) study, "The relationship between servant leadership and athlete satisfaction" (pp. 528-537); and, Padron's (2012) dissertation, "Higher education leadership: Servant leadership and the effects on student satisfaction" (pp. 1-90).

Watson and Lea (1997) acknowledged that caring is difficult to quantify but said they were determined to develop an instrument that could be used to measure "existing conceptualizations of caring" (p. 87). The second part of this study was to survey the pre-licensure baccalaureate nursing students to assess their caring dimensions. According to Watson and Lea (1997), the 25 core questions that make up the Caring Dimensions Inventory - 25 (CDI-25) (Attachment H) are used to measure the subjects' "agreement to statements about their nursing practice as constituting caring" (Watson & Lea, 1997, p. 90).

The CDI-25 instrument is used to measure the caring dimensions of nurses, and "the CDI scale was related to the constructs of age and sex of respondents" (Watson & Lea, 1997, p. 87). Cronbach's alpha was used to measure the reliability and internal consistency of the 25 core items. According to Watson and Lea (1997), Cronbach's alpha is a measure "which is the average of all the split half measures which could be applied to the data and is a measure of the extent to which each of the items in a questionnaire is measuring the same phenomenon as the overall inventory. The reliability value for the 25 core items of the CDI-25 was 0.91, indicating that it had a high degree of internal consistency" (p. 89).

This researcher used an electronic survey sent to participants via email to collect quantitative data describing the pre-licensure baccalaureate nursing student caring dimensions. A five-point Likert scale was implemented, ranging from Strongly Agree to Strongly Disagree. Responses were as follows: Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2, and Strongly Disagree = 1. Likert responses were combined into a composite inventory score that ranges from 25 to 125 points (Leedy & Ormrod, 2019, pp. 155-156). A score of 25 will be the lowest possible score on this 25-question inventory, and a score of 125 will be the highest. A score of 25 means the subject possesses very little to no caring in their nursing practice, whereas a score of 125 means the participant is very caring in their nursing practice.

Over the past twenty-five years, the CDI-25 instrument has been used in numerous studies, both domestic and international such as Fernandez-Trinidad et al. (2019) study, “Perception of caring among nursing students: Results from a cross-sectional survey” (pp. 1-7); Salimi et al. (2014) study, “Psychometric properties of the Persian version of the Caring Dimension Inventory (PCDI-25)” (pp. 173-179); and Bergen and Barber’s (2019) study, “Student identification and demonstration of caring behaviors during simulated patient experiences” (pp. 221-233).

Validity

Roberts (2010) described the importance of the validity of the instrument as “the degree to which the instrument truly measures what it purports to measure, i.e., can the researcher trust that findings from the instrument are true?” (p. 151). Laub (1999) produced the OLA-SV instrument through the work he did on his dissertation. Many researchers scrutinized and highly regarded his research, as evidenced by the numerous times the assessment instrument has been used in research both here and abroad, exhibiting face validity.

Leedy and Ormrod (2019) defined face validity as “the extent to which, on the surface, a strategy appears to yield an accurate assessment of a particular characteristic [and] is often useful for ensuring the cooperation of people who are participating in a research study” (p. 104).

In addition to face validity, the literature discussed the homogenous composition of the nursing profession, which only added to the validity of the instruments. The AACN (2019) Policy Brief indicated that while some progress has been made to increase diversity, work still needs “to be done nationwide and on state levels to increase diverse student representation in the nursing field” (p. 2). The NLN’s (2020) statement on diversity acknowledged that diversity continues to be an issue for nurse educators and nursing students (Green, 2020, p. 280).

The researcher believes construct validity will be such that the student nurses will not directly observe the organization’s servant leadership characteristics but “is assumed to exist based on patterns in people’s behaviors or creations such as more caring characteristics” (Leedy & Ormrod, 2019, p. 105). Further, Leedy and Ormrod (2019) described the purpose of an expert panel of judges as “to scrutinize and assess the instrument or other assessment strategy and give informed opinions about its validity for determining the quantity or quality of a characteristic under investigation (p. 106). However, considering the demonstrated strength of the OLA-SV and CDI-25’s validity and the homogenous nature of the nursing profession, this researcher did not think employing an expert panel of judges would increase the validity to any greater degree.

Parametric statistics, such as multiple regression and the Analysis of Variance (ANOVA), are powerful tests that were used to “examine differences among three or more means by comparing the variances (s^2) both within and across groups” (Leedy & Ormrod, 2019, p. 334).

Reliability

When measuring an instrument's reliability, one must consider "the degree to which an assessment strategy consistently yields very similar results when the entity being assessed hasn't changed" (Leedy & Ormrod, 2019, p. 107). Reliability can assume several forms that researchers must be aware of, such as interrater reliability, test-retest reliability, equivalent-forms reliability, and internal consistency reliability (Leedy & Ormrod, 2019, p. 107).

Some important concepts to understand regarding reliability are "1) an assessment strategy can be valid only to the extent that it is also reliable, and 2) reliability is a necessary but insufficient condition for validity" (Leedy & Ormrod, 2019, p. 107).

Standardization is the strategy this researcher used to improve reliability and thus improve validity. The instruments used in the study have consistently been proven valid in numerous studies. Further, a third party sent the surveys to each participant's private school email address with identical content, format, administration procedures, and evaluation criteria, as Leedy and Ormrod (2019, p. 108) discussed.

To show instrument reliability, Cronbach's alpha was run using the Qualtrics web-based software where "indices of homogeneity or internal consistency estimate the extent to which different subparts of [the OLA-SV and CDI-25] instruments are equivalent in terms of measuring the critical attribute" (Polit & Hungler, 1991, p. 372).

Research Procedures

This research was conducted following established scientific research methods. The researcher emailed the university personnel approving the study, i.e., Liberty University and University A through H's top leadership (Appendix E). Permission to conduct research was

granted by the appropriate nursing program's top leadership person via a Liberty University IRB-approved email.

After Liberty University IRB approval, a request to participate letter containing a link to the OLA-SV survey was sent out via a third-party designee selected by the Deans of Nursing to the Faculty/Staff, Supervisors, and the nursing school's Top Leadership via private school email with a link to the *Qualtrics* survey software for participation (Appendix J). The Consent document was on the first page of the survey, and informed consent was obtained when the participant agreed to participate in the study by clicking yes (Appendix K). Upon completion of the OLA-SV assessment, the raw data was automatically forwarded to Dr. Laub's olagroup.com website for his ongoing maintenance of the instrument. When Dr. Laub completed his due diligence, he sent this researcher a Microsoft Excel spreadsheet as an attachment containing the raw data for analysis (Appendix E).

The CDI-25 survey link was sent to the pre-licensure baccalaureate nursing students in the same letter containing the OLA-SV survey link (Appendix J). The Consent document was on the first page of the survey, and informed consent was obtained from the students before they started the study by clicking yes to proceed, just as above. When the participant completed the survey, the raw data was automatically entered into the *Qualtrics* software for compilation, analysis, and export to Microsoft Excel.

This researcher requested approximately six months to complete the administration of the tests. After all the data was compiled from the 229 combined OLA-SV and CDI-25 surveys, the raw data was packaged for export from the *Qualtrics* software to Microsoft Excel for analysis. Once the information was compiled, organized, and refined, it was ready to be utilized as the basis for Chapter 4, Analysis of Findings.

Data Analysis and Statistical Procedures

Statistical analysis is usually done to summarize, explore the meaning of data, compare or contrast, test relationships, infer findings from the sample that may represent the larger population, predict, and find causality (Burns & Grove, 2005, p. 452). An online survey using the *Qualtrics* survey software available through Liberty University and the raw data from Dr. Laub's OLA-SV survey was utilized to prepare the data for examination and exported to Microsoft Excel for analysis.

Polit and Hungler (1991) described data analysis as “the systematic organization and synthesis of research data, and the testing of research hypotheses using those data” (p. 643). A good design has four characteristics: appropriateness for research questions, lack of bias, precision, and power. The research questions attempt to investigate and find an answer to the research problem; therefore, the importance of asking the appropriate research questions cannot be overstated.

The researcher must be cognizant of any bias allowing anything to influence or distort the data received or conclusions drawn (Leedy & Ormrod, 2019, p. 181). Knowing the sources of bias that can enter a study is critical to preventing it in the first place. Leedy and Ormrod (2019) defined the four categories of bias like this,

- Sampling bias is any factor that causes a researcher to obtain a nonrepresentative sample of the studied population inadvertently.
- Instrumentation bias is how particular assessment strategies slant the obtained results in one direction.
- Response bias is the tendency for people to make inaccurate statements (often inadvertently) in their responses to questions in interviews or on questionnaires.
- Researcher bias is the potential effects of a researcher's expectations, values, and general belief systems, which can predispose the researcher to study particular and no other variables and draw specific and no different conclusions. (pp. 181-184)

Bias may be subtle or overt, and the sign of a good study would be the lack of bias. Precision refers to the sensitivity of the methods that place “control over variability in the dependent measures” to ensure a more precise estimate of the effect of participation in the research. Finally, power is “the ability of a research design to detect relationships among variables” (Polit & Hungler, 1991, pp. 240-242). For the proposal, Creswell (2014) recommended that the researcher “present information about the steps involved in analyzing the data as a series of steps so that a reader can see how one step leads to another for a complete discussion of the data analysis procedures” (p. 162).

Data Analysis

Two instruments, the OLA-SV and CDI-25, were used to measure the correlation between nursing program servant organizational leadership characteristics and the pre-licensure baccalaureate student nurses’ caring dimensions, respectively. The OLA-SV instrument is a copyrighted instrument. Dr. James Laub, the proprietor, processed this instrument’s raw data for a fee before handing it back to this researcher. This researcher was responsible for all data analysis of the OLA-SV instrument’s raw data associated with this study.

Once an agreement with Dr. Laub’s terms was reached, he retained access to the study’s findings for ongoing maintenance of his instrument. After Dr. Laub completed his data analysis, he forwarded the raw data in Microsoft Excel format and the OLA report to this researcher. From there, this researcher processed and analyzed the OLA data for this study using Microsoft Excel.

Dr. Laub may be contacted for questions regarding the OLA-SV instrument via his organization’s website, www.olagroup.com. He also required a copy of the researcher’s completed dissertation for his record. The CDI-25 instrument is not copyrighted, and the authors do not require any prior authorization to use the instrument. An email requesting the use of his

instrument was sent to Dr. Watson's email address on record but was returned to the sender, unreceived.

Statistics describe the data, i.e., "where their midpoint is, how broadly spread, how closely two or more variables within the data are associated with one another" (Leedy & Ormrod, 2019, p. 310). This study looked to describe the measures of central tendency, which is the "middle number around which the data regarding a particular variable seem to hover, such as the mode, median, and mean" for the level of servant organizational leadership and the pre-licensure baccalaureate nursing student caring dimensions (Leedy & Ormrod, 2019, p. 315).

Polit and Hungler (1991) defined a scatter plot as "the graphic representation of a correlation between two variables" (p. 419). Scatterplots visually represent the linear relationships between Laub's servant organizational leadership constructs of Christian and Non-Christian baccalaureate nursing programs and their pre-licensure baccalaureate nursing students' caring dimensions deemed by this researcher to be equivalent to the OLA subscores.

As an adjunct to the scatter plot, the mathematical way of numerically expressing the direction and magnitude of a linear relationship is called a correlation coefficient. Polit and Hungler (1991) described a correlation coefficient as "an index whose values range from -1.0 for a perfect negative correlation, through zero for no relationship, to +1.0 for a perfect positive correlation. The higher the absolute value of the coefficient, the stronger the relationship" (p. 420-421).

Pearson's r is a commonly used correlation index that measures the strength of the study's two variables in the sample (Polit & Hungler, 1991, p. 421). The Microsoft Excel software provided the calculations using this method to determine whether the correlations were statistically significant.

Creswell (2014) recommended that the researcher “present information about the steps involved in analyzing the data as a series of steps so that a reader can see how one step leads to another for a complete discussion of the data analysis procedures” (p. 162). What follows is a step-by-step presentation of the methods used to analyze the data presented:

Step 1: The first steps were to prepare for conducting this research by getting preliminary demographic data on the nursing programs organized and the authorizations from the Christian Leadership Program. Approval by Dr. Laub for using the OLA instrument was obtained (Appendix C), LU IRB approval to conduct this research (Appendix H), and University D IRB approval (Appendix I) was obtained. Initial emails were sent to four nursing programs requesting permission to conduct research at their university.

Step 2: The study went live as the *Request to Participate* emails began to be received by the participants. The response to the initial mailing was dismal; therefore, this researcher received LU IRB approval to modify the request to participate in this research to 101 nursing programs across the Midwestern region of the United States in a second mailing. A table of frequency and percentages depicting the demographic composition of the pre-licensure baccalaureate nursing students who responded to this survey is given in Table 1.

Table 1*CDI-25 Participant Demographic Data*

Variable	Frequency	%	Cumulative %
Age			
18-24	169	84.9%	84.9%
25-34	21	10.5%	95.4%
35-44	3	1.5%	96.9%
45 and older	6	3.0%	100.0%
Gender			
Male	16	8.0%	8.0%
Female	183	92.0%	100.0%
Non-Binary/Third Gender	0	0.0%	0.0%
Prefer not to say	0	0.0%	0.0%
Highest Education Level Attained			
High School or equivalent	136	68.3%	68.3%
Associate's	28	14.1%	82.4%
Bachelor's	31	15.6%	98.0%
Master's	4	2.0%	100.0%
Doctorate	0	0.0%	0.0%
Religious Affiliation/School Type			
Christian in Christian School	67	34.7%	34.7%
Christian in a Non-Christian School	73	37.8%	72.5%
Non-Christian in Christian School	8	4.2%	76.7%
Non-Christian in Non-Christian School	45	23.3%	100.0%
Year in Nursing School			
First Year	16	8.1%	8.1%
Second Year	41	20.7%	28.8%
Third Year	62	31.3%	60.1%
Fourth Year	79	39.9%	100.0%
“Called” to be a Nurse			
True	145	72.9%	72.9%
False	54	27.1%	100.0%

The response by the University subgroups, Faculty/Staff, Supervisors, and the nursing program's Top Leadership participants was even less than the pre-licensure baccalaureate

nursing student responses. The frequency and percentages describing the demographic composition of the OLA-SV participants are presented in Table 2.

Table 2

OLA-SV Participant Demographic Data

Variable	Frequency	%	Cumulative %
Role in Organization			
Top Leadership	2	6.25%	6.25%
Supervisor	7	21.88%	28.13%
Faculty/Staff	23	71.88%	100.00%
Religious Affiliation			
Christian/Christian School	13	40.06%	40.06%
Christian/Non-Christian School	11	34.40%	74.46%
Non-Christian/Christian School	0	00.00%	74.46%
Non-Christian/Non-Christian School	8	25.00%	100.00%
Christian or Non-Christian School			
Christian	13	40.60%	40.60%
Non-Christian	19	59.40%	100.00%

Table 3 depicts the OLA-SV participatory response of each individual nursing program. The size of the university did not matter when it came to the nursing program's employee participation. Out of 309 potential nursing program employee participants, a grand total of only 32 completed surveys. University F is a moderately large Non-Christian school that had the greatest participation with 47% of participants. University A was a small Christian nursing program with an 18.8% participatory rate. University B, another small Christian nursing program, had a participation rate of 12.5%. Neither of the four remaining universities, University C, University D, University G, and University H, had a participation rate greater than 10% and, therefore, contributed very little to this study.

Table 3

Demographic Characteristics of the OLA-SV Respondents by University (N = 32)

Variable	Frequency	Percent
Organization Subgroup		
University A	6	18.8%
University B	4	12.5%
University C	3	9.3%
University D	1	3.1%
University F	15	47.0%
University G	1	3.1%
University H	2	6.2%

Step 3: Descriptive statistics were used in the study to answer RQ1 and RQ2. Nursing program employees' perception of servant organizational leadership and nursing students' perception of caring dimensions were calculated with a focus on measures of central tendencies and the standard deviation.

Step 4: Inferential statistics were used to answer research question three. Polit and Hungler (1991) defined inferential statistics as statistical analysis that permits us to infer whether relationships found in a sample are likely to occur in the larger population (p. 429). The OLA-SV employee subgroup responses required an equal number of datasets in each group to perform multiple regression analysis on the sample populations. Further, the OLA-SV instrument employee subgroup responses needed equally numbered datasets matching the CDI-25 instrument responses to derive meaningful data for answering RQ3. Therefore, there needed to be equalized datasets across all samples to conduct inferential statistical analysis.

Step 5: Prepared the samples using the bootstrap method composed of randomly selected datasets from the original datasets. Specifically, the bootstrap technique provided a method to randomly create sufficient datasets to measure statistical inferences between the OLA-SV and CDI-25 samples.

According to Efron and Tibshirani (1994), “the bootstrap is a computer-based method for assigning measures of accuracy to statistical estimates where bootstrap confidence intervals are directly constructed from real datasets, using a simple algorithm” (p. 10). Interestingly, the bootstrap method can be more accurate than “classical inferences based on Normal or t distributions” (Bland & Altman, 2015, p. 1). Therefore, using randomly selected datasets from participants in each sample, the researcher employed the statistical bootstrap technique using Microsoft Excel to create computer-generated random datasets for each sample that could be useful for understanding the relationship between the OLA-SV constructs and the CDI-25 equivalent caring dimensions statements.

Statistical Procedures

Step 1: Descriptive analysis using Microsoft Excel software was used to measure frequency, central tendency, and standard deviation.

Step 2: Factor analysis was performed on results from both the OLA-SV and CDI-25 instruments to measure pre-licensure baccalaureate nursing student caring dimensions. Each instrument’s authors used Cronbach’s alpha to measure internal consistency and establish their respective survey’s well-established reliability.

Step 3: Inferential statistics describing the relationship between Christian vs. Non-Christian nursing programs’ servant organizational leadership and their pre-licensure baccalaureate nursing students’ caring dimensions were obtained using the Microsoft Excel calculator. ANOVA methodology was used to infer the properties of the populations, the independent (X) variables, Christian and Non-Christian baccalaureate nursing programs level of servant organizational leadership, and the dependent (Y) variable, pre-licensure baccalaureate nursing students caring dimensions.

Step 4: The final step in the data analysis was to present the results in tables or figures and interpret the results. The researcher was able to reach conclusions regarding the research questions and hypotheses based on the results of the statistical analysis.

Chapter Summary

In conclusion, this chapter discussed the research design, including the problem and purpose statement. The research questions were presented along with the populations and sampling procedures. The research hypotheses were given based on the research questions. The research design and methodology were identified and described. The limits of generalization were given to determine the appropriate application range of the research based on the sampling approach. Ethical considerations were discussed regarding consent, anonymity, and confidentiality. The well-established OLA-SV and CDI-25 instruments were described, and much discussion was given on how the survey was designed, validated, and checked for reliability. The instrument's authors established each instrument's validity and reliability using Cronbach's Alpha. A Likert scale was used to measure the subjects' responses. A step-by-step procedure was given for ease of replication by other researchers. The data were compiled and analyzed, and all research questions were answered. Tables were presented to help explain the findings. The statistical procedures used to describe the results were given.

CHAPTER FOUR: FINDINGS

Overview

This quantitative correlational study aimed to understand if a relationship exists between Midwest baccalaureate Christian baccalaureate nursing programs and Non-Christian baccalaureate nursing programs' servant organizational leadership characteristics and their pre-licensure baccalaureate nursing student's caring dimensions. The researcher's interest in this study stems from the nursing literature that describes the nursing culture as uncivil and his observations from being in the nursing field for nearly thirty years.

With a desire to improve the culture in nursing that is enlightened and led by the Holy Spirit, this researcher explored the relationship between Christian and Non-Christian servant organizational leadership in baccalaureate nursing education and the caring dimensions of their pre-licensure nursing students. The literature shows that much of the uncivil culture results from the business/medical leadership model prominent in university nursing programs and the healthcare profession. The literature holds the promise that exposing nursing students to the servant leadership model early in their education may foster a more caring approach to patient care by empowering nurses through shared leadership and knowledge creation, leading to an improved nursing culture.

Chapter Four reviews the research methods discussed in the previous chapters concerning the research questions and hypotheses. Then, it discusses the study's compilation protocol and measures and thoroughly examines the study's demographic and sample data. Fundamental to chapter four is its discussion of data analysis and findings. Lastly, the chapter finishes with an evaluation of the research design.

Research Questions

RQ1. What relationship, if any, exists between the Christian servant organizational leadership nursing program's level of servant leadership and their pre-licensure baccalaureate nursing students caring dimensions?

RQ2. What relationship, if any, exists between the Non-Christian servant organizational leadership nursing program's level of servant leadership and their pre-licensure baccalaureate nursing students caring dimensions?

RQ3. What relationship, if any, exists between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students caring dimensions?

Hypotheses

H₀₁. There is no statistical correlation between the Christian nursing program's servant organizational leadership level and their pre-licensure baccalaureate nursing students caring dimensions.

H₀₂. There is no statistical correlation between the Non-Christian nursing program's servant organizational leadership level and their pre-licensure baccalaureate nursing students caring dimensions.

H₀₃. There is no statistical correlation between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students caring dimensions.

Compilation Protocol and Measures

This section describes how this quantitative research gathered and analyzed the information. Numerical values were assigned to each survey question that measured the participants' attitudes toward the questions. The data were organized and manipulated in such a way as to describe the characteristics of the sample and the unique relationships between the variables under study. This study's appropriate statistical methods and analysis were determined once the raw data were collected.

Protocol

The data were collected from two separate groups of participants using two survey instruments. The CDI-25 instrument collected the pre-licensure baccalaureate nursing student's data via the Qualtrics web-based software and exported it to a Microsoft Excel spreadsheet. The OLA-SV survey is a copyrighted instrument; therefore, the researcher had to obtain permission from the proprietor, Dr. James Laub, to use it for this research (Appendix C). Laub's approval to use his instrument was based on the merits and nature of this study. The researcher understood that Dr. Laub would be involved in the study only for the ongoing maintenance of his instrument. It is important to note that beyond that, Laub had no further participation in this research.

Dr. Laub's participation in this study consisted of preparing the OLA-SV instrument's access for the participants at his olagroup.com website. This researcher provided the nursing program's third-party designee with the Recruitment email containing the Qualtrics link (Appendix J). The nursing program's third-party designee emailed the Recruitment letter with the OLA-SV link to potential participants taking them to the OLA-SV survey's consent page in Qualtrics to ensure anonymity. At the end of the consent page (Appendix K), participants were given the option to decline participation or to participate with directions on how to continue to the olagroup.com website to complete the survey in their assigned subgroup. Each of the seven nursing programs that agreed to participate was a designated employee subgroup. Each employee subgroup was further subdivided into the nursing program's Top Leadership, Supervisor-level, and Faculty/Staff roles. Dr. Laub then gathered and reviewed the raw data to confirm his instrument's validity and reliability as the participants began to take the survey. Once the survey was shut down, Laub gave this researcher the raw data via Microsoft Excel spreadsheet for his examination and application in this study (Appendix E).

Descriptive Statistical Measures

Descriptive statistics describe the study's data using central tendency, i.e., mode, median, mean, variability, and relationships between variables (Leedy & Ormrod, 2019). This research utilized descriptive statistics to “render quantitative information meaningful and intelligible” (Polit & Hungler, 1991). The measures of central tendency, variability, and correlation between variables gave quantifiable information that addressed the research questions and hypotheses. This study sought to understand the correlation between the independent and dependent variables.

Central Tendencies

Population characteristics can be described using measures of central tendency like the mode, median, and mean (Leedy & Ormrod, 2019). This study utilized the mean to compute scores related to servant organizational leadership characteristics in Christian and Non-Christian baccalaureate nursing programs (independent variable) and their pre-licensure baccalaureate nursing students' caring dimensions (dependent variable). Likert scales were used to quantify the independent and dependent variables into data that could be treated at the ordinal or interval levels (Polit & Hungler, 1991).

Leedy and Ormrod (2019) point out that “ordinal data are those for which the assigned numbers reflect an order or sequence, indicate the degree to which people, objects, or other entities have a certain quality or characteristic (a variable) of interest, but not how great the differences are” (p. 312). For example, the OLA-SV score represents an organization's faculty and staff's mean response to sixty questions about servant organizational leadership in their workplace using a 1 to 5 Likert scale.

The OLA-SV instrument measures the six constructs of servant leadership that were identified by Dr. Laub's original research, i.e., values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership. For the purposes of this research, this researcher will refer to Laub's six constructs/subscores as constructs. Additionally, the CDI-25 score represents ordinal data that reflect a participant's mean response to twenty-five statements about nurse caring dimensions using a 1 to 5 Likert scale.

Variability

Because the instruments used for this study included ordinal level scales, i.e., the Likert scale, standard deviations could be used to calculate and discover the spread of the data. Leedy and Ormrod (2019) noted, "As specific data points recede farther from the mean, they lose more and more of the quality that makes them 'average'" (p. 101).

Correlation

This correlational study attempted to discover whether the independent variable, servant organizational leadership in a Christian or Non-Christian baccalaureate nursing program, was related to the dependent variable, pre-licensure baccalaureate nursing student caring dimensions. However, this study did not "in and of itself, indicate causation" (Leedy & Ormrod, 2019, pp. 148-149). The Pearson product-moment (parametric) correlation test was utilized for this purpose. The Pearson product-moment test (Pearson's r) is "the most commonly used correlation index" (Polit & Hungler, 1991, p. 421).

Demographic and Sample Data

This study relied on a non-probability purposive sampling strategy. While random sampling may be the best possible method to accurately describe a population under study (Polit & Hungler, 1991), it was not a practical strategy for this study. This study examined three

populations closely associated with one another in the nursing education profession. The three populations are (1) the Christian baccalaureate nursing program employees, including the three subgroups of Faculty/Staff, Supervisors, and the nursing program's Top Leadership, (2) the Non-Christian baccalaureate nursing program employees, including the three subgroups of Faculty/Staff, Supervisors, and the nursing program's Top Leadership, and (3) their pre-licensure baccalaureate nursing students.

The nursing population is uniformly homogeneous, with only slight characteristic variations across the different regions of the United States (American Association of Colleges of Nursing, 2019). The sample in this research consisted of seven baccalaureate nursing programs in the United States Midwest region. The nursing programs were further divided into four Christian and three Non-Christian programs. The nursing programs were only identified as Christian (Universities A through D) versus Non-Christian (Universities F through H) to maintain anonymity.

To form a sample that genuinely reflects the nursing program employees and pre-licensure baccalaureate nursing students, the number of nursing program employees and students in the United States Midwest region must be a known entity. However, identifying the exact or actual number of nursing program employees and students was impossible due to the cost and time requirements to identify these individuals, hence the purposive sample design of this study.

The Midwest region of the United States consists of twelve states. The researcher sent a *Request to Conduct Research* email to the Deans of Nursing at 101 universities in six of those 12 Midwestern states. He did this to ensure an adequate sample size for this study.

The literature discussed the difficulty of enlisting nurses and nursing students to participate in survey research (Nulty, 2008; Corner & Lemonde, 2019). This researcher,

therefore, anticipated it might be challenging to enlist enough participants for this study, hence the need for casting such a wide net. True to form, only eight Deans of Nursing agreed to participate in this study, and one backed out just before the surveys went live. It became clear that the targeted number of 400 participants to meet the minimum sample size for the pre-licensure baccalaureate nursing students or the 250 participants for the Faculty/Staff, Supervisors, and nursing program Top Leadership recommended by Leedy and Ormrod (2019) could not apply in these samples (p. 179).

For anonymity, the researcher emailed the Deans of those nursing programs to request that they forward a Recruitment Letter to each nursing program employee working for them and each pre-licensure baccalaureate nursing student attending their nursing programs. Therefore, the Dean or their designee acted as a third party who forwarded the Recruitment emails with the survey links requesting their people's participation in this study. This left the researcher blind to the participants' identities, thereby maintaining anonymity.

The Deans of each nursing program provided the researcher with quantitative demographic information describing the number of potential participants that composed both of this study's samples. Even though there was no way to determine whether the sample participants were valid, one can assume they were valid because the surveys were directly delivered by one in authority to the specific demographic of this study. Again, the survey response rate by Faculty/Supervisors, nursing program Top Leadership, and pre-licensure baccalaureate nursing students was dismal.

There was no way the researcher could know and, therefore, could not accurately calculate how many potential respondents received the recruitment documents versus those who participated in this research. Consequently, this required the researcher to reanalyze the

minimum sample of this homogenous population based on the quantitative demographic information provided by the Deans of Nursing and the raw data returned.

Reanalysis of the minimum sample required all valid and completed data to be utilized. The researcher received preliminary demographic data from each nursing program describing the personnel employed by the nursing program and the pre-licensure nursing students in attendance. Of the eight nursing programs that agreed to participate in the study, 394 faculty/staff, supervisors, and nursing program top leadership could potentially complete the OLA-SV survey, and 4,118 pre-licensure baccalaureate nursing students could complete the CDI-25 survey.

Out of the 4,118 potential CDI-25 participants, per the Deans of Nursing, 245 CDI-25 surveys were returned. Of the 245 CDI-25 surveys returned, 43 still needed to be completed, and five were opened by nursing students who declined to consent to the study. It is assumed they still need to meet participation requirements. That makes 197 valid and completed CDI-25 surveys returned (see Table 4).

Further, out of the 394 potential OLA-SV participants, there were 32 OLA-SV surveys received. Once again, one can assume all the acquired OLA-SV surveys were valid and completed because the surveys were delivered via email by one in authority directly to the specific demographic of this study. Of the 32 OLA-SV surveys returned, Christian nursing program employees completed 14, and participants by non-Christian nursing program employees completed 18 surveys, as shown in Table 4.

Table 4*Survey Response Data*

	CDI-25 Instrument	OLA-SV Instrument
Potential Participants (per Deans of Nursing)	4,118	394
All Surveys Collected	245	32
All Surveys Not Completed	43	0
Participants who Opened Survey but did not Consent to Participate	5	0
Valid & Completed Surveys	197	32

This study's lackluster response rate made it impossible to achieve the recommended 400 minimum sample size outlined in the literature for the pre-licensure baccalaureate nursing students (Leedy & Ormrod, 2019, p. 179). To explain the difference between potential samples versus returned samples, the researcher had to determine whether the collected surveys constituted a large enough sample to evaluate the data at a 95% confidence interval (CI), keeping in mind that the academic nursing population is homogeneous across the Midwestern United States (AACN Policy Brief, 2019). Polit and Hungler (1991) noted that if the population under study is homogeneous in the relevant attributes, systematic biases may be minimal or nonexistent (p. 260). Therefore, the researcher presumed that the Midwestern Christian and Non-Christian pre-licensure baccalaureate nursing student population would be uniform in their composition.

Only five pre-licensure baccalaureate nursing student participants selected "no" for meeting participation requirements, which comprised 2.45% of the 197 participants in the sample population. Therefore, the researcher felt comfortable reassessing the \hat{p} -value to .9, which placed the \hat{q} -value at .1. The sampling distribution of the \hat{p} -value is verified through the

following formula: $n\hat{p}\text{-value} \geq 5$, $n\hat{q}\text{-value} \geq 5$, and so if $n = 4,118$ the values result in the following sampling distribution values of \hat{p} $3,706 \geq 5$, $412 \geq 5$.

Refining $\hat{p}\text{-value}$ and $\hat{q}\text{-values}$ based on the participant responses made it possible to obtain the margin of error value to seek a minimum sample size using $n = 197$ valid pre-licensure baccalaureate nursing student participants. With a 95% CI or an approximate z_c score of 1.96, a margin of error (E) was calculated thusly, $E = 1.96 \sqrt{(.9)(.1)/197} = .042$, rounded up to $E = 5\%$. It follows that with a 5% margin of error, the new distribution of $.85 < p < .95$ is understood. Thus, with 95% confidence, the preceding calculations state that the sampled population of valid pre-licensure baccalaureate nursing students is between 85% and 95%. Based on the point estimate for the refined population proportion and margin of error, the refined sample size becomes $n = (1.96)^2(.9)(.1)/(.05)^2$ or $n = 138$ valid and complete CDI-25 surveys.

Similarly, with the baccalaureate nursing program Faculty/Staff, Supervisors, and Top Leadership, the researcher assumed that 95% of this sample population met the criteria for participation in this study. Likewise, it would be unusual for the Deans of Nursing or their designees to email the survey to someone in their nursing program who did not meet the criteria for study in this homogeneous population. It is worth mentioning that all participants in this sample population selected “yes” for meeting participation requirements before they could move forward with the survey.

For populations of 500 (plus or minus 100), Leedy and Ormrod (2019) suggested using a 50% sample size for this population of 394 nursing program Faculty/Staff, Supervisors, and Top Leadership (p. 179). However, the anemic response rate of this sample population did not permit using the recommended 50%, or roughly 250 participant sample size. Therefore, the researcher had to determine whether the acquired surveys constituted a large enough sample to evaluate the

data at a 95% CI, keeping in mind that the academic nursing population is homogeneous across the Midwestern United States (AACN Policy Brief, 2019).

Therefore, the researcher felt comfortable reassessing the \hat{p} -value to .95, which placed the \hat{q} -values at .05. The sampling distribution of the \hat{p} -value is verified through the following formula: $n\hat{p} \geq 5$, $n\hat{q} \geq 5$, and so if $n = 394$, the stated quantities result in the following sampling distribution values of $\hat{p} \ 374 \geq 5$, $20 \geq 5$.

Refining \hat{p} -value and \hat{q} -value based on the participant responses made it possible to obtain the margin of error value to seek a minimum sample size using $n = 374$ valid nursing program Faculty/Staff, Supervisors, and Top Leadership participants. With a 95% CI or an approximate z_c score of 1.96, a margin of error (E) was calculated thusly, $E = 1.96 \sqrt{(.95)(.05)/32} = .075$, making the $E = 7.5\%$. It follows that with a 7.5% margin of error, the new distribution of $.85 < p < .95$ is understood. Thus, with 95% confidence, the preceding calculations state that the valid sampled population of nursing program Faculty/Staff, Supervisors, and Top Leadership is between 85% and 95%. Based on the point estimate for the refined population proportion and margin of error, the refined sample size becomes $n = (1.96)^2(.95)(.05)/(.075)^2$ or $n = 32$ valid and completed OLA-SV surveys.

Table 1, *CDI Participant Demographic Data*, on page 101, shows the participants' demographic data of the pre-licensure baccalaureate nursing students taking the CDI-25 survey. Most of the respondents were female high school graduates between the ages of 18 to 24 years. The participant age ranges were from 18 to greater than 45 years. This study's nursing student participants gender demographic closely reflected the larger nursing population, where men constituted 8.0% in this sample versus 12.0% of the reported nationwide nursing population. This study included four gender sub-categories, i.e., male, female, non-binary/third gender, and

those who preferred not to say. There were no selections for non-binary/third gender and for those who preferred not to say. Christians comprised 72.5% of the study's sample, and Non-Christians comprised 27.5%. Those individuals who experienced a Christian influence, i.e., whether they were personally Christian or a Non-Christian attending a Christian school, constituted 76.7% of the sample and 23.3% without a Christian influence, i.e., a Non-Christian in a Non-Christian school. Third- and fourth-year nursing students comprised the majority of participants or 41.2% of the respondents. There were more students, 72.9%, in this study who believed they were "called" to be nurses than the 66% who reported being "called" in the Prater and McEwen (2006) study.

Previously, Table 2, *OLA-SV Participant Demographic Data*, on page 102, shows the participant demographic data of the nursing program employees taking the OLA-SV survey. The majority of respondents were from the workforce positions in the Faculty/Supervisor role, constituting 21.9% of the participants, with only 6.25% of the Top Leadership participants completing the survey. Out of the 32 participants, the majority of the religious affiliation category, 40.6%, were Christians working in a Christian school. The next largest religious affiliation demographic, 34.4%, was that of Christians working in a Non-Christian school. Interestingly, there were not any Non-Christian participants working in a Christian school. The number of Non-Christians working in Non-Christian schools comprised 25.0% of the sample. Finally, in response to the question of whether the participant worked in a faith-based institution, 13 participants, or 40.6%, responded yes, that they worked in a faith-based institution, whereas 19 participants, or 59.5%, responded no, that they did not work in a faith-based institution.

Boos (2003) described a statistical model as "a set of probability distributions that attempts to describe the true state of nature and the related random data available to understand

that true state” (p. 168). Therefore, this researcher utilized the bootstrap method to prepare the samples obtained through this study’s anonymous surveys. The 197 completed CDI-25 surveys constituted the largest sample; therefore, the other samples were adjusted via the bootstrap technique to create random samples with equal datasets to enable inferential statistical methodology. Because the OLA-SV sample size of 32 was determined to be sufficient, this researcher used those returned surveys for measures of central tendencies. When the sample subgroups were broken down into separate categories, the sample sizes were too small for meaningful statistical analysis. Therefore, the bootstrap technique was employed to equalize the subgroups’ size to enable inferential statistical analysis.

To obtain random bootstrap datasets in Microsoft Excel, a dataset column was highlighted, and the formula =INDEX(\$A\$2:\$A\$60, RANDBETWEEN(1, ROWS(\$A\$2:\$A\$16)), 1) was entered into the function line. Note that numeric values entered into the formula will vary depending on the dataset’s size and location in the Microsoft Excel spreadsheet.

Overall, 32 completed OLA-SV surveys were returned; therefore, 165 bootstrap datasets were created. There were 14 completed OLA-SV Christian surveys; therefore, 183 Christian bootstrap datasets were created. Eighteen completed OLA-SV Non-Christian surveys were returned; thus, 179 Non-Christian bootstrap datasets were created. One hundred eighteen Non-Christian CDI-25 surveys were returned, leaving 79 Non-Christian bootstraps created. 75 completed Christian CDI-25 surveys were returned, and 122 Christian bootstrap datasets were made. Table 5 describes the breakdown of the completed surveys and the bootstrap datasets needed to make a sample size equal to 197.

Table 5*Completed samples returned vs. bootstrap datasets created*

Sample Group	Completed Samples	Bootstrap Datasets Created
CDI-25	197	-
Christian School CDI-25	63	134
Non-Christian School CDI-25	134	63
OLA-SV	32	165
Christian School OLA-SV	14	183
Non-Christian School OLA-SV	18	179

Data Analysis and Findings

This researcher first used ordinal-level measures of central tendency (means) to examine the relationship between Christian and Non-Christian servant organizational leadership characteristics at Midwestern baccalaureate nursing programs and their pre-licensure baccalaureate nursing students' caring dimensions to measure correlation to answer RQ1 and RQ2.

The study's independent variables were the Christian and Non-Christian nursing program's level of servant organizational leadership characteristics defined by Laub's OLA constructs and the dependent variable pre-licensure baccalaureate nursing students caring dimensions. Each CDI-25 participant completed the same standardized survey, and each OLA-SV participant completed the same standardized survey. This resulted in servant organizational leadership construct and pre-licensure baccalaureate nursing student caring dimension mean values that permitted interval-level multiple regression analysis to answer RQ3. The standard deviations indicate very little variability within homogeneous samples.

Tables 6 and 7 provide the mean scores for the samples. University A through H's measures of central tendencies, i.e., mean, minimum, maximum, range, and standard deviation for their nursing students' perception of caring dimensions. Further, University A through H's employees' perceptions of their nursing program's servant organizational leadership central tendencies and standard deviation was measured and presented in the following tables.

Table 6

Nursing Student Perception of Caring Dimensions (CDI-25) by Nursing Program

Program	N	Minimum	Maximum	Mean	St. Dev.
Christian					
University A	3	1	5	3.88	0.55
University B	12	1	5	4.14	0.88
University C	38	1	5	4.33	0.63
University D	10	1	5	4.20	0.85
Non-Christ					
University F	99	1	5	4.28	0.79
University G	5	1	5	3.86	0.64
University H	18	1	5	4.29	0.70

Table 7

Employee Perception of Servant Organizational Leadership (OLA-SV) by Nursing Program

Program	N	Minimum	Maximum	Mean	St. Dev.
Christian					
University A	6	2	5	4.29	0.61
University B	4	2	5	3.66	0.47
University C	3	1	5	3.47	1.23
University D	1	3	5	3.98	0.62
Non-Christ					
University F	15	1	5	3.40	1.02
University G	1	2	5	4.43	0.62
University H	2	2	5	4.35	0.59

Research Question One

RQ1 was prompted by the nursing literature that described the incivility that has existed in the profession for decades and spoke of the promise that servant organization leadership holds to improve the culture where it is practiced. A study of the relationship between a Christian

servant organizational leadership nursing program and the pre-licensure baccalaureate nursing students' caring dimensions in attendance depends on what the literature purports. It is important to note that the Christian baccalaureate nursing program comprises Christian and Non-Christian nursing students. The researcher sought information to investigate whether this population would support the literature.

To answer RQ1, what relationship, if any, exists between the Christian servant organizational leadership program's level of servant leadership, and their pre-licensure baccalaureate nursing student's caring dimensions, the researcher first had to determine the Christian schools' level of servant organizational leadership. This is the mean score from the 14 Christian survey participants and the 183 bootstrap datasets that comprised the OLA-SV raw data.

The researcher used the original datasets from the Christian school's workforce subgroup #3, Faculty/Staff, to create the bootstrap datasets. Dr. Laub reasoned using subgroup #3 because there might be a gap in the workplace perceptions between the Top Leadership, Supervisors, and the Faculty/Staff. He further reasoned that the Faculty/Staff subgroup usually constitutes the largest proportion of the OLA respondents, which was the case with this study (Laub, 2017). This sample had 23 Faculty/Staff, seven Supervisors, and two Top Leadership respondents.

The sample data produced a mean Christian nursing program servant organizational leadership (OLA-SV) score of 4.07 with a standard deviation of 0.17. These values show outstanding servant organizational leadership health and minimal variability in the Christian baccalaureate nursing program's workforce organizational leadership health.

A mean score of 4.07 placed the Christian baccalaureate nursing program's level of organizational health at Organization Health Level 5 out of 6 possible organizational health

levels. The score of 4.07 fell within the Organizational Health Level 5 range of 4.0 to 4.49, which Laub's research determined to be at the "Servant" level, meaning the Christian nursing programs practiced servant organizational leadership and had "Excellent" organizational leadership health. For reference, Table 8 depicts the Christian and Non-Christian nursing program OLA-SV measures of central tendencies and their standard deviations.

Table 8

Christian vs. Non-Christian Nursing Program Measures of Central Tendency

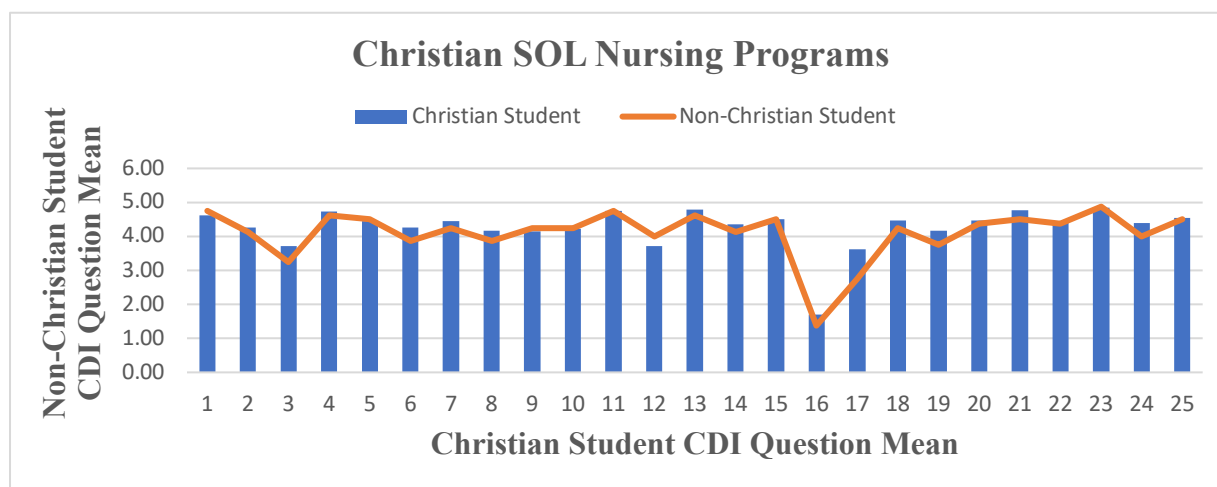
Variable	Christian OLA-SV	Non-Christian OLA-SV
Mean (OLA score)	4.07	3.23
Mode	4.10	3.15
Minimum	2.50	2.22
Maximum	4.83	4.83
Range	2.33	2.62
Standard Deviation	0.17	0.26

The Christian nursing program's Christian students scored 4.26 on the CDI-25 in a servant-level organizational leadership environment with a standard deviation of 0.74. Their fellow Non-Christian classmates scored 4.10 on the CDI-25 with a standard deviation of 0.76. Therefore, both groups of pre-licensure baccalaureate nursing students in the Christian nursing programs show minimal variability in the caring dimensions, leading this researcher to conclude that the sample is homogeneous. The ordinal-level data was obtained using a 1 to 5 Likert scale: strongly disagree = 1, disagree = 2, neither agree nor disagree = 3, agree = 4, and strongly agree = 5.

Figure 1 is a graphical representation of the Christian nursing program pre-licensure baccalaureate nursing students' caring dimensions in a servant organizational leadership nursing program. The students' mean scores do not reveal a significant difference in Christian and Non-Christian pre-licensure baccalaureate nursing students caring dimensions in an Organizational Health Level 5 Christian servant organizational leadership (SOL) nursing program. At first glance, a homogeneous Christian University servant leadership nursing program with excellent organizational health appears to produce pre-licensure baccalaureate nursing students with high-level caring dimensions.

Figure 1

Christian Universities Servant Organizational Leadership (SOL) Nursing Student Performance on CDI-25



Research Question Two

RQ2 is similar to research question one. It stems from the nursing literature that described the incivility that nursing has become famous for over the past several decades and the optimism of servant organization leadership's potential to improve the organization's culture where it is practiced. A study of the relationship between a Non-Christian servant organizational

leadership nursing program and their pre-licensure baccalaureate nursing student's caring dimensions depends on what is written in the literature.

To answer RQ2, what relationship, if any, exists between the Non-Christian servant organizational leadership nursing program's level of servant leadership, and their pre-licensure baccalaureate nursing student's caring dimensions, this researcher first had to quantify the Non-Christian nursing program's level of servant organizational leadership.

The level of servant organizational leadership is the mean score from the 118 survey participants and the 79 bootstrap datasets that comprised the OLA-SV raw data. Like in question one, the researcher used the original datasets from the workforce subgroup #3, Faculty/Staff, to create the bootstrap datasets. Dr. Laub reasoned using subgroup #3 because there might be a gap in the workplace perceptions between the Top Leadership, Supervisors, and the Faculty/Staff. He further reasoned that the Faculty/Staff usually constitutes the largest proportion of the OLA respondents, which was the case with this study (Laub, 2017).

A sample mean of 3.23 placed the Non-Christian baccalaureate nursing program's level of organizational health at Organizational Health Level 3 out of 6 possible. The mean score of 3.23 fell within the Organizational Health Level 3 range of 3.0 to 3.49, which Laub described as the "Negative Paternalistic" level, meaning the Non-Christian nursing programs did not practice servant organizational leadership and had "Limited" organizational leadership health. Table 8, *Christian vs. Non-Christian Nursing Program Measures of Central Tendency*, depicts the Christian and Non-Christian nursing program OLA-SV measures of central tendencies and standard deviation.

The Non-Christian baccalaureate nursing program's Christian pre-licensure baccalaureate nursing students scored 4.27 on the CDI-25 in a negative paternalistic level organizational

leadership environment with a standard deviation of 0.82. Their fellow Non-Christian classmates scored 4.24 on the CDI-25 with a standard deviation of 1.00. Therefore, both groups of pre-licensure baccalaureate nursing students in the Non-Christian nursing programs show minimal variability in the caring dimensions, leading this researcher to conclude that this sample is homogeneous. The ordinal-level data was measured using a 1 to 5 Likert scale: strongly disagree = 1, disagree = 2, neither agree nor disagree = 3, agree = 4, and strongly agree = 5.

Figure 2

Non-Christian Universities Negative-Paternalistic Organizational Leadership Performance on CDI-25

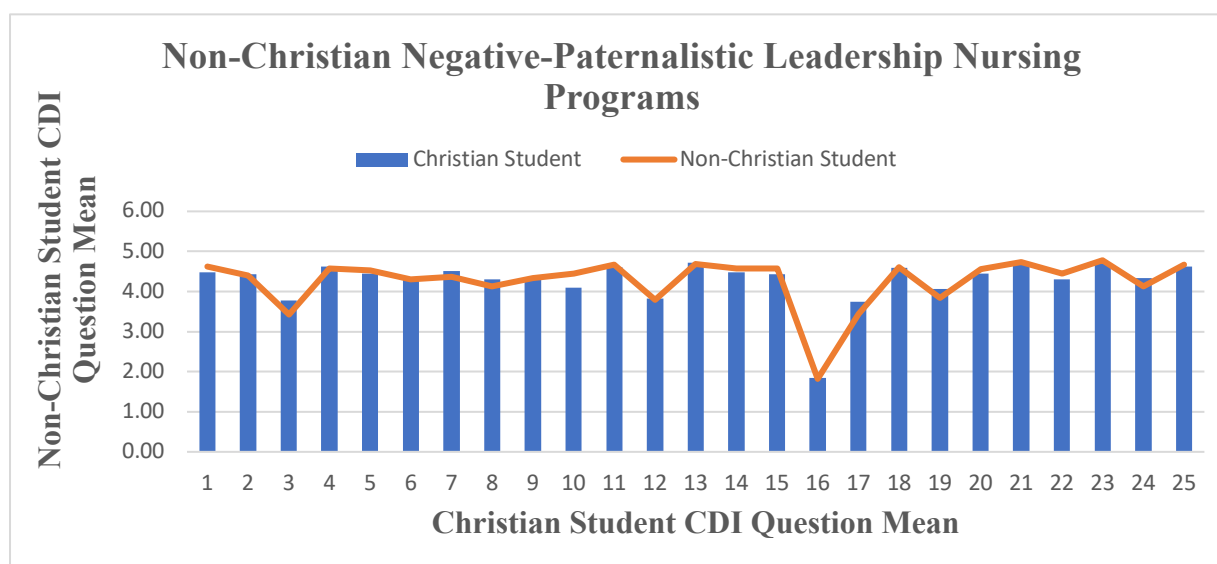


Figure 2 depicts the Non-Christian nursing program Christian and Non-Christian pre-licensure baccalaureate nursing students' caring dimensions in a Negative Paternalistic leadership nursing program. The students' mean scores graphically reveal no statistical difference indicating minimal variation in Christian and Non-Christian pre-licensure baccalaureate nursing students caring dimensions in a Non-Christian, negative paternalistic organizational leadership baccalaureate nursing program. Therefore, it would appear from the

data that the Non-Christian University baccalaureate nursing program's pre-licensure baccalaureate nursing students had a high level of caring despite their nursing program's limited health level of servant organizational leadership.

Research Question Three

To describe the relationship between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students caring dimensions, the researcher needed to find commonality between the two population samples.

McCance et al. (2008) measured the dynamic between caring and person-centeredness in nursing at five points over their two-year study using the CDI-25 instrument. Their study found that nurses clearly agree about what constitutes nurse caring by revealing the "12 'core' statements considered caring on all five data collection points" (p. 413). The study's top 12 CDI-25 statements are listed by rank order in Table 9.

Table 9

Twelve core CDI-25 statements constituting nurse caring

CDI-25 Statement	Rank
Listening to a patient	1
Explaining a clinical procedure	2
Being with a patient during a clinical procedure	3
Involving a patient in care	4
Measuring the vital signs of a patient	5
Consulting with a doctor	6
Reporting a patient's condition to a senior nurse	7
Being Honest with a patient	8
Instructing a patient about aspects of self-care	9
Observing the effects of medication on a patient	10
Making a nursing record about a patient	11
Keeping relatives informed about a patient	12

In a straightforward fashion, this researcher matched the six top-ranking CDI-25 caring statements, according to McCance et al., to six equivalent questions, one each from Laub's constructs. Laub's six OLA constructs are: values people (VP), develops people (DP), builds community (BC), displays authenticity (DA), provides leadership (PL), and shares leadership (SL). For comparison, Table 10 presents the six top-ranking CDI-25 statements and their corresponding question from each OLA construct/subscore.

Table 10

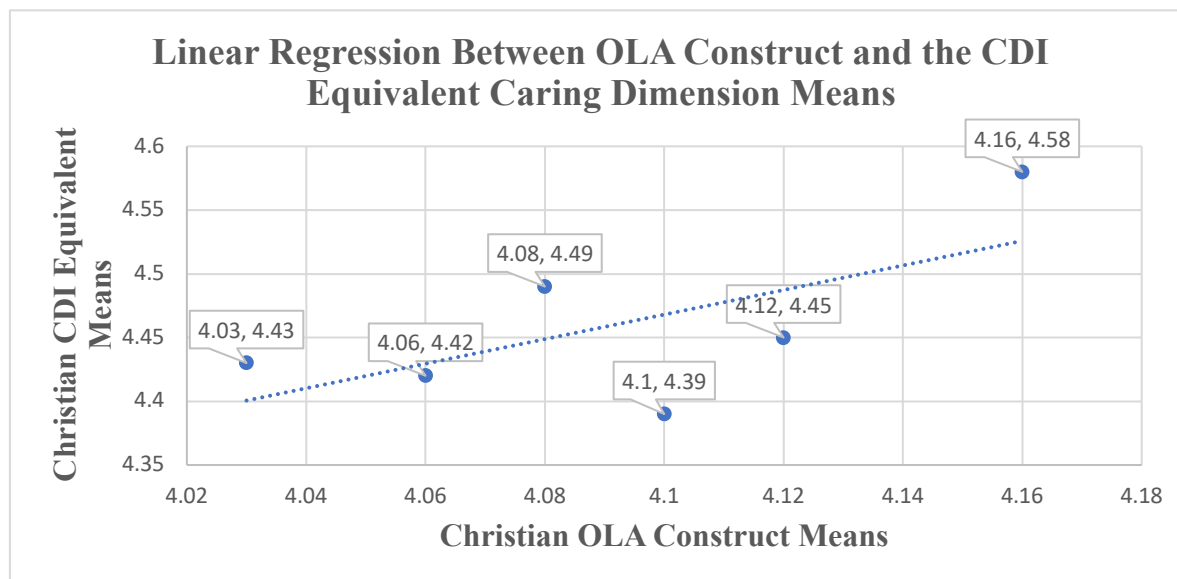
Top-ranking CDI-25 caring statements and corresponding OLA-SV construct statements

<u>Top-Ranked CDI-25 Statements</u>	<u>Corresponding OLA-SV Statements by Construct/Subscore</u>
1. Listening to a patient	VP. Are receptive listeners
2. Explaining a clinical procedure to a patient	DP. Use their power and authority to benefit the workers
3. Being with a patient during a clinical procedure	BC. Work alongside the workers instead of separate from them
4. Involving a patient in care	DA. Promote open communication and sharing of information
5. Measuring the vital signs of a patient	PL. Take appropriate action when it is needed
6. Consulting with a doctor	SL. Encourage each person in the organization to exercise leadership

The scatter plot in Figure 3 visually depicts the linear regression between the X variable, Christian University OLA construct mean scores, and the Y variable, CDI-25 nursing student caring dimensions mean scores. Pearson's correlation calculations were performed using the Microsoft Excel calculator. The calculated Pearson product-moment correlation coefficient was $r = 0.65$, indicating a strong positive correlation between the Christian University OLA constructs and their pre-licensure baccalaureate nursing student caring dimensions.

Figure 3

Linear regression between OLA constructs and CDI caring dimension means at Christian nursing programs



The scatter plot in Figure 4 visually represents the linear regression between the X variable, Non-Christian University OLA Construct mean scores, and the Y variable, CDI-25 nursing student caring dimension mean scores. Pearson's correlation calculations were performed using the Microsoft Excel calculator. The calculated Pearson product-moment correlation coefficient was $r = -0.81$, indicating a strong negative correlation between the Non-Christian University OLA constructs and their nursing student caring dimensions. A negative correlation describes the relationship between the lower OLA construct means and their nursing students' high mean scores on the CDI-25 caring dimensions (Polit & Hungler, 1991, pp. 462-464).

Figure 4

Linear regression between OLA Constructs and CDI caring dimension means at Non-Christian nursing programs

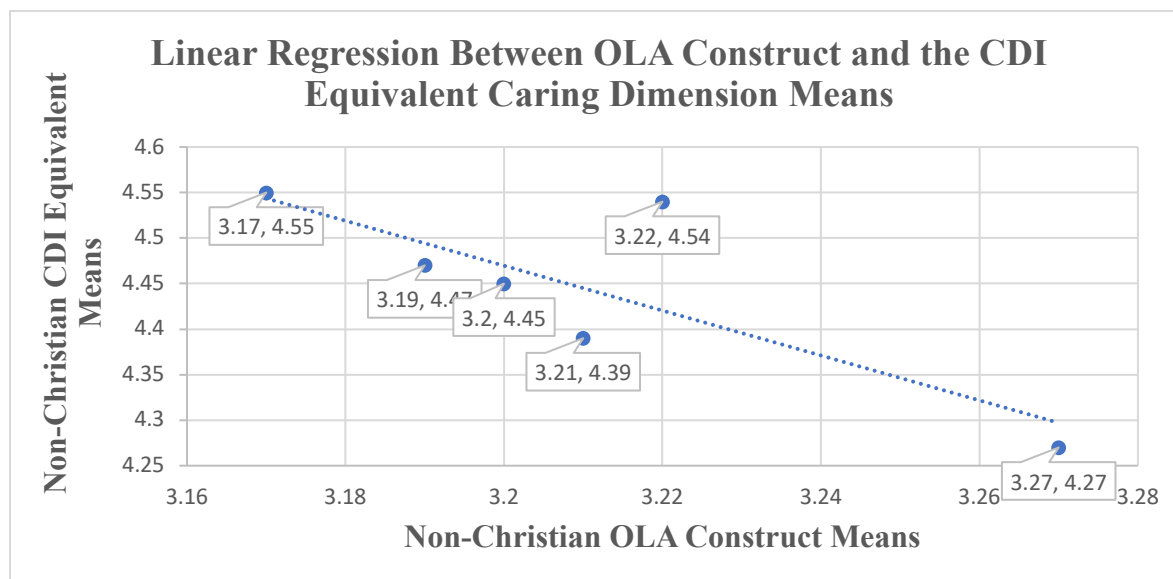


Table 11 lists the quantitative data displayed in Figure 5 that compares the Christian vs. Non-Christian servant organizational leadership mean constructs and the nursing student CDI-25 mean caring dimensions. This information quantifies the servant organizational leadership in the Christian and Non-Christian baccalaureate nursing programs that constitute the environment where pre-licensure baccalaureate nursing students learn to be caring nurses.

Table 11

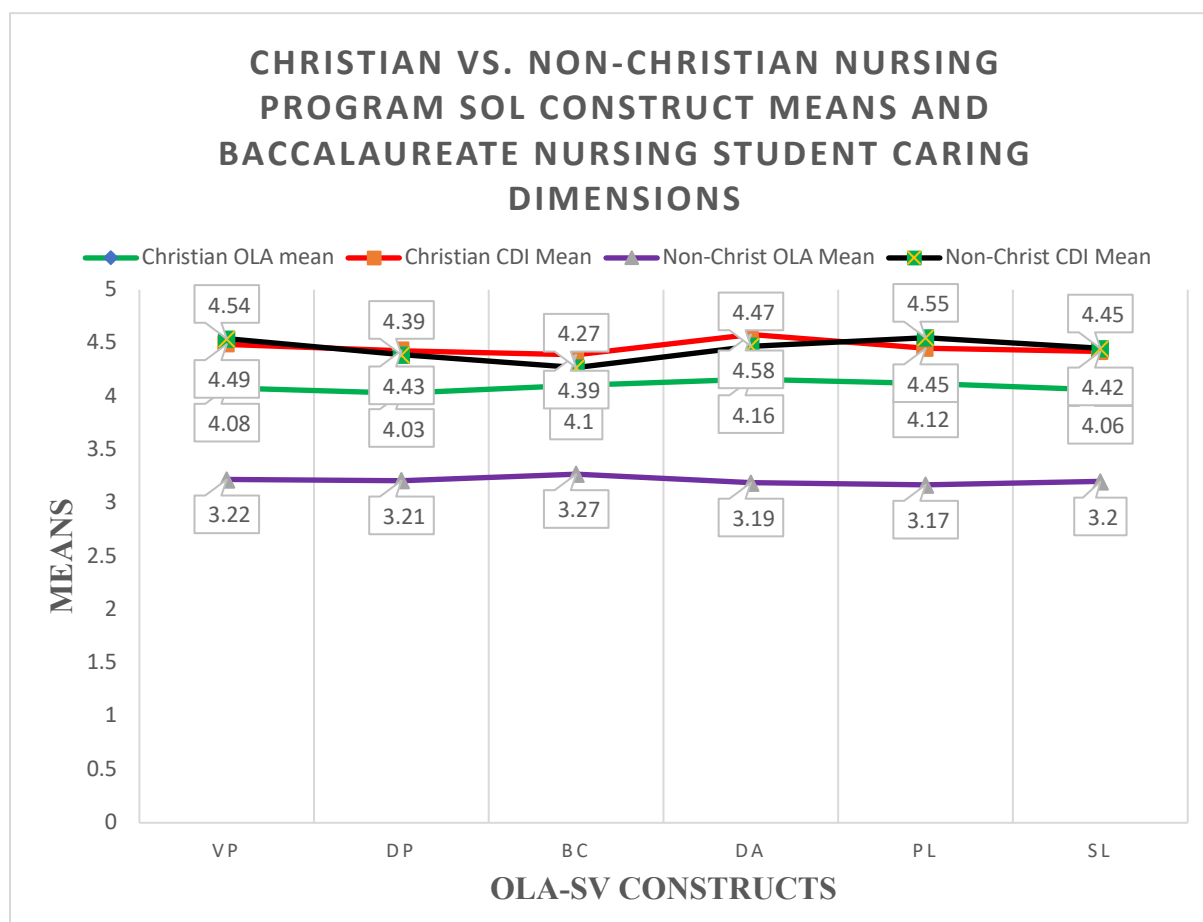
Christian, Non-Christian SOL construct means, and nursing student caring dimension mean scores

	VP	DP	BC	DA	PL	SL
Christian OLA mean	4.08	4.03	4.1	4.16	4.12	4.06
Christian CDI Mean	4.49	4.43	4.39	4.58	4.45	4.42
Non-Christ OLA Mean	3.22	3.21	3.27	3.19	3.17	3.2
Non-Christ CDI Mean	4.54	4.39	4.27	4.47	4.55	4.45

Figure 5 graphically depicts the OLA-SV mean constructs for Christian and Non-Christian nursing programs representing the servant leadership environment the nursing students learn to care within, and their nursing students' mean caring dimensions. Even though the Non-Christian baccalaureate nursing program servant organizational leadership score is significantly lower in each construct than the Christian nursing program servant organizational leadership scores, there does not appear to be a significant difference in their pre-licensure baccalaureate nursing student's caring dimensions.

Figure 5

Christian & Non-Christian nursing programs' servant OLA construct means, and nursing student CDI-25 caring dimension means



The literature has shown the applicability and effectiveness of parametric tests to measure ordinal-level Likert scale responses (Norman, 2010; Sullivan & Artino, 2013). Multiple regression methodologies are parametric tests used to help understand relationships between variables by estimating how the dependent variable changes as the independent variables change (Burns & Grove, 2005; Polit & Hungler, 1991). Therefore, the researcher used multiple regression analysis to understand the relationship between the pre-licensure baccalaureate student nurse caring dimensions and the matching Christian and Non-Christian baccalaureate nursing program OLA-SV constructs.

Table 12

Multiple Regression of the six top-ranked OLA-SV Constructs & Corresponding Items in the CDI-25

OLA Construct/CDI Statement	R²	df	Standard Error	t-value	p-value
Christian University					
Are Receptive Listeners/Listening to a Patient	0.00	2	0.85	9.72	0.82
Uses their Power & Authority to Benefit the Workers/Explaining a Clinical Procedure to a Patient	0.01	2	0.86	11.74	0.38
Work Alongside the Workers Instead of Separate From Them/Being with a Patient During a Clinical Procedure	0.01	2	0.90	10.18	0.44
Promote Open Communication & Sharing of Information/Involving a Patient in Their Care	0.01	2	0.74	14.08	0.33
Take Appropriate Action When it is Needed/Measuring the Vital Signs	0.01	2	0.81	10.49	0.56
Encourage Each Person in the Organization to Exercise Leadership/Consulting with a Doctor	0.00	2	0.84	9.92	0.82
Non-Christian University					
Are Receptive Listeners/Listening to a Patient	0.00	2	0.98	8.88	0.84
Uses their Power & Authority to Benefit the Workers/Explaining a Clinical Procedure to a Patient	0.00	2	1.02	9.19	0.68
Work Alongside the Workers Instead of Separate From Them/Being with a Patient During a Clinical Procedure	0.00	2	1.03	7.64	0.64
Promote Open Communication & Sharing of Information/Involving a Patient in Their Care	0.02	2	1.08	10.12	0.11
Take Appropriate Action When it is Needed/Measuring the Vital Signs	0.01	2	0.93	9.36	0.43
Encourage Each Person in the Organization to Exercise Leadership/Consulting with a Doctor	0.01	2	1.05	8.72	0.59

Table 12 lists the multiple regression values of the OLA-SV constructs for Christian and Non-Christian nursing programs and the corresponding CDI-25 statements that measured pre-licensure baccalaureate student nurse caring dimensions.

To add perspective, a high R^2 value is necessary to predict correlation with high accuracy, but an R^2 value of less than 0.4 demonstrates a low correlation (Burns & Grove, 2005; Polit & Hungler, 1991). Each derived R^2 value for RQ3 was no greater than 0.02, indicating zero to very little correlation between the dependent variable pre-licensure baccalaureate nursing student caring dimensions and the independent variables Christian and Non-Christian nursing program OLA construct means. This finding reinforces the nursing literature describing the homogeneous nursing population.

The more considerable the T-values, the greater the evidence against the null hypothesis (Polit & Hungler, 1991, p. 440). The calculated t-values for RQ3 ranged from 7.64 to 14.08. However, the true value this researcher was interested in to investigate the relationship, if any, between the dependent and independent variables was the derived p-value. Therefore, the t-value was used as an intermediate step for calculating the p-value and did not figure into any conclusions reached for RQ3.

Polit and Hungler (1991) defined the p-value as the “probability that the obtained results result from chance alone” (p. 651). The corresponding p-values for RQ3 were significantly greater than the alpha 0.05, ranging from 0.11 to 0.97. Thus, the calculated p-values were not strong enough to reject the RQ3 null hypothesis. This finding shows there is no statistical correlation between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure

baccalaureate nursing students caring dimensions. Therefore, the null hypothesis was accepted, meaning there were no differences or relationships between the variables.

Evaluation of the Research Design

This quantitative study was designed to gather objective information regarding the relationship between the three variables: (a) the Christian servant organizational leadership nursing program's level of servant leadership, (b) the Non-Christian servant organizational leadership nursing program's level of servant leadership, and (c) their pre-licensure baccalaureate nursing students' caring dimensions. Because this study did not attempt to discern causation between the variables, non-experimental survey instruments were chosen (Creswell & Creswell, 2018).

The survey instruments were well-established, and each was determined to be valid and reliable by numerous studies. Study participants provided data describing how they felt responding to a specific question at a particular moment, with many internal and external influences that could affect their response. Therefore, adding a follow-up survey to establish consistency in their replies could have improved this research design.

The quantitative design employed to obtain valuable data during this study can be considered a strength of the research design. Quantitative research is the predominant design currently used in nursing science, with a proven knowledge base to guide nursing practice (Burns & Grove, 2005, p. 23). This quantitative investigation used valid and reliable instruments to reveal a "numeric description of trends, attitudes, or opinions of a population" in the sample population obtained (Cresswell & Cresswell, 2018, p. 12). Still, findings from this study could also be applied to the overall nursing population for use in future quantitative and qualitative research due to the population's homogeneity.

Despite the researcher using a purposive sampling method, the obtained samples could not have been selected more randomly due to the mass mailing of the standardized requests to participate in the research emails sent out to a wide range of Midwestern nursing programs. The researcher was blinded to which nursing programs would respond to the request or permit the study to occur at their school. Further, the bootstrap methodology helped with the study's overall random nature, minimizing the introduction of bias and preparing the samples for the multiple regression methodology.

A weakness of this study might have been the reliance on online surveys to gather the raw data. The literature described the difficulty of getting nurses and nursing students to participate in online surveys. True to form, the researcher needed the help of the Deans of Nursing to send reminder emails to get the university employees and the nursing students to participate in the research. The following are the number of reminders sent per university after the study commenced: University A 5, University B 3, University C 4, University D 3, University E 3 before they decided not to participate, University F 4, University G 4, and University H 4.

Another weakness of the research design involved the assumption that a sufficient sample size could be obtained based on the study's large nurse educator and student nurse populations. Based on the literature, the researcher deferred to the recommended sample size of 400 participants for each sample (Leedy & Ormrod, 2019). A more specific method for estimating nursing samples would have helped increase the accuracy of the sample sizes and establish greater confidence in the inferences to the greater population.

Lastly, a significant design weakness was the lack of an instrument allowing direct statistical correlation and multiple regression methodology of the three variables identified in

RQ3. As a result, the researcher had to utilize a less direct method to calculate and derive the information using the OLA-SV instrument, CDI-25 instrument, bootstrap technique, and his expert nursing judgment to permit multiple regression statistical calculations and analysis.

CHAPTER FIVE: CONCLUSIONS

Overview

This quantitative descriptive study discusses the research conclusions based on the compilation of data from the study's participants and the results derived. The researcher considered the implications and applications of the study and provided recommendations for further research. The chapter concluded with a summary and final thoughts.

Research Purpose

The purpose of this quantitative correlational study was to examine the relationship, if any, that exists between Midwestern baccalaureate Christian nursing programs and Non-Christian baccalaureate nursing programs' servant organizational leadership characteristics and their pre-licensure baccalaureate nursing students' caring dimensions. Since the study's purposive sample was limited to the Midwestern region of the United States baccalaureate nursing programs and their pre-licensure baccalaureate nursing students, the results may not be generalizable to the greater nursing population.

Research Questions

RQ1. What relationship, if any, exists between the Christian servant organizational leadership nursing program's level of servant leadership and their pre-licensure baccalaureate nursing students caring dimensions?

RQ2. What relationship, if any, exists between the Non-Christian servant organizational leadership nursing program's level of servant leadership and their pre-licensure baccalaureate nursing students caring dimensions?

RQ3. What relationship, if any, exists between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students caring dimensions?

Research Conclusions, Implications, and Applications

Mary Elizabeth O'Brien, SFCC, PhD, MTS, RN, FAAN (2008) acknowledged that God is present in the act of a nurse's caring, "For it is here, in the act of serving a brother or sister in need, that the nurse truly encounters God" (p. 1). Scripture teaches us to "Be shepherds of God's flock that is under your care, watching over them – not because you must, but because you are willing, as God wants you to be; not pursuing dishonest gain, but eager to serve" (LASB, NIV, 1973/2005, 1 Peter 5:2). In nursing, therefore, being a servant is virtually inseparable from caring. In the absence of *servicing* a brother or sister in need, nursing *care* cannot occur. This research investigated the relationship between servant organizational leadership in Christian and Non-Christian baccalaureate nursing programs and their pre-licensure baccalaureate student nurse caring dimensions to see if more caring student nurses result from servant leadership.

The researcher found no prior research examining the relationship between servant organizational leadership in Christian and Non-Christian University baccalaureate nursing programs and their pre-licensure baccalaureate nursing students' caring dimensions. Therefore, the study was timely and necessary for the nursing profession to move from the present culture of incivility to a more servant-oriented and caring culture.

The demographic data received from the pre-licensure baccalaureate nursing students in both Christian and Non-Christian nursing programs revealed most nursing students were female (92.0%), between the ages of 18 – 24 years of age (84.9%), with a high school diploma (68.3%). The majority were Christian attending a Non-Christian university nursing program (37.8%), in their fourth year of nursing school (39.9%). Most of these students believed they were called to be a nurse (72.9%).

This homogeneous population's survey responses were too few to sufficiently examine whether a relationship exists between the variables. Therefore, the researcher performed a reanalysis to refine the minimum sample. Once the new acceptable minimum samples were calculated, the researcher utilized the bootstrap method to create sample equality to allow for inferential statistical analysis.

The measures of central tendency and standard deviation were obtained to answer RQ1 and RQ2 regarding the variables of interest and their significance. In the case of RQ3, the statistical methods employed were the measures of central tendencies, standard deviation, and multiple regression. The methodology shows that the results were not statistically significant, and the related null hypotheses were accepted. The researcher concluded, therefore, based on the study results:

1. The Christian baccalaureate nursing programs were at an excellent servant organizational leadership health level.
2. The Non-Christian baccalaureate nursing programs were at the negative paternalistic servant organizational leadership health level.
3. The Christian baccalaureate nursing program's Christian and Non-Christian pre-licensure baccalaureate nursing students exhibited high levels of caring, and their caring scores were nearly identical.
4. The Non-Christian baccalaureate nursing program's Christian and Non-Christian pre-licensure baccalaureate nursing students exhibited high levels of caring, and their caring scores were nearly identical.
5. There were no differences or relationships between attending a Christian versus Non-Christian baccalaureate servant organizational leadership nursing program and their pre-licensure baccalaureate nursing students' caring dimensions.
6. The p-values were greater than the level of significance 0.05 indicating that the evidence was not strong enough or that no effect was observed to establish a relationship between a Christian versus Non-Christian baccalaureate servant organizational leadership nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students caring dimensions.

Research Conclusion One

Pre-licensure baccalaureate nursing students attending a Christian baccalaureate nursing program consistently scored high on the Caring Dimensions Inventory instrument within a servant organizational learning environment. This means their Christian and Non-Christian nursing students were very caring. This conclusion is based on the statistical methodology employed for RQ1, including measures of central tendencies and standard deviation.

The question was prompted by the literature describing the practice of servant organizational leadership creating more caring and civil work cultures by placing the needs of followers above their own (O'Brien, 2008; Erickson & Hustad, 2015; Greenleaf, 2008; van Dierendonck, 2011; Noland & Richards, 2015; Patterson, 2003; Northouse, 2013; Robinson, 2009). This study determined that Christian baccalaureate nursing programs' mean servant organizational health level was 4.07. This servant organizational health level was considered to be ranked at the servant leadership level with excellent health.

The nursing students' demographic questions asked them to delineate whether they were Christian in a Christian school or Non-Christian in a Christian School. These students comprised 72.5% of the entire student nurse sample. The Christian student mean caring dimensions inventory score was 4.26, and their Non-Christian classmates scored 4.10. Figure 1, *Christian Universities Servant Organizational Leadership Nursing Student Performance on CDI-25*, represents how these students responded to the 25 caring dimensions inventory statements. At a glance, the reader sees how similarly caring both groups of students are for their patients.

Therefore, Christian and Non-Christian nursing students in a Christian servant-level nursing program exhibit high levels of caring in a learning environment measured at excellent health. However, the picture could be clearer based on the student's performance in the Non-Christian nursing programs.

Research Conclusion Two

Like in RQ1, the pre-licensure baccalaureate nursing students attending a Non-Christian baccalaureate nursing program also scored high on the Caring Dimensions Inventory instrument. However, unlike their Christian counterparts, they did not participate in a servant organizational leadership nursing program that achieved a servant level of organizational health. The Non-Christian programs attained an OLA-SV mean sample score of 3.23, placing them in the Negative Paternalistic level of organizational health, with limited fitness. In this scenario, however, the lack of the Non-Christian nursing program's servant organizational leadership status did not negatively influence their Non-Christian or Christian pre-licensure baccalaureate nursing student level of caring.

This group of nursing students' demographic questions asked them to appropriately select whether they were Non-Christian in a Christian school or Non-Christian in a Non-Christian school. These students comprised 27.5% of the nursing student sample. The Non-Christian pre-licensure baccalaureate nursing student's mean caring dimensions inventory score was 4.24, and their Christian classmates scored 4.27. Figure 2, *Non-Christian Universities Negative-Paternalistic Organizational Leadership Performance on CDI-25*, graphically represents how these students responded to the 25 caring dimensions inventory statements. At once, the reader sees how nearly identically caring both groups of students are for their patients.

This research demonstrated that Non-Christian and Christian pre-licensure baccalaureate nursing students in Non-Christian negative paternalistic level organizational leadership nursing programs were still very caring despite learning in a non-servant leadership health environment. Therefore, it would appear that the level of servant organizational leadership in a Non-Christian University baccalaureate nursing program does not affect their pre-licensure nursing student's

level of caring. In the following conclusion, in addition to measures of central tendencies and standard deviation, research question three used multiple regression methodology to investigate the relationship between the study's variables.

Research Conclusion Three

With expert nursing judgment, the researcher matched the six top-ranking McCance et al. CDI-25 statements with Laub's six servant organizational leadership constructs (McCance et al., 2008; Laub, 2017). Table 10, *Top-ranking CDI-25 caring statements and corresponding OLA-SV construct statements*, presented the matched CDI-25 statements side-by-side with the OLA constructs. The bootstrap technique provided a method for the derivation and statistical analysis of central tendencies, standard error, correlation, and multiple regression leading the researcher to accept RQ3's null hypothesis.

Figure 3, *Linear regression between OLA constructs and CDI caring dimension means at Christian nursing programs*, is a scatter plot depicting the correlation between the study's Christian Universities OLA-SV constructs and their pre-licensure baccalaureate nursing student caring dimensions. This group's calculated Pearson product-moment correlation coefficient was $r = 0.65$, indicating a strong positive correlation between the variables. However, finding a strong correlation between the variables in this instance could be deceiving without considering the study's other information in context.

Figure 4, *Linear regression between OLA Constructs and CDI caring dimension means at Non-Christian nursing programs*, is a scatter plot illustrating the correlation between the study's Non-Christian Universities OLA-SV constructs and their pre-licensure baccalaureate nursing student caring dimensions. This scatter plot depicts a negative linear regression between the variables, the opposite of the positive linear regression found between the Christian

Universities OLA-SV constructs and their pre-licensure baccalaureate nursing student caring dimensions. This group's calculated Pearson product-moment correlation coefficient was $r = -0.81$, indicating a strong negative correlation.

The researcher's first impression was that the strong negative correlation may have resulted from the negative paternalistic/limited health culture found in the Non-Christian baccalaureate nursing programs. Figure 5, *Christian & Non-Christian nursing programs' servant OLA construct means, and nursing student CDI-25 caring dimension means*, shows the large gap between the Non-Christian baccalaureate nursing program OLA scores and the other variables. However, more information was needed to reach a definitive conclusion for RQ3.

Next, the researcher employed multiple regression analysis to help understand the relationship between the pre-licensure baccalaureate nursing student caring dimensions and the matching Christian and Non-Christian nursing program OLA-SV construct means. The R^2 values for each independent variable were no greater than 0.02, indicating zero to very little correlation between the variables.

Table 13 depicts the correlation between Christian nursing program OLA-SV construct items and the corresponding Christian nursing student caring dimensions. Table 14 shows the correlation between Non-Christian nursing program OLA-SV construct items and the corresponding Non-Christian nursing student caring dimensions.

Table 13

Correlation between Christian Nursing Program OLA-SV Construct Items & Corresponding Christian Student Caring Dimensions

OLA-SV CONSTRUCTS	Values People	Develops People	Builds Community	Displays Authenticity	Provides Leadership	Shares Leadership
OLA-SV ITEM	Are Receptive Listeners	Use their Power & Authority to Benefit the Workers	Work Alongside the Workers Instead of Separate From Them	Promote Open Communication & Sharing of Information	Take Appropriate Action When it is Needed	Encourage each Person in the Organization to Exercise Leadership
	↓	↓	↓	↓	↓	↓
CORRESPONDING CDI-25 CARING DIMENSION ITEM	Listening to a patient	Explaining a Clinical Procedure to a Patient	Being with a Patient During a Clinical Procedure	Involving a Patient in Their Care	Measuring the Vital Signs	Consulting With a Doctor
	↓	↓	↓	↓	↓	↓
R ²	0.00	0.01	0.01	0.01	0.01	0.00
df	2	2	2	2	2	2
Standard Error	0.85	0.86	0.90	0.74	0.81	0.84
t-value	9.72	11.74	10.18	14.08	10.49	9.92
p value	0.82	0.38	0.44	0.33	0.56	0.82

Table 14

Correlation between Non-Christian Nursing Program OLA-SV Construct Items & Corresponding Non-Christian Student Caring Dimensions

OLA-SV CONSTRUCTS	Values People	Develops People	Builds Community	Displays Authenticity	Provides Leadership	Shares Leadership
OLA-SV ITEM	Are Receptive Listeners	Use their Power & Authority to Benefit the Workers	Work Alongside the Workers Instead of Separate From Them	Promote Open Communication & Sharing of Information	Take Appropriate Action When it is Needed	Encourage each Person in the Organization to Exercise Leadership
	↓	↓	↓	↓	↓	↓
CORRESPONDING CDI-25 CARING DIMENSION ITEM	Listening to a patient	Explaining a Clinical Procedure to a Patient	Being with a Patient During a Clinical Procedure	Involving a Patient in Their Care	Measuring the Vital Signs	Consulting With a Doctor
	↓	↓	↓	↓	↓	↓
R ²	0.00	0.00	0.00	0.02	0.01	0.01
df	2	2	2	2	2	2
Standard Error	0.98	1.02	1.03	1.08	0.93	1.05
t-value	8.88	9.19	7.64	10.12	9.36	8.72
p-value	0.84	0.68	0.64	0.11	0.43	0.59

In each case, i.e., Christian versus Non-Christian nursing program and their pre-licensure baccalaureate nursing student caring dimensions, the corresponding p-values for RQ3 were significantly greater than the level of significance of 0.05, meaning the calculated p-values were not strong enough to reject the RQ3 null hypothesis. This finding suggests there is no statistical correlation between attending a Christian versus Non-Christian servant organizational leadership baccalaureate nursing program in the Midwest region of the United States and their pre-licensure baccalaureate nursing students caring dimensions. Therefore, the null hypothesis was accepted, meaning no differences or relationships existed between variables.

Research Implications

The research implications associated with this study are based on the sincere desire to provide nurse educators with a model of leadership, i.e., servant organizational leadership, capable of reversing the decades-long trend in nursing from a business model that creates incivility to a servant model that promotes civility. After all, a nurse's purpose is to serve their patients. Despite this study's inability to establish a relationship between servant organizational leadership in nursing programs and their nursing students' level of caring, the implications of this research reassuringly show that pre-licensure baccalaureate nursing students have a high degree of caring in organizations with either excellent, servant organizational leadership or limited, negative paternalistic, levels of organizational health.

The precedent literature says the way the nursing teacher interacts with their students could significantly impact how the student will approach the care they provide to their patients. A large majority (73%) of the students and Faculty/Staff (74.5%) in this study answered they were Christians. Grady et al. (2008) noted that in the nursing profession, "The faculty-student caring relationship is a prerequisite 'to the students' acquisition of caring attitudes and behaviors" (p. 315). As followers of Christ and servants of men, Christian servant nurse educators, therefore, must freely apply their God-given gift of teaching to build the Church and nurture students (Wilkes, 1996, p. 5).

Some nursing students who participated in this research attended programs with excellent servant organizational leadership health levels, while others attended nursing programs lacking entirely in servant organizational leadership. In either environment, the nursing students scored high in their caring dimensions leading one to question whether a variable other than Christian or Non-Christian servant organizational leadership may affect their nursing students' level of caring

dimensions. This finding may provide the basis for additional research to identify the variable that leads to greater student nurse care.

Another notable finding was that 72.9% of the nursing student participants believed they were “called” to be a nurse. To be called into the profession means that they enter the profession in response to their personal need to serve others. White (2002) contends a calling is when “Nurses responded not in their own interests but *for* the patient and *for the sake* of the patient,” and Christian nurses are serving in God’s interest (p. 284). Therefore, this study reinforces the notion that nursing schools should focus on recruiting students who were called to the profession for their willingness to place the fundamental needs of their patients, community, and coworkers ahead of their own.

Research Applications

The intended purpose of this research was to explore the relationship between servant organizational leadership in Christian and Non-Christian nursing schools to measure the relationship, if any, with their nursing students’ caring dimensions. The intent was to use the data obtained from this study to create a more civil nursing profession that leads to better patient outcomes.

The literature is replete with information confirming that servant organizational leadership provides an environment where leaders are more “attentive to the concerns of the followers, empathize with them, and nurture them” (Northouse, 2013). Christian servant leaders are called by God to “serve Him, are cleansed and commissioned by God, and are empowered and guided by the Holy Spirit and are faithful to the Word of God” (Kirkpatrick, 1988). Despite not finding any relationship between servant organizational leadership and student nurse caring dimensions, this research may encourage others to explore the relationship.

Research Limitations

The implications and applications of this research hold promise for future studies. However, a notable limitation regarding this research is the need for an instrument to directly measure servant organizational leadership and student nurse caring dimensions. While the instruments employed in this study were well-established to be valid and reliable, they needed equivalent sample sizes to enable multiple regression studies. The OLA-SV instrument had 60 questions, and the CDI-25 instrument had 25 questions. Even though the bootstrap technique is a proven method for supplementing random datasets and statistical analysis, the researcher thinks a single instrument to measure the independent and dependent variables may have been more suitable for this study's purposes.

Further Research

This study attempted to fill the gap in the literature regarding the potential relationship between the Christian and Non-Christian baccalaureate nursing program servant organizational leadership and its effect on the pre-licensure baccalaureate nursing student's caring dimensions attending their programs. Because this is such a broad and diverse topic, many avenues of future research came to mind over the course of this study that an interested researcher could pursue. The three areas of interest to be discussed here are developing a single instrument appropriate for these populations, proctoring students taking the survey on location at the university, and conducting a qualitative or mixed-methods study.

This study discussed both instruments used for gathering the raw data in great detail. Both were well-established and known to be valid and reliable. Further, these excellent instruments continue to be used in several international studies marking significant advances in the knowledge of their respective fields. However, the differences in the instruments made it

difficult to perform multiple regression on the two samples for this study. The OLA-SV instrument had 60 questions, and the CDI-25 had 25 questions. Therefore, it became necessary to use the bootstrap technique to randomly create two samples with equal datasets to perform statistical analysis using a truly experimental design (Polit & Hungler, 1991, p. 154). With the development of a single instrument that can explore the relationship between Christian and Non-Christian baccalaureate nursing program servant organizational leadership levels, and their pre-licensure baccalaureate nursing students' caring dimensions, the extra step of creating bootstrap datasets to equalize the samples could be avoided entirely.

The literature accurately documented how difficult it is to get nurses and nursing students to take the time and effort to participate in survey research. This study was conducted through electronic mail via the participant's personal devices at the leisure and location of their choice. It occurred to the researcher that future studies may avoid the pitfalls of emailing individual surveys and benefit from visiting each nursing program to introduce the instrument to the participants and proctor them while taking the survey either electronically or by the paper-and-pencil method (Leedy & Ormrod, 2019).

Finally, a qualitative methodology or mixed-methods design could be conducted to gain insights into this little-studied topic. A qualitative design can investigate the complex nature of this study to test certain assumptions and claims "within real-world contexts" (Leedy & Ormrod, 2019). A mixed-methods design could be helpful for the future researcher to comprehensively address all aspects of the study "by collecting, analyzing, and interpreting both quantitative and qualitative data" (Leedy & Ormrod, 2019). The mixed-methods design is complementary, allowing for the "quantitative aspects of the study to compensate for weaknesses in the qualitative research, and vice versa" (Leedy & Ormrod, 2019).

There is a gap in the literature addressing this study's topic, and it is the hope and desire of this researcher that others will explore the potential servant organizational leadership has in creating a more caring and civil nursing profession. Our healthcare system and patient outcomes depend on it.

Summary

The study found a positive linear regression between Christian servant organizational leadership nursing programs and their nursing students' caring dimensions. However, there was a negative linear regression between the Non-Christian negative paternalistic nursing programs and their student nurses' caring dimensions. When looking at the results of RQ1 and RQ2 individually, it would appear that the Christian nursing programs, with their excellent servant-level organizational health characteristics, created an environment that encouraged their nursing students to be more caring. Conversely, it would appear that the Non-Christian nursing programs, with their limited negative paternalistic level of organizational health characteristics, would have created an environment less conducive to caring, which would be reflected in their nursing students. That is not what this study revealed, however.

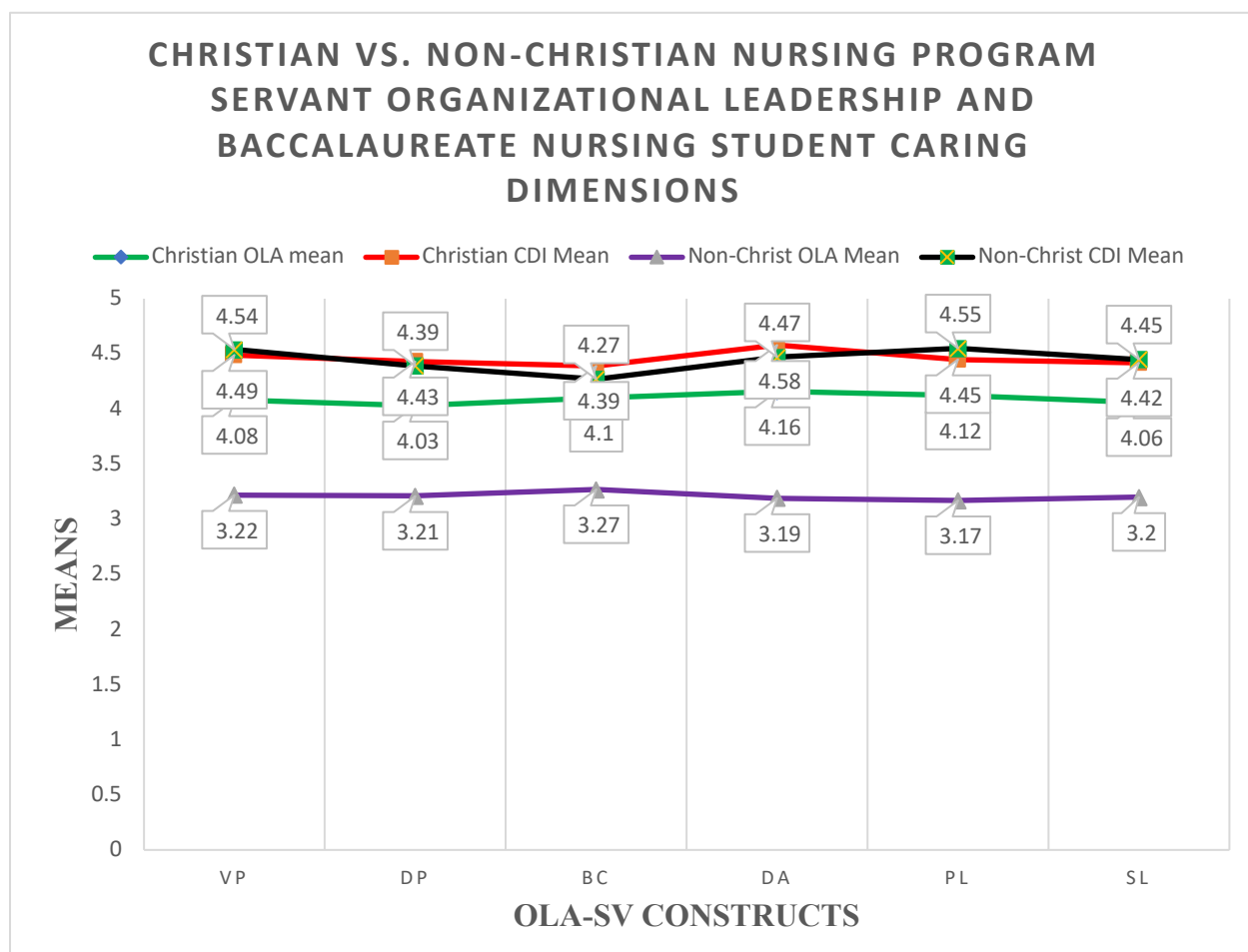
The Non-Christian pre-licensure baccalaureate nursing students were just as caring as their Christian classmates. Therefore, it was through multiple regression analysis in RQ3 that the relationship, or lack thereof, emerged between the independent variables, Christian and Non-Christian organizational leadership characteristics, and the dependent variable pre-licensure baccalaureate nursing student caring dimensions. The multiple regression and correlation analysis yielded p-values significantly greater than 0.05, and correlation (R^2) values less than 0.02 in the relationships between the organizational leadership constructs and nursing student caring dimensions. Therefore, this research failed to reject the null hypothesis. There were no

differences or no relationships found between Christian and Non-Christian baccalaureate nursing program servant organizational leadership characteristics and their pre-licensure baccalaureate nursing student caring dimensions.

Figure 5 shows that despite the low organizational leadership health found in the Non-Christian nursing programs, their nursing students had a high degree of caring on par with their Christian nursing student classmates. These results may apply to Christian and Non-Christian baccalaureate servant organizational leadership nursing programs and their pre-licensure baccalaureate nursing student caring dimensions in the Midwestern United States.

Figure 5

Christian & Non-Christian nursing programs' servant OLA construct means, and nursing student CDI-25 caring dimension means



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**APPENDIX A -OLA ORGANIZATIONAL LEADERSHIP ASSESSMENT – STANDARD
VERSION (OLA-SV)**

1 of 5 Pages

OLA Organizational Leadership Assessment

General Instructions

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

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

IMPORTANT please complete the following

School being assessed: _____

Name of your work unit: _____

Indicate **your present role/position** in the school. Please **circle one**.

- 1 = School Leadership (top level of leadership)
- 2 = Management (supervisor, manager)
- 3 = Teacher/Staff (member, worker)

Please provide your response to each statement by placing an **X**

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

Section 1

In this section, please respond to each statement as you believe it applies to **the entire school** including teachers/staff, managers/supervisors and school leadership.

In general, people within this school

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

Please provide your response to each statement by placing an **X**

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

Section 2

In this next section, please respond to each statement as you believe it applies to the **leadership** of the school including managers/supervisors and school leadership

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

42	Provide opportunities for all teachers/staff to develop to their full potential					
43	Honestly evaluate themselves before seeking to evaluate others					
44	Use their power and authority to benefit the teachers/staff					
45	Take appropriate action when it is needed					

Please provide your response to each statement by placing an **X**

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

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

Section 3

In this next section, please respond to each statement, as you believe it is true about **you personally** and **your role** in the school.

In viewing my own role ...		1	2	3	4	5
55	I feel appreciated by my principal for what I contribute					
56	I am working at a high level of productivity					
57	I am listened to by those <i>above</i> me in the school					
58	I feel good about my contribution to the school					
59	I receive encouragement and affirmation from those <i>above</i> me in the school					
60	My job is important to the success of this school					

61	I trust the leadership of this school					
62	I enjoy working in this school					
63	I am respected by those <i>above</i> me in the school					
64	I am able to be creative in my job					
65	In this school, a person's <i>work</i> is valued more than their <i>title</i>					
66	I am able to use my best gifts and abilities in my job					

APPENDIX B -REQUEST TO USE THE OLA INSTRUMENT

Spiridigliozi, Scott

To: Jim Laub, Ed.D. [REDACTED]

Tuesday, 1/25/2022, 8:59 PM

Greetings, Dr. Laub,

My name is Scott Spiridigliozi. As a doctoral candidate in the School of Divinity at Liberty University, I am conducting research as part of the requirements for a Doctor of Education in Christian Leadership degree. The purpose of my research is to investigate the relationship between servant organizational leadership and pre-licensure baccalaureate nursing student caring dimensions in the Midwest region of the United States.

I have designed my study, in part, around your servant Organizational Leadership Assessment instrument. Therefore, I have requested approval to use your instrument by filling out the questionnaire on the olagroup website. It has been a couple of weeks now, and I have not heard back from you.

Do you think you could provide me with feedback on where my application is in the process? I would be grateful as I am requesting approvals from several institutional review boards, also.

Thank you for your help!

Best Regards,

Scott Spiridigliozi, MSN, RN, CRNA
[REDACTED]

APPENDIX C-PERMISSION TO USE THE OLA INSTRUMENT

Jim Laub, Ed.D. [REDACTED]

To: Spiridigliozzi, Scott

Cc: Servant Leader Performance

Wed 2/2/2022 4:32 PM

Subject: Custom question added – Information needed to set up the OLA for your Organization.docx

Scott – Yes, I am open to you using the OLA for your research if you determine that it will work well for your specific research design.

I will need you to provide the setup information for each of the 4 organizations you are assessing. Please send me the specific setup info for each one.

Please also provide the precise wording desired for your demographic questions (both the questions and the response options).

The cost for this will be:

\$400 for OLA Setup for 4 organizations (to include the raw data report for each organization) + \$25 for the setup of each custom (demographic) question.

Normally researchers pay ½ of the total cost at the time the organizations are set up – and then the final ½ payment once you have received your raw data report.

Let me know if you have any questions about this – and thank you for using the OLA for your study.

Jim Laub, Ed.D.

Servant Leader Performance
[REDACTED]

APPENDIX D-THE OLA SET UP

1 of 3 Pages

Information needed to set up the OLA for your Organization

Please provide the following information for the organization. If any item is unclear, please contact the OLAgroup to discuss it. It is critical that these questions be answered accurately before the OLA is set up for your organization to help ensure that the OLA report is accurate.

1. Name of the Organization
2. Size of the Organization (approximate # of employees)
3. Type of Organization (Business, non-profit, healthcare, religious, education, government)
4. Name of the Contact Person - this is probably you (the researcher) but could be someone that you designate to receive the OLA Instructional Email
5. Contact Person's (1) mailing address (2) phone numbers (work, fax, cell)
6. Contact Person's Email Address - The OLA Instructional Email will be sent to this address - please double-check it for accuracy
7. Contact Person Username - this can be your regular name or anything you choose
8. Contact Person Password - anything you choose
9. What is the Focus of the assessment? The "Total Organization" or a select Organizational Unit within the organization? If it is an Organizational Unit, what is the name of that Unit?
10. Do you desire to subdivide the larger Total Organization or Organizational Unit into Sub-groups? If so, what are the names of the Sub-groups? (note: selecting sub-groups will provide you with an additional OLA report per Sub-group in addition to the Total Organization OLA report - be sure that the Sub-groups are set up so that everyone who will be taking the OLA will have one Sub-group to select)
11. Acknowledgment that all three Positional Roles will be represented (Top Leadership, Managers/Supervisors & Workforce) ... or which will be missing
12. Acknowledgment that the Total Organization (all members) will be asked to participate in the assessment Or, if you will be seeking a Random Sample
13. The Number of OLA instruments needed for this organization

14. Any Custom Questions needed? If so, please list the question and the responses as you need to see them listed on the OLA. (if an instrument other than English is to be used, please provide both the question and the responses in the appropriate language. Once the OLA has been set up for your organization you will receive the OLA Instructional Email that will provide you with ...
1. Instructions for taking the OLA instrument – you can customize the introduction and directions as needed for your organization. This section of the email is what you will send out to everyone who will be taking the OLA.
 2. Instructions for you to access the OLA site – to monitor the completion of the OLA. You will be able to see how many OLAs have been completed (Total, by Role/position and by Sub-group).

Once a sufficient number have completed the OLA and you are ready for your report to be produced contact the OLAgrouP to ask for your report. Be sure to provide the name of the organization.

Here is a copy of the OLA Instructional Email:



Dear Contact Person Name of Organization Name,

Thank you for signing up your organization or group to take the OLA. This e-mail provides you everything you will need to complete and monitor the OLA assessment process.

Your "Take the OLA" Message

 [Please customize the message below then forward it to the people you would like to take the OLA. It explains how to take the assessment. For anonymity reasons, your co-workers will use the same username and password to take the OLA. But the username and password only works 85 times, because that is the amount of OLAs you purchased.]

Dear Co-Workers,

We desire to know what you think about our organization and leadership. To get your honest and candid feedback, we need you to complete the Organizational Leadership Assessment (OLA) on-line. It will **only take 15 minutes of your time** but will provide us all with valuable insights that will help us to improve how we work together. Please know that the answers you provide are **completely confidential and anonymous**. We will only be receiving back the averaged responses of the total group taking the assessment. Thank you for completing this as quickly and thoroughly as possible.

TO TAKE THE ASSESSMENT

1. Go to: <http://www.olagroup.com> and click "Take the OLA" on the upper right of the screen.
2. Type in **XXXX** as the organizational code
3. Type in **XXXX** as the pin
4. Choose the version of the OLA that pertains to our organization
5. Choose the language option you are most comfortable with
6. Click "Start"
7. Read the brief Introduction
8. Select your Present Role/Position in the organization

9. Click "Take the OLA"

Thank you again for taking time out of your busy workday to respond. I believe that the feedback from this assessment will help our organization improve for the benefit of us all.

Your "Track the OLA Process" Information

[This information is for you as the organizational contact person and allows you to monitor the OLA assessment process]

As the organization contact person, you can now track your assessments on the OLAGroup.com website by going to: <http://www.olagroup.com> and clicking the "My Account" button at the top right of the page. Use the following username and password to track information on your account:

Username: _____

Password: _____

You can track the assessments, view a breakdown of the assessments completed to date and also purchase more assessments - all from one page! Once all of the OLAs have been completed by your group and you are ready to have the report run contact the OLAGroup to let them know.

Everyone at the OLAGroup would like to thank you for inviting us to help your organization reach its potential. If you have any questions about the assessment, taking the assessment or the OLAGroup, please do not hesitate to let us know.

Sincerely,

Your OLAGroup Representative
[REDACTED]

APPENDIX E-EMAIL WITH MICROSOFT EXCEL RAW DATA ATTACHMENT

Jim Laub, Ed.D. [REDACTED]

To: Spiridigliozzi, Scott

Cc: Servant Leader Performance

2 Attachments (Raw Data)

Scott – here is your raw data report for your Nursing Program Assessment, along with a document with key information for working with this raw OLA data. I wish you all the best with the rest of your study.

Jim Laub, Ed.D.

Servant Leader Performance
[REDACTED]

APPENDIX F-CARING DIMENSIONS INVENTORY – 25 INSTRUMENT

1 of 2 Pages

CARING DIMENSIONS INVENTORY (CDI)*

Stem Question: “Do you consider the following aspects of nursing practice to be caring?”

Response on a five-point Likert scale: 1 (strongly disagree) to 5 (strongly agree).

Circle the number that corresponds to your perception of the intervention as caring.

	1	2	3	4	5
Strongly Disagree					Strongly Agree
	1	2	3	4	5
1. Assisting a patient with an activity of daily living (washing, dressing, etc.)	1	2	3	4	5
2. Making a nursing record about the patient	1	2	3	4	5
3. Feeling sorry for a patient	1	2	3	4	5
4. Getting to know the patient as a person	1	2	3	4	5
5. Explaining a clinical procedure to a patient	1	2	3	4	5
6. Being neatly dressed when working with a patient	1	2	3	4	5
7. Sitting with a patient	1	2	3	4	5
8. Exploring a patient’s lifestyle	1	2	3	4	5
9. Reporting a patient’s condition to a senior nurse	1	2	3	4	5
10. Being with a patient during a clinical procedure	1	2	3	4	5
11. Being honest with a patient	1	2	3	4	5
12. Organizing the work of others for a patient	1	2	3	4	5
13. Listening to a patient	1	2	3	4	5
14. Consulting with a doctor about a patient	1	2	3	4	5
15. Instructing a patient about an aspect	1	2	3	4	5

of self-care (washing, dressing, etc.)	1	2	3	4	5
16. Sharing your personal problems with a patient	1	2	3	4	5
17. Keeping relatives informed about a patient	1	2	3	4	5
18. Measuring the vital signs of a patient (e.g., pulse and blood pressure)	1	2	3	4	5
19. Putting the needs of a patient before your own	1	2	3	4	5
20. Being technically competent with a clinical procedure	1	2	3	4	5
21. Involving a patient with his or her care	1	2	3	4	5
22. Giving reassurance about a clinical procedure	1	2	3	4	5
23. Providing privacy for a patient	1	2	3	4	5
24. Being cheerful with a patient	1	2	3	4	5
25. Observing the effects of a medication on a patient	1	2	3	4	5

APPENDIX G-PERMISSION TO CONDUCT RESEARCH EMAIL

Dear Recipient,

As a graduate student in the School of Divinity at Liberty University, I am conducting research as part of the requirements for a Doctor of Education degree. The title of my research project is, *Understanding Correlation between Christian and Non-Christian Servant Organizational Leadership and Pre-Licensure Baccalaureate Nursing Student Caring Dimensions*. The purpose of this quantitative correlational study will be to understand if a relationship exists between Midwest baccalaureate Christian affiliated nursing programs and non-Christian affiliated nursing programs' servant organizational leadership characteristics and its effect upon their pre-licensure baccalaureate nursing students' caring dimensions.

I am writing to request your permission to conduct my research at your School of Nursing. I would also request the Dean's office or the Nursing office to act as a third party to send my study via email to maintain anonymity. The program's designated person would forward the recruitment letter to the nursing program's faculty/staff, supervisors, and top leadership containing the link to the Organizational Leadership Assessment – Standard Version questionnaire and forward the same email to the pre-licensure baccalaureate nursing students who will select the link for taking the Caring Dimensions Inventory – 25 questionnaire. Therefore, the participants will select the appropriate link to their questionnaire to be completed anonymously online.

Participants will be asked to complete the attached anonymous survey via the web-based survey software *Qualtrics* Surveys. Participants will be presented with informed consent information prior to participating.

Thank you for considering my request. If you choose to grant permission, please respond by email to: [REDACTED].

Sincerely,

Scott Spiridigliozzi, MSN, RN, CRNA
Principal Investigator
[REDACTED]

APPENDIX H-LIBERTY UNIVERSITY IRB APPROVAL LETTER**1 of 2 Pages**

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

May 23, 2022

Scott Spiridigliozzi
Leonard MomenyRe: IRB Exemption - **IRB-FY21-22-574** UNDERSTANDING CORRELATION BETWEEN
CHRISTIAN AND NON-CHRISTIAN SERVANT ORGANIZATIONAL LEADERSHIP AND PRE-
LICENSURE BACCALAUREATE NURSING STUDENT CARING DIMENSIONS

Dear Scott Spiridigliozzi, Leonard Momeny,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data-safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants' research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording).

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects.

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP

Administrative Chair of Institutional Research

Research Ethics Office



APPENDIX I-UNIVERSITY D, IRB APPROVAL EMAIL

To: Spiridigliozzi, Scott

Scott,

Sorry for the delay, but your IRB application has finally been approved. Please let me know what you need from me to proceed.

Regards


Dean, School of Natural and Social Sciences


APPENDIX J-RECRUITMENT EMAIL

1 of 2 Pages

Dear Potential Participant:

As a doctoral candidate in the School of Divinity at Liberty University, I am conducting research as part of the requirements for a Doctor of Education in Christian Leadership degree. The purpose of my study is to understand if a relationship exists between the Midwest Region of the United States baccalaureate Christian affiliated nursing programs and Non-Christian affiliated nursing programs' servant organizational leadership characteristics and its effect upon their pre-licensure baccalaureate nursing students' caring dimensions. I am writing to invite eligible participants to join my study.

Participants in this study must be 18 years of age or older, employed/assigned in the nursing program as a faculty/staff member, supervisor, or a member of your nursing program's top leadership. Concurrently, participants will also be pre-licensure baccalaureate nursing students.

Participants, if willing, will be asked to complete a short anonymous survey. Nursing program faculty/staff, supervisors, and top leadership will complete the Organizational Leadership Assessment - Standard Version (OLA-SV) survey. Pre-licensure baccalaureate nursing students will complete the Caring Dimensions Inventory - 25 (CDI-25) survey. Each survey should take approximately five to ten minutes to complete. Participation will be completely anonymous, and no personal, identifying information will be collected.

To participate, please click the link below that applies to your role in the nursing program:

Role #1: Pre-licensure baccalaureate nursing students

https://liberty.co1.qualtrics.com/jfe/form/SV_8hTnbyOgnbvKXY2

Role #2: Nursing program faculty/staff, supervisor, and top leadership

https://liberty.co1.qualtrics.com/jfe/form/SV_8GIZP0BNZESeJMy

A consent document is provided on the first page of the survey. The consent document contains additional information about my research. After you have read the consent form, please click the link to proceed to the survey. Doing so will indicate that you have read the consent information and would like to participate in the survey.

Participants will have the opportunity to enter a raffle to win a \$500.00 Amazon gift card. At the conclusion of their survey, participants will be forwarded to another separate Compensation Survey where they can enter their email information for the raffle.

With Best Wishes,

Scott Jeffery Spiridigliozi, MSN, RN, CRNA
Principal Investigator



APPENDIX K-CONSENT FORM

1 of 3 Pages

Consent

Title of the Project: Understanding Correlation Between Christian and Non-Christian Servant Organizational Leadership and Pre-Licensure Baccalaureate Nursing Student Caring Dimensions.

Principal Investigator: Scott Jeffery Spiridigliozzi, MSN, RN, CRNA, Primary Investigator, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. Taking part in this research project is voluntary. To participate, you must be 18 years of age or older and be a baccalaureate nursing program's teacher/staff, manager, or member of your nursing program's leadership to complete the Organizational Leadership Assessment – Standard Version survey. To complete the Caring Dimensions Inventory – 25 survey, you must be 18 years of age or older and be a baccalaureate nursing program pre-licensure baccalaureate nursing student.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about, and why is it being done?

The purpose of my research is to investigate the relationship between servant organizational leadership and pre-licensure baccalaureate nursing student caring dimensions in the Midwest Region of the United States. This study is being done to investigate whether exposure to servant organizational leadership in pre-licensure baccalaureate nursing programs will teach nursing students to be more caring.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

- Complete either of the two questionnaires online at your leisure. The questionnaire will take approximately 5 to 15 minutes to complete.
- If you are at least 18 years old and a teacher/staff, manager, or member of your nursing program's leadership, you will be completing the Organizational Leadership Assessment – Standard Version survey.
- If you are at least 18 years old and a pre-licensure baccalaureate nursing student, you will be completing the Caring Dimensions Inventory - 25 survey.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include improved healthcare culture that leads to improved patient outcomes.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

Include the following in this section:

- Participant responses will be anonymous.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.

How will you be compensated for being part of the study?

To maintain anonymity and at the conclusion of the survey, participants will click on a link to be automatically forwarded to another separate compensation survey where they can enter their email information for a chance to win a \$500 Amazon gift card. The gift card will be sent via email to the winner.

What are the costs to you to be part of the study?

There are no costs to participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision on whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free not to answer any question or withdraw at any time prior to submitting the survey without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Scott Spiridigliozzi, MSN, RN, CRNA. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at [REDACTED] and/or [REDACTED]. You may also contact the researcher's faculty sponsor, Leonard Momeny, EdD, at [REDACTED].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered, and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.