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Impact of Servant Leadership Style on Customer Service and Patient Satisfaction

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Abstract

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MA, La Sierra University, 2011

BSc, Babcock University, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services - Healthcare Administration

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Abstract

Patient satisfaction presents an emerging area of research for healthcare providers because major healthcare providers like Medicare/Medicaid control the finances of healthcare institutions as based on their patient and customer satisfaction. The purpose of this study was to examine the impact of servant leadership on customer service, and patient satisfaction, in the Inland Empire Region of Southern California. The theoretical framework applied to this study was the servant leadership theory. Participants consisted of 82 managerial staff within the University Health System, which is comprised of a teaching hospital, 5 behavioral health centers, 10 federally qualified health centers, and a public health division. Data were collected using Barbuto and Wheeler's Servant Leadership Questionnaire (SLQ) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The results showed a significant negative relationships between patient satisfaction and quality of care, communication, and patient safety. Patient satisfaction was significantly related with customer service. However, mediation could not be supported because the servant leadership style was not significantly related to any of the predictors (quality of care, communication, patient safety, health education, and customer satisfaction). Healthcare providers may use the results of this study to design and implement measures that would enhance the patient-perceived value of the healthcare services and improve the lived experience of patients as customers in healthcare centers of the Inland Empire, California.

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Dedication

I dedicate this doctoral study to the Almighty God who has seen me through these ten years of continuous study in America without a break. I also dedicate this study to my family especially my dear wife, Ogonna Onyemeta who throughout this study was the pillar of support through encouragement and taking care of kids while I burned the midnight candles, and to my Children; Ekele, Chigo and Ada who always come to me to ask "Daddy are you studying?" the times I was alone in our home office. I'm blessed to have a happy family. To my big uncle, Chibuike Nwaobia who saw the potentials in me while I was in high school and supported me though my college days, I say thank you. And my reliable friends Chinedu Madukoma who is also completing his doctoral studies, Dr. Kirlos Guerguis who kept on motivating and encouraging me even when I felt I would not have made it to this level and to my Walden "4forlife"; Samuel Jacobs-Abbey, Grace and Charles; you unwavering support and love will forever linger in my heart. To my parents Elden and Mrs. Godwin and Christiana Nwaobia who taught me that there is no shortcut to success earlier in life. Your continuous prayers and parental lessons have resulted in this great milestone. I say a big thank you. To my staff and colleagues in all my organizations who stood by me and believed that I can achieve whatever I set my mind to do. You were all right! I have done it and I wish all of you the very best in your various endeavors.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

As of 2018, healthcare is the largest employer in the United States. Creating and sustaining patient care, while ensuring limited turnover of staff, and the evolution of practices and knowledge present some of the significant challenges facing the healthcare industry in the United States (Capolongo et al., 2015). The purpose of healthcare structures is to protect and improve public health (Capolongo et al., 2015). Patient satisfaction is predominantly used to measure the quality of healthcare provisions by a healthcare institution (Prakash, 2010). In the contemporary healthcare workplace, patient satisfaction has been quantitatively measured through metrics such as the number of patients treated, patient outcomes, and other forms of success linked to patient health (Prakash, 2010).

In this quantitative correlational study, I used a predeveloped survey (CAHPs) in the investigation of servant leadership style management on customer service in healthcare, as measured by patient satisfaction in the Inland Empire region of Southern California. Healthcare providers implemented a servant leadership style of management in the study area, and as CAHPs is a predeveloped means of data collection by Center for Medicare and Medicaid Services (CMS), the main healthcare provider in the region, it was important to establish the impact of this practice on patient satisfaction. In this study, I aimed to position patient satisfaction as the metric for customer service quality and to establish the strengths of servant leadership in delivering higher rates of customer service.

In this chapter, a background of the literature related to the major themes in servant leadership, healthcare, customer service, and patient satisfaction is presented. Following this, the problem that I aimed to solve will be discussed, which leads into an explanation for the purpose of the study. Research questions will then be described per the findings of the preceding three subsections, before the chapter turns to an introduction to the methodological design used. The chapter concludes with the significance of the study and a summary of the chapter.

Background

Patient satisfaction is an emerging area of research for healthcare providers. It is a well-developed and evolving field of research. Healthcare managers who continue to achieve excellence consider patient satisfaction when designing strategic plans for quality improvement of care (Al-Abri & Al-Balushi, 2014). As a result, healthcare providers now incorporate patient satisfaction as a component in their healthcare delivery goals (Tsai, Orav, & Jha, 2015), and there have been improvements in modifying organizational goals until a satisfactory outcome is achieved.

DiGiancinto, Gildon, Keenan, and Patton (2016) identified correlations between customer service factors that increase patient satisfaction. These factors were length of wait time, perceived wait time, and communication between the patient and healthcare provider (DiGiancinto et al., 2016). Gupta, Rodeghier, and Lis (2014) identified ties between service quality and patient survival, suggesting that improvements to customer service will improve the satisfaction and health of patients. Scholars in the field of healthcare to argue that service quality is becoming an important area of interest for healthcare providers, but an eternally complex area of research, particularly as a tool for

providers to demonstrate patient focus and differentiation in the healthcare community, all while enhancing the patient experience (Gupta et al., 2014).

Assessing customer satisfaction is a means of identifying sources of actionable data to improve the quality of the workplace (Gupta & Rokade, 2016). Within the Institution of Medicine, the quality of healthcare is defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (as cited in Gupta & Rokade, 2016, p. 84). However, DiGiancinto et al. (2016) stated that patient satisfaction has been focused on interaction with physicians and other relevant hospital stakeholders. There are limitations in understanding how leadership can improve overall patient satisfaction through increased customer service quality.

A majority of the research on patient satisfaction, customer service, leadership style, and healthcare provision are either specific or highly generalized. These factors will be further identified as a limitation of prior research and a gap in knowledge in Chapter 2. Some scholars have identified key areas of customer service, leadership, and practice that positively influence overall patient satisfaction. However, even when combined with the generalized research, there is a gap in knowledge pertaining to means of improving quality of care (Lonial & Raju, 2015).

Servant leadership has been described as more than a management technique and is more like a way of life (Russell, 2017). Under servant leadership, individuals must develop a sense of wanting to serve others first; ideally, this feeling will come naturally to servant leadership (Russell, 2017). Originally developed by Greenleaf (1970), the theoretical framework of servant leadership has been employed throughout the private

and public sector. Proponents of the management style posit that servant leadership improves customer satisfaction by creating cultural shifts in the workplace (Liden, Wayne, Liao, & Meuser, 2014). When staff, employees, and leaders feel that they are contributors to organizational success and intellectual assets of their workplace, there is a direct impact on the quality customer service delivery (Flynn, Smither, & Walker, 2016).

Researchers within the healthcare field have sought to identify the core constructs of servant leadership that improve patient satisfaction. Neubert, Hunter, and Tolentino (2016) found that nurse job satisfaction is tied to servant leadership practices through stimulating collaboration and creativity, engaging employees, and establishing various other positive outcomes for organizations and their members. The results identified by Neubert et al. are likely a result of the principles of servant leadership, such as humility, empathy, and agape love, which develop a social identity of service for those practicing the leadership style (Sun, 2013). Perceptions of leader identity as one of service has also been associated with improved service quality in healthcare settings (Kondasani & Panda, 2016; Tsai et al., 2015). Despite the ties between customer services, as measured by patient satisfaction, there is a gap in the literature relating to how servant leadership can help improve customer service in healthcare settings through improvements to the quality of care.

The lack of understanding of contributors to patient satisfaction presents a gap in knowledge and hinders ongoing healthcare practices. Patient satisfaction continues to be the most significant factor in assessing the quality of services being provided by healthcare service providers. However, internal practices within healthcare services continue to limit patient satisfaction (Martelo-Landroguez, Barroso-Castro, & Cepeda,

2015). As a result, it is necessary to explore how servant leadership practices can continue to improve patient satisfaction across healthcare service environments and whether a customer service approach guided by servant leadership styles is the means of improving patient satisfaction.

Problem Statement

To address servant leadership style of management on customer service as measured by patient satisfaction, major healthcare providers in California, such as Medicare/Medicaid, have a financial control based on customer satisfaction, which means that hospitals must have a near perfect customer satisfaction scores to obtain reimbursement (John-Nosacek, 2015). This process is a significant change from the 20th century practice for treating patients, when hospitals traditionally were driven by the volume of patients entering and not the actual quality of treatment being provided to those patients (Scotti & Harmon, 2014). A key means of measuring and reporting quality outcomes in healthcare organizations is by assessing patient satisfaction (Anhang Price et al., 2014).

Customer service is one of the most important elements of healthcare delivery. Similar to the private sector, healthcare organizations choose to use a customer service approach to enact quality improvements for patient experience and outcome (Vogus & MClelland, 2016). For hospital leaders, the Consumer Assessment of Healthcare Providers and Systems (CAHPs) survey is the current paradigm for gathering primary data on patient perspectives of satisfaction (Anhang Price et al., 2014).

Measuring patient satisfaction under a guideline of customer service is a complex way of approaching healthcare provision (Pizam, Shapoval, & Ellis, 2016). The relative nature of the term satisfaction, which many patients will reflect upon in contrasting ways, has made evaluating actual customer service problematic in the past (Pizam et al., 2016). Gaps remain regarding satisfaction in diverse populations (Vogus & McClelland, 2016), and the concept of patient satisfaction is too poorly understood to create actionable data from any information collected (Batbaatar, Dorjdagva, Luvsannyam, & Amenta, 2015). Flaws in healthcare delivery may contribute to the inability to collect accurate patient satisfaction data.

Trastek, Hamilton, and Niles (2014) further argued that the U.S. healthcare system is broken and unsustainable, both financially and as a result of the quality of care being provided to patients. The existing limitations and failures of healthcare systems across the United States have caused the public to distrust hospitals and their staff (Trastek et al., 2014). To regain the trust of the public, and to deliver the highest quality of care, servant leadership is the best model for practice (Trastek et al., 2014). Servant leaders concentrate on ensuring that healthcare providers are fully equipped to enact changes to meet the needs of the diverse stakeholders affiliated with healthcare providers (Trastek et al., 2014). However, further research is needed to establish the elements of servant leadership that lead to increased satisfaction of patients as customers to the healthcare industry.

Other researchers in the healthcare field mirror the need for further research. Kitapci, Akdogan, and Dortyol (2014) argued that, as healthcare is predominantly a private sector industry where patients are customers, improving satisfaction is imperative

for financial reasons. Patient satisfaction has been linked to word of mouth communication and repurchase intention, both of which have been associated with improved customer service (Kitapci et al., 2014). As much as customer service is linked to patient satisfaction, so too is it associated with workplace climate (Menguc, Auh, Yeniaras, & Katsikeas, 2017). Healthcare providers must ensure that their staff, patients, and all relevant stakeholders are satisfied (Holtom & Burch, 2016). There is a wealth of data on using servant leadership to improve workplace climate, but there is limited research on servant leadership and its influence on customer service. This study was important to understand the impact of the servant leadership style of management on customer service as measured by patient satisfaction using the CAHPs survey.

Purpose of the Study

The purpose of this study was to determine the impact of the servant leadership style of management on customer service, as measured by patient satisfaction. Within this purpose, the impact of servant leadership on quality of care, communication, health education, and patient safety, as well as levels of patient satisfaction, was investigated. To complete this research, data were collected using a cross-sectional methodology employing Barbuto and Wheeler's (2006) Servant Leadership Questionnaire (SLQ) and the CAHPs survey.

I used a respondent participant sample of healthcare managers, who completed the SLQ. The SLQ was developed to measure the frequency with which an individual believes he or she exhibits servant-leader qualities. The CAHPS Survey is an integral part of the Center for Medicare and Medicaid Services' (CMS) efforts to improve healthcare in the United States by paying for high-quality services. The Customer Effort Score

(CES) is used to measure the customer service experienced by the respondents. To improve customer experience, it is important for service providers to model and measure customer experience in healthcare settings (Spiess, T'Joens, Dragnea, Spencer, & Philippart, 2014). Surveys have become a valuable tool to quantify the consumer experience (Farley et al., 2014). The SLQ is a leading survey used in healthcare services (Farley et al., 2014).

The purpose of this research was to measure the correlation of servant leadership management styles on customer service via patient satisfaction surveys, as there is a gap in research regarding this influence of servant leadership in healthcare.

Research Questions

1. Does the servant leadership style of management, as measured by SLQ, positively influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$1: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$1: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

2. Does the servant leadership style of management, as measured by SLQ, influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$2: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$2: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

3. Does the servant leadership style of management, as measured by SLQ, influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$3: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$3: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

4. Does the servant leadership style of management, as measured by SLQ, influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$4: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$4: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

5. Does the servant leadership style of management, as measured by SLQ, influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$5: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$5: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

Theoretical Framework

The theoretical foundation applied to this study was servant leadership theory. Servant leadership is a philosophical set of practices designed to create a sense of unity within a workplace, wherein employees are made to feel like part of the organization and not just employed by it (Harwiki, 2016). Employees who are made to feel like part of the organization often claim to have their ideas for practice heard and adopted by leadership, and part of the purpose of their work is to grow the organization. Employees who do not feel any emotional investment in their commitment to an organization typically report feeling like a cog in a machine, wherein their only purpose is to serve those above them by doing the same tasks over and over again (Harwiki, 2016). Servant leaders guide their followers in emulating the core tenants of their behavior, which prioritizes the needs of others above their own (Liden et al., 2014). In prior research, servant leadership has been associated with improvements to the lived experience of all workplace stakeholders, including the end customer.

Within the field of healthcare, managers have been found to be absent from participation in the construction of organizational development, despite the evidence that facilitating change is best practiced by first line management (Gunnarsdottir, Edwards, & Dellve, 2018). This focus on management involvement in the development of systems stems from a key element of servant leadership with sincere followers and a servant focus through continuous involvements with the interconnection of goals, values, and challenges (Gunnarsdottir et al., 2018). In the globalized workplace, even hospitals and other healthcare centers now benefit from diverse staff demographics. The interconnection of hierarchies and teams allows for the development and implementation

of new care practices in a strategic manner, built from actionable data from community building (Liden et al., 2014).

Community building is an area of servant leadership management practice (Spears & Lawrence, 2016). Community building relates to customer service quality as the purpose of community building is to (a) standardize care practices, (b) reduce employee burnout and turnover, and (c) ensure the satisfaction of the patient using the patient's unique care requirements (Sipe & Frick, 2015). Linuesa-Langreo, Ruiz-Palomino, and Elche-Hortelano (2018) argued that servant leadership creates a sense of group citizenship behavior, which unites a team of individuals in achieving their desired end goal without removing autonomy from each individual's role.

The community building element of servant leadership is also tied to the commitment of growth of people using foresight, awareness, and empathy to determine the needs of the customer/patient (Spears & Lawrence, 2016). Listening is a key tool within the practice of servant leadership, as patients who are satisfied often report that they felt their healing process was conducted in a way that was unique to their needs (Vogus & McClelland, 2016). The healthcare provider is the steward to the patient's satisfaction and long-term survival, so conceptualizing means of treatment and bedside manner for each patient is another core theoretical proposition of servant leadership practice (Patrnchak, 2016).

As a result of these core theoretical propositions within servant leadership theory, the research questions employed in this study were honed to ensure thorough exploration. For example, in RQ1, I sought to identify the relationship between customer service and patient satisfaction. In RQ2, I furthered this exploration through the connection of

customer service and patient satisfaction under a servant leadership management style. In RQ3, I explored communication skills and their influence on patient satisfaction, which leads into RQ4 and the evaluation of themes: leading, motivating, and influencing others, all of which depend on the quality of communication skills within the community of healthcare providers. Finally, RQ5 ties back to the original research question, and whether servant leadership improves customer service through improvements to patient safety.

Nature of the Study

I employed a quantitative, correlational approach. The data for this research came from the 2018 CAHPS survey and the SLQ. Specifically, the areas of customer service and patient satisfaction were measured using the CAHPS survey while the servant leadership style of management was measured using the SLQ. These Likert scale measures of 1= *unsatisfied*, 2= *neutral*, 3 = *satisfied*, 4 = *very satisfied* were administered to healthcare managers of a county hospital in the Inland Empire region. The respondents completed the measures by providing a numerical score for choice selection.

For the data analysis, descriptive statistics (including the measure of central tendencies and dispersion) were used for the demographic variables. I tested the relationship between the areas of customer service (quality of care, communication, health education, and patient safety) and patient satisfaction and the mediating role of servant leadership style of management on this relationship using the multiple linear regression analysis (see Cohen, Cohen, West, & Aiken, 2013) and measure the impact of servant leadership style of management on customer service as measured by patient satisfaction using regression analysis.

Using a quantitative approach to examine the relationship between the areas of customer service and patient satisfaction and how servant leadership management styles mediates such relationship allowed for the standardization of the methodological procedure. Eva, Robin, Sendjaya, van Dierendonck, and Liden (2018) argued that, despite the proliferation of servant leadership studies, there is a significant lack of coherence and clarity around servant leadership as a construct. This lack of clarity has impeded servant leadership theory development (Eva et al., 2018). Therefore, the nature of the methodology in this study has been designed for replication in other subjective areas.

Definitions

For the purpose of examining the quality of customer service rendered by healthcare providers, the following key terms are defined:

CAHPs: Consumer Assessment of Healthcare Providers and Systems survey (Anhang Price et al., 2014).

Communication: The influence that servant leadership style management has on the clarity, consistency, and understanding of medical information from healthcare providers to patients; specifically, does servant leadership improve communication structures in such a way that overall customer service is improved? (Sipe & Frick, 2015).

Customer effort score: A measure used for customer service experienced by the respondents (Fortenberry & McGoldrick, 2016).

Customer satisfaction: The degree to which patients felt satisfied with the healthcare they have been provided (Pitt, Chotipanich, Issarasak, Mulholland, &

Panupattanapong, 2016) under servant leadership style manager by healthcare institutions in the Inland Empire, California.

Health education: How effective servant leadership communication styles are on educating patients about their health and whether this leads to improved customer service experiences with Medicare/Medicaid (Yeh, Wu, & Tung, 2018).

Healthcare community: All relevant stakeholders in healthcare institutions, including doctors, patients, hospital managers, family and friends of patients, subsidiary employees within a healthcare institution, other agencies, corporations, and industries associated with the healthcare provider/institution (Seibert, 2015).

Healthcare provider: Individuals, institutions, and all relevant stakeholders involved in providing care to patients.

Inland Empire: A metropolitan region of Riverside and San Bernardino counties in the Greater Los Angeles area of Southern California.

Patient safety: How hospital and healthcare providers protect their patients from errors in medical provision, injuries as a result of the environment, and infections commonly found in healthcare settings (Thom et al., 2016).

Patient satisfaction: An important and commonly used indicator for measuring the quality in healthcare (Prakash, 2010).

Quality of care: How effective the care provided by the institutions being investigated was and whether servant leadership ultimately improves the quality of care provided.

Servant leadership: How leaders have the mindset of serving first and caring for those they serve.

Service delivery models: The methods employed by teams of healthcare providers that seek to improve the overall quality of care and patient satisfaction (Batalden et al., 2015).

Assumptions

To improve patient satisfaction, the quality of care must be improved (Farley et al., 2014). This assumption was a necessary element of this study as it has been identified throughout previously published literature, as will be discussed in Chapter 2. The goal of the research was to determine the impact of servant leadership style of management on customer service as measured by patient satisfaction. Therefore, it was assumed that when the quality of care is improved, so too is patient satisfaction.

It was also assumed that healthcare managers are the appropriate population to be used when researching the impact of servant leadership styles of management on customer service. Healthcare managers have only been used a few times in prior research, presenting a gap in the literature. Despite this gap, the perceptions of healthcare managers have been used throughout previously published research (Al-Abri & Al-Balushi, 2014), suggesting that their input is of value in creating actionable data to improve patient satisfaction.

Scope and Delimitations

This study involved an analysis of the SLQ and CAHPs survey data, gathered from healthcare managers in the Inland Empire region of Southern California. The theoretical framework used to guide the research was servant leadership style management, as this had previously been adopted as the leadership style of healthcare workers in this region. The results of this study may provide insights as to how servant

leadership management styles mediate the relationship between the areas of customer service and patient satisfaction.

The research area was chosen for this study due to the preexistence of content management systems (CMS), who practice servant leadership as their dominant leadership style. Servant leadership has been researched in previously published literature and has been determined as a core means of improving patient care as a healthcare leadership practice. In this study, I aimed to fill the gaps in literature pertaining to the academic understanding of the extent to which the servant leadership style of management influences rates of patient satisfaction in a small geographic area. However, the transferability of these findings may be limited, as the Inland Empire region of Southern California is a small geographic area with demographic factors that may not be present in other regions. Therefore, the methodology employed in this research was developed with the purpose of allowing further exploration of the core themes across similarly sized regions in the United States, although this may not occur in reality.

Limitations

Limitations of the study included (a) a small spatial area, which does not allow for generalizability; (b) potential response biases of healthcare managers; and (c) quantitative survey data does not allow for the exploration of how and why servant leadership does or does not improve customer service, just whether or not it does (see Creswell, 2009; Moser & Kalton, 2017). The small spatial area under investigation in this study does not limit the generalizability of the results. The research purpose was to determine the impact of the servant leadership style of management on customer service as measured by patient satisfaction, a purpose and methodological design that can be replicated by

researchers across the United States and rest of the world. Therefore, this research may prompt other researchers to test whether they find similar results in other social demographics and geographic areas where servant leadership is practiced within healthcare settings.

Response bias, a general term used to describe conditions or factors that occur while responding to surveys, may be the way responses are provided (McPeake, Bateson, & O'Neill, 2014). When response bias occurs, it is generally viewed as a deviation, so anomalies within the response data were investigated and noted during the analysis process of this study. To mitigate instances of response bias, research questions were honed for specificity and were communicated clearly to the respondents. In addition to this, respondent screening took place to ensure that all respondents held appropriate positions, knowledge, literacy, and understanding of the themes for required responses.

Finally, the results derived from this study may lay the foundation for future qualitative research on the topic of customer service as measured by patient satisfaction with servant leadership. It is hoped that future researchers will continue to seek to fill this gap in knowledge.

Significance

The purpose of this study was to examine the quality of customer service rendered by healthcare providers in the Inland Empire region of Southern California, as this has been tied to reimbursement for Medicare/Medicaid. Only a few studies conducted on the servant leadership style of management have connected this management style to customer service using a participant sample of healthcare managers as their study population. The need to improve the quality of care is a constant within the healthcare

industry. Establishing true metrics for evaluating the effectiveness of the servant leadership style of management in the Inland Empire Region of Southern California will allow healthcare managers across the United States to replicate research and develop actionable plans for improved customer service and care quality. The results of this study will provide insight into understanding, promoting, and improving overall patient satisfaction within healthcare organizations. Furthermore, patient satisfaction has been directly linked to patient survival, so any research aimed at improving overall patient satisfaction also has the potential to save lives, while improving the lived experienced of all those employed in the healthcare industry.

Summary

This chapter was an introduction to the research conducted in this study. I outlined the relevant literature pertaining to the problem and purpose of the study. Following this, the research questions were outlined, a theoretical framework was discussed, and a methodology was introduced. Methodology introduction included the nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study.

Chapter 2: Literature Review

Introduction and Contextual Background

Healthcare is an area that has witnessed the application of novel concepts with a view to alleviating patient illnesses and elevating a patient's overall sense of wellbeing by offering positive patient experiences. In this literature review, I will assess the influence of the employment of servant leadership as a vehicle to significantly customer service levels as measured by patient satisfaction in the Inland Empire Region of Southern California. The various factors that establish the criticality of conducting research on this subject will be assessed in this literature review.

Products Versus Services Industries

Most publications on quality standards have exhorted providers of customer products and services to offer the highest quantum of value they can to their customers. The attention to quality is key to these organizations pursuing sustained growth of their businesses and industries from a long-term standpoint. Unlike products where the consumer deals with something tangible as part of the use experience, the services industries involve "moments of truth" (Muzellec & O'Raghallaigh, 2018) when customers work with professionals, managers, and staff from the services firm to address their respective needs. The heterogeneity of the humans delivering the service during these moments of truth heightens the need to prioritize service quality measures (Jiahuan, 2016).

The Uniqueness of the Healthcare Service Industry

The need to deliver quality and improved customer satisfaction becomes more pronounced in the case of the healthcare industry, where the moments of truth would

have far-reaching implications on the customers, namely the patients receiving the service. Mekoth and Dalvi (2015) highlighted that positive patient experience could lift the spirits of patients and provide them with the reassurance that the healthcare professionals interacting with them view the best interests of the patients as their highest priority. A focus on patient values, in turn, could motivate the patients to improve upon service delivery models and enable patients to follow prescribed medication, diet, or health regimens. On the other hand, according to Koomans and Hilders (2017), a negative patient experience could cause patient apathy in following treatment recommendations, and in extreme scenarios, lead to declines in mental (or physical) wellbeing.

Proposed Application of Servant Leadership to Patient Healthcare

Servant leadership theory focuses on service to others. According to service leadership theory, the role of organizations is to create people who can build a better tomorrow (Parris & Peachey, 2013). This theory is rooted in ethical and caring behavior, demonstrated by not only the way the lives of individuals are shaped behaviorally but other directions as well (Dierendonck, 2011). With servant leadership theory as a primary focus and inherent motivation to serve, the organization is fueled to provide customer service that will enhance positive patient outcomes.

Heightened Significance of Service Quality in the US Patient HealthCare Space

Misra (2018) observed that consumers of healthcare have invested their energy demanding quality services, increasing its importance in the areas of conceptual and empirical research. Patient care experiences contribute to high levels of adherence to prescribed treatment regimens, better patient safety measures, and overall reduced costs

through decreased healthcare use (Anhang et al., 2014). Scholars have outlined the need for further research concerning the impact of customer service on patients' satisfaction.

Recent Measures by the Center for Medicare and Medicaid Services

The need for improvements in-patient satisfaction has been emphasized with the CMS efforts to improve healthcare in the United States. These measures include value-based reimbursement strategies in paying for high-quality services and measures to improve customer service and patient experiences (Kessel et al., 2015). To this effect, it is imperative that more research be conducted to establish whether there is a definitive causal relationship between the employment of servant leadership measures and a salient rise in satisfaction levels among patients as part of their care experiences.

Structure of the Literature Review

The next few subsections of this chapter commence with outlining the academic literature, texts, and journal articles used in this chapter, and the scope, both in terms of relevance and timeframe, that I emphasized in compiling this literature review. I establish a theoretical foundation of servant leadership as a means to upholding the criticality of service quality across service industries in general and among healthcare institutions in particular. Servant leadership is compared with other conventional forms of leadership, such a transactional and transformational leadership, seeking to further reinforce the relevance of servant leadership to healthcare delivery. The concepts of service quality and patient experience are explained, and the differences from the patient's viewpoint and the healthcare professional's perspective of service quality are assessed. The role of servant leadership in aligning these two perspectives of service quality is critically examined and is linked back to the research questions to establish how servant leadership

can foster positive patient experience through quality of care, communication, health education, and patient safety.

Literature Search Strategy

The databases used to complete the search for this section included EBSCOhost, Business Source Complete, MEDLINE, ABI/Inform Complete, PubMed, CINAHL, Google Scholar, PsycINFO, and PubMed. The search terms used to ensure that the review conducted only articles and texts most relevant to the research subject were *customer service, patient satisfaction, service quality, patient care experience, servant leadership theory, CAHPS, customer effort score, patient care outcome* and *health care service delivery.* These sources were obtained and reviewed digitally as well as from traditional professional journals. Current textbooks on the topic of customer service and patient care experiences were reviewed for a complete understanding of the subject matter.

Theoretical Foundation

Leadership Theories

Leadership was first theorized in the early 20th century by academicians in the area of human behavioral theory as a set of personality traits that distinguished a leader from those that followed him.

Personality traits and skills-based leadership. These personality traits could be summarized as six headline attributes:

- The drive or the desire to achieve results (could be expressed as ambition, initiative or perseverance; Agrawal, 2015)

- Motivation to lead the employees for the development of the organization as a whole
- Honesty, uprightness, and integrity (Mishra & Tripathi, 2016)
- Soundness of thought and action, also manifesting in the form of emotional soundness
- Work competence, including awareness of the duties and responsibilities to be discharged by the leader
- Cognitive abilities, as highlighted by Hurtado and Mukherji (2015), with the ability to see the whole picture, analyze given situations quickly, and make timely and right decisions.

The skills and competencies-based approach to assessing leadership moves away from attributing successful leadership to personal traits and establishes skills possessed by leaders mainly interpersonal, technical, and cognitive, as definitive predictors of successful leadership.

Situational leadership. This approach to leadership moves away from who the leaders are, as was emphasized in the personality traits or skills-based approach, to what the leader does and under what situations and working conditions. This change in emphasis led to the theorizing of different styles of leadership, based on the given working situation and employee needs. These could range from directing to delegating, and the corresponding leadership styles involved could be transactional, transformational, or laissez-faire (Zareen, Razzaq, & Mujtaba, (2015).

The ethical leadership genres. The personality traits or skills-based approaches tend to view leadership in isolation. For instance, although the personality traits-based approach to leadership focuses on what leaders are, the skills and competencies perspective includes the expertise that they develop. Similarly, the situational approach is restricted to what leaders do. The ethical leadership school of thought combines all these facets to present a holistic view on leadership, as the traits, skills, and situational behavior are all taken into account in this paradigm.

The ethical leadership approach places a priority on the personal values of the leader such as honesty, integrity, moral development, altruism, and a sense of purpose (Crews, 2015). All individuals, including leaders and followers, develop their sense of propriety and integrity throughout their lives; hence, for a group of employees to hold a leader in high esteem, the leader should be a role model for these traits. The leaders should also be judged on how they behave in any given work situation, or in the face of external influence. Such behavior demonstrated by the leader should be ethical, both from a moral standpoint, as well as in compliance with rules and regulations laid down by the government, industry regulatory bodies, and the firm itself. There are three defined types of ethical leadership: authentic, spiritual, and servant leadership (Hunt, 2017).

The servant leadership theory. Coined by Greenleaf in 1970, servant leadership is not just a management technique but a way of life, which begins with the natural feeling of always wanting to serve others first (Russell, 2016). The emphasis of servant leadership is to move from the conventional approach where staff and employees are treated as commoditized suppliers of labor in exchange for wages earned to contributors

to organizational success and intellectual assets of the firm. The servant leader's priority is on the wellbeing of his or her staff and followers, rather than putting self-interest or parochial interests of the organization above those of the employees. Selladurai (2014) highlighted

> Leaders who act as stewards of organizational resources and who see their primary objectives as serving others and developing their followers are typically referred to as servant leaders, and the related influence process is called Servant Leadership. (p. 1)

***Fostering trust among followers while stewarding organizational resources*.** The hierarchical setup within the organization provides leaders with positions of authority, thereby granting them the legitimacy to influence the opinions and actions of their followers. However, it is up to the leader to build trust among employees to ensure that the leader commands their respect and loyalty (instead of demanding it). Such trust creates the process of mutual influence, where the leader prioritizes employees' interests while the employees trust the leader to stand by them across all situations.

The leader must also balance the above relational approach with taking responsibility for the stewardship of organizational resources (Chen, Zhu, & Zhou, 2015). If the leader observes wasteful behavior among employees, such as squandering or misusing the firm's resources thereby causing harm to the firm as well as employees, it is up to the leader to take corrective action. This dual role characterized by the desire to serve and the motivation to lead constitutes servant leadership.

According to the servant leadership theory, organizations exist to create a positive impact on their employees and the surrounding community. The first stakeholder group

whose interests are of paramount importance to the servant leader are the employees with whom he or she shares a relationship of trust (Coggins & Bocarnea, 2015). The servant leader ensures that the concepts of social injustice and improved equality are reinforced by adopting an inclusive approach that ensures even the most marginalized or numerically underrepresented employee social groups have equal rights and privileges. The other stakeholders are the consumers of the firm's products or services. Servant leaders exhibit higher levels of employee empowerment (Newman, Schwarz, Cooper, & Sendjaya, 2017), which motivates the followers to exhibit the same service ethos that is promoted by the leader. The above phenomena augment service levels offered by the leader as well as his or her followers, thereby building a long-term sense of goodwill both for the leader as well as the firm. Finally, the servant leader is an advocate of social responsibility, thereby building an entire employee pool that serves as moral agents in society (Agard, 2016).

There is overlap between the customer service approach adopted by servant leaders and the levels of patient services that the healthcare industry mandates. The process of prioritizing patient values and also promoting the servant leadership culture among employees makes a servant leader an ideal fit for the healthcare industry. As has been corroborated by Coetzer, Bussin and Geldenhuys (2017), this empathy and service orientation would also align the providers' and consumers' views on what constitutes excellent customer service, thereby maximizing the vision of customer service translating to better patient satisfaction.

Figure 1 below provides a pictorial depiction of tenets of servant leadership, and is followed by a critical analysis of each:

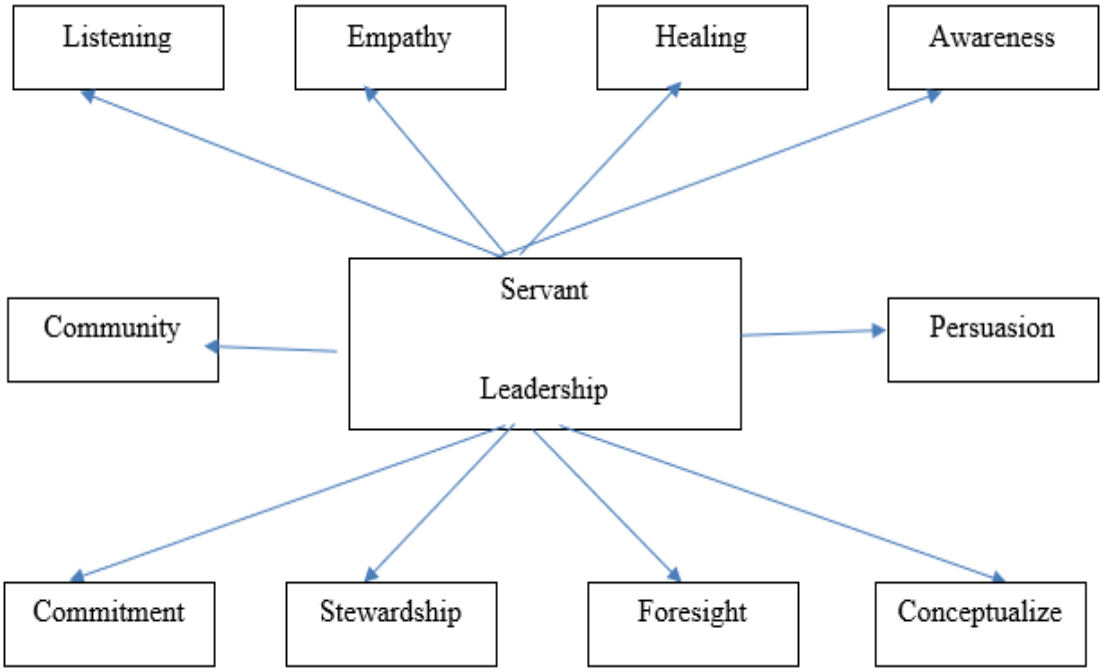

Figure 1. Servant leadership spider diagram.

Beginning from the top left and moving clockwise, the first tenet of servant leadership is the ability to listen. Although leaders are typically acclaimed for their oratory skills, the skill of listening is highly developed among servant leaders. This skill is employed by listening carefully to concerns and opinions of followers and reinforcing the will to excel in their work. In the context of the healthcare industry, the benefits of listening would also extend to leader and staff interactions with patients, as they would be better placed to uncover the unstated healthcare wants and needs of their patients (Tischier, Giambatista, McKeage, & McCormick, 2016).

The next attribute is that of exercising empathy towards a person's followers and other stakeholders. Empathy is achieved by identifying with followers and promoting a sense of belonging within the organization. In the case of the healthcare industry, countries and governments tend to get mired in target-oriented approaches to healthcare, such as minimizing waiting times at clinics and institutions or measuring numbers of patients served. In the midst of these quantitative measures, the qualitative aspects of service tend to be overlooked, which could cause patient grievance should they conclude that they are being treated as mere numbers and not actual human beings. Empathy, when extended to these consumers of healthcare service, tends to humanize the moments of truth when the patient accesses the service, and it results in generating higher levels of patient satisfaction.

Healing is a process by which the leader extends emotional support to employees who are undergoing some form of distress in their personal or professional lives. By standing with these employees during their time of emotional weakness, the servant leader enables them to recover from their problems and do their best at work (Jit, Sharma, & Kawatra, 2017). Healing is also linked to the overarching objectives of healthcare–to heal the patients treated by these institutions. By complementing medical treatment to these patients with emotional support and motivation, servant leaders and their followers could motivate their patients to improve health and wellbeing. Awareness among servant leaders is key for them to appreciate the nuances of morals, values, norms, and rules and also perceive any potential conflicts as part of regular work interactions with followers or service consumers.

The servant leader must be self-aware, knowing personal strengths and limitations and those of each follower, the role of the leader within the organization, and how this role contributes to organizational goals (Panaccio, Henderson, Liden, Wayne, & Cao, 2015). This personal awareness must also be accompanied by an awareness of the institution itself and the environment within which it operates. In healthcare, the higher the degree of awareness among servant leaders, the better they can serve their patients by addressing complex service requirements. According to Winston and Fields (2015), servant leaders also treat their followers as mature individuals, who when faced with misgivings about any existing or new organizational policy, need to be reasoned with rather than dealt with oppressively or authoritatively. I stopped reviewing here due to time constraints. Please go through the rest of your chapter and look for the patterns I pointed out to you. I will now look at Chapter 3.

Through the earlier mentioned tenet of *listening*, the leader first hears the concerns or discomfort the follower might be experiencing and then alleviate these concerns through persuasive, logical arguments and anecdotal evidence to corroborate the follower's viewpoint. Patients who come into healthcare can often be experiencing emotional difficulties which can be demonstrated by obstinacy or shirking prescribed medical precautions, prescriptions, or diet regimens. Patience and gentle persuasion could go a long way in improving patient appreciation for the benefits of working towards improved health... This improvement in customer or patient motivation is a compelling case for use of the Servant Leadership model to improve customer service and patient satisfaction.

For the next two facets of servant leaders, namely *conceptualization* and *foresight*, the cognitive abilities of leaders including a big-picture approach, problem-solving and intuition based on prior experiences are emphasized (Spears & Lawrence,2016). These twin attributes go a long way in facilitating the leader shielding the followers from extraneous influences and policy changes within the institution to the best extent possible. These attributes can also be extended to administering services to patients by servant leaders and their staff. This application of services would especially be most beneficial where patients with life-threatening ailments are being treated, and servant leaders and their followers can share and use empirical information from their prior experiences to safeguard such patients. The concept of *stewardship* can be viewed as the larger objective of serving the needs of others and investing in those served, be they employees following the leader, or customers receiving services. This concept provides an ideal focus for the healthcare industry, where patients often need to be protected from high costs and, through stewardship, can be provided genuine care and attention.

Commitment to the growth of people is a cause most championed by servant leaders by ensuring that their followers develop a sense of self-worth. Allen et al (2016) observed that servant leaders facilitate their followers by ensuring absolute best practices into service delivery activities, thereby bettering the prospects of achieving personal and organizational goals. This is a departure from conventional leadership approaches, which were more task-based, and motivation among employees was under-explored. This commitment to growth also includes encouraging followers to emulate the best practices

of their leader, thus contributing to the next tenet, namely that of building small communities of potential servant leaders for the future (Van Winkle, Allen, De Vore, & Winston, 2014).

In the healthcare industry, the commitment to growth and building of servant leader communities ensures that even when one servant leader moves on and out of the institution, the patient experience does not decline. Instead, the outgoing servant leader is replaced by one of his followers, who has internalized the concepts and practices of servant leadership by working closely with the outgoing leader. This collaboration has the effect of eliminating person-dependent subjectivity from the quality of customer service and ensuring positive patient experience as a whole.

Comparison of Servant Leadership to other Documented Types of Leadership.

As mentioned in previous subsections of this literature review, the conventional views of leadership progressed from an inside-out perspective, namely the leaders' inherent traits and attributes, or skills and competencies developed over a period, to the outside-in viewpoint, based on leader situational behavior. Based on the situational leadership school of thought, three types of leadership were identified; transactional, transformational and laissez-faire (Zareen et al., 2015). This subsection compares these leadership approaches to servant leadership, outlining applicable key benefits and drawbacks.

Transactional Leadership versus Servant Leadership – a Comparison

Transactional leadership is a form of leadership that motivates followers by exchanging rewards for high performance and reprimanding subordinates for substandard

levels of performance (Bertocci 2015). In the conventional school of thought, this was also termed as Management by Exception (Birasnav, 2014). This simplistic view of leadership emphasizes overall business objectives, determines individual tasks that need to be accomplished to achieve these objectives, and then frames rewards for performance towards achievement of these tasks (Fröber, & Dreisbach, 2014). The leader thereafter guides his followers on how to achieve the rewards by using elementary path-goal concepts in the process. The path-goal concepts involve putting the leader's behavior into perspective which motivates the followers to accomplish the required task. (Zareen et al., 2015).

The transactional leadership model is predominantly task-oriented (McCleskey, 2014), and emphasizes understanding of task requirements, procedures, and internal organizational processes, culminating in the completion of predetermined tasks. This model of leadership is hierarchical and hence can be advantageous in certain limited work situations as policy decisions can be unilaterally communicated in a top-down fashion, thereby minimizing conflict. However, transactional leadership tends to have a negative effect on morale and motivation levels among followers, as explained by MacGregor's X-Y theory (McGrath & Bates, 2017). MacGregor's theory explains the two fundamental approaches to managing followers which is called the X-Y theory. The success of this model depends largely on the leader's attitude and trust in staff. The Theory X leaders are those that tend to consider their staff as commoditized, homogeneous, and mechanical entities, who may not be highly trusted or respected. This approach to leadership contends that employees are essentially unable and unwilling to

execute responsibilities that are assigned to them, unless they are offered a reward to do so, and presented with negative consequences for unsatisfactory work. As a result, such leaders adopt a fundamentally distrusting approach towards their employees, which results in low self-respect, morale, and motivation among staff. This approach in turn negatively impacts overall organizational progress.

Servant leadership, in stark contrast, focuses mainly on the leader serving employees and helping them develop a sense of self-worth and self-belief, which in turn motivates improved performance in the workplace (Parolini, 2012). While rewards for work well executed may still be present in servant leadership, employees often tend to value appreciation and self-esteem in the workplace either at the same level or even more than tangible rewards. When mapped back to Maslow's hierarchy of needs, the followers who work under a Servant Leader can be viewed as having transcended the three base levels of physiological, safety and belongingness needs, and find themselves at self-esteem or self-actualization levels (McLellan, 2017). By emphasizing the rewards as the main driver for work completion, the transactional leadership approach tends to degrade employees and assume they are still at one of the base levels of motivation in the workplace.

In the healthcare space, many professionals entering the field do so not only to address the need to make a livelihood but also out of altruistic, well-intentioned motives of public service. For these employees, transactional leadership would be ineffective. This misappropriation of leadership style can be compared directly to professionals working in

non-profit organizations, where servant leadership is the most effective approach to leadership compared to the transactional form of leadership (Agard, 2016).

To summarize, transactional leadership upholds the concept of contingent rewards, management by exception, and downplays the need to motivate employees through non-tangible means by building trust and effective working relationships (Doucet et al, 2015). Servant Leadership, on the other hand, prioritizes workplace relationships, especially between the leader and followers, and views motivation, self-worth, and self-belief among followers to be of paramount importance. Transactional leadership would prove to be of limited utility within healthcare institutions since the success of this particular service industry is measured by intangible aspects of patient well-being. Healthcare leadership requires providers to internalize intangible measures within their work environment and leadership styles.

Transformational Leadership versus Servant Leadership – a Comparison

Transformational Leadership represents a novel approach to leadership compared to transactional leadership, where the emphasis is not on the 'what' or task-oriented approaches, but rather, the focus is on the 'how' or is process oriented. Transformational leadership encompasses a set of ground rules that leaders typically pursue when working on transforming their workplace, department or organization, or when working in transforming contexts. Instead of focusing on individual outcomes, this leadership style takes a holistic view of transforming how the leader gets organizational goals achieved in partnership with his followers. (Avolio et al, 2004)

Transformational leadership constitutes four 'I's when practiced within an organization.

- Idealized Influence, which translates to leaders *doing the right things* as against cutting corners to save time or costs, to build trust among followers (Mumford & Hemlin, 2017). It also promotes transparency in communication between the leader and followers.
- Intellectual Stimulation, exhorting followers to come up with innovative solutions to workplace problem statements and question conventional approaches to carrying out any work task or activity, as explained by Champoux (2016).
- Individualized Consideration, encouraging the followers to grow and work closely in partnership with the leader, who acts as a mentor and facilitator for his followers (Joyce, 2016).
- Inspirational Motivation, whereby the leader leads by example and establishes himself as a role model, inspiring appropriate behaviors among his followers, beyond their own expectations and responsibilities (Stone et al, 2004)

Table 1 below outlines the differences between transformational leadership and servant leadership.

Table 1

Difference between Transformational and Servant Leadership (Agard, 2016)

	Servant Leadership	*Transformational Leadership*
Nature of theory	Normative	Normative
Role of leader	To serve followers	To inspire followers to pursue organizational goals
Role of follower	To become wiser, freer, and more autonomous	To pursue organizational goals
Moral component	Explicit	Unspecified
Outcomes expected	Follower satisfaction, development, and commitment to service and societal betterment	Goal congruence; increased effort, satisfaction, and productivity; organizational gain
Individual level	Desire to serve	Desire to lead
Interpersonal level	Leader serves followers	Leader inspires followers
Group level	Leader serves group to meet member needs	Leader unites group to pursue group goals
Organizational level	Leader prepares organization to serve community	Leader inspires followers to pursue organizational goals
Societal level	Leader leaves a positive legacy for the betterment of society	Leader inspires society to pursue articulated goals

As has been outlined in detail earlier in this chapter, the servant leader is a servant first. Hence the leader's primary role is to serve followers. In comparison, the transformational leader views his primary role as that of inspiring followers to pursue organizational goals. From the followers' viewpoint, their role under transformational leadership is to pursue organizational goals as part of their work, while servant leadership views the role of the followers as one of becoming autonomous and independent so that they can mimic the leader and deliver their services with minimal direction from the leader. Regarding outcomes and morality, transformational leadership has multiple

benefits as it strives for goal congruence and productivity, thus benefiting the organization.

At the same time, Sumi & Mesner-Andolsek (2016) also pointed out that transformational leadership could also degenerate into unethical territory, potentially due to the leader indulging megalomania and getting overzealous due to strong backing from his followers. On the other hand, servant leadership is a genre of ethical leadership where morality is a key component. Expected outcomes from this model constitute follower satisfaction and development, which is in keeping with the perceived role of the servant leader.

While adopting the transformational style of leadership within a healthcare institution would certainly prove much more effective than the transactional approach, it would still be less effective compared to servant leadership. This improved effectiveness is because the transformational leader prioritizes the organizational goals (Anderson, 2017), while seeking to lead through participative management and partnering, while the servant leader serves the group and prioritizes followers' objectives. Selfless service advocated by servant leadership is more in keeping with the fundamental ethos of the way healthcare institutions aspire to deliver services to their patients, making it a better fit as a leadership style for these institutions.

Laissez-faire Leadership versus Servant Leadership – a Comparison

The laissez-faire approach to leadership is potentially the most diametrically opposite to servant leadership. In this approach, the endeavor is for the leader to take on minimal responsibilities for the actions and assignments of his followers and assume that work

will get done. Intervention is minimal, and often only when it is too late, and work standards have steeply dropped (Muenjohn & McMurray, 2017). This is in obvious contrast to servant leadership, where the leader not only assumes responsibility for his followers and for the stewardship of organizational resources, but actually views his primary role as one in service to followers.

While the laissez-faire approach to leadership may sound archaic and ineffective, there is evidence of such a form of leadership for applications, to post-modern organizations such as collaborative firms (Wikipedia, Linux, etc.). These are firms that work based on peer reviews, and while there might be a leader or a chief sponsor for such collaborative firms, they assume a highly passive role in everyday proceedings and activities, subordinating their control to peer reviews and corrective actions. However, in the healthcare industry, where the service provided is highly attendant-intensive, and the stakes are significantly higher involving patient health and wellbeing, such an approach would be ill-advised. This argument again makes a strong case for a preference for the servant leadership school of thought at these healthcare institutions. Specific benefits that accrue as a result of servant leadership compared to laissez-faire leadership across a wide range of both subjective and objective outcomes include higher levels of motivation, job satisfaction, and performance among followers, reduced stress, turnover and burnout amongst staff, more collaborative, innovative and harmonious teams, and higher morale and productivity overall within the firm (Farrington & Lillah, 2018).

Prior Research Studies on Servant Leadership and the Healthcare Industry

Sun (2013) focused on the identity of servant leaders, recognizing identity as one's sense of self and how it influences the way a leader cognitively processes socially relevant information, and how servant leaders exercise leadership behaviors in response to a situation. The author further identifies servant leaders as those who are concerned with the needs of their followers and possess the desire to be socially identified as someone who comes from a position of service (Sun 2013). The author, therefore, concluded leaders with servant identity could consciously refer to a set of servant attributes like calling, humility, and empathy, when the situation requires servant behavior (Sun, 2013).

In another study within the field of healthcare, nurse behavior, and patient satisfaction, Neubert et al. (2016) demonstrated that servant leadership is directly related to nursing helping and creative behaviors to improve patient satisfaction through improved nurse job satisfaction. Nurse job satisfaction predominantly stems from servant leaders putting employee interests ahead of other considerations and promoting their well-being and growth. Neubert et al. examined the extent of the associations between servant leadership and stakeholder outcomes within units of a multi-facility regional hospital system. They found evidence indicating that servant leadership is associated with engaging employees, stimulating collaboration and creativity, as well as a range of positive outcomes for organizations and their members (Neubert et al., 2016).

Apart from the above studies, a relative paucity has been observed for research studies on the employment of the servant leadership approach, and its implications on

customer services levels and patient satisfaction, specifically in the healthcare sector. This lack of research demonstrates the gap that this research project seeks to address.

Traits, Skills and Behaviors Demonstrated by True Servant Leaders

Based on the above subsections of the literature review, a focused and definitive set of characteristics, including personality traits, skills, and behavioral responses of true servant leaders can be compiled. This compilation represents the amalgamation of the inside-out and the outside-in views as elaborated earlier. These seven facets that allow leaders to best serve followers and encourage them to be autonomous and contribute their best to the organizational goals are summarized here.

Communication skills. Servant Leaders are required to excel in their ability to communicate. However, unlike the transactional leadership approach where communication is mainly top-down in direction, servant leadership views communication as bidirectional with more emphasis on the leader listening to his followers and their inputs, problem statements and grievances. In the context of a healthcare institution, this also assumes significance when the servant leader and his followers are dealing with their patients and providing healthcare services to them. This particular aspect of servant leadership maps back directly to the research question RQ3 as was set out in Chapter 1 under research aims and objectives.

Problem-solving and decision-making skills. Customer service levels at healthcare firms can often be augmented if leaders exhibit the abilities to take a holistic view of problems that they encounter as they go about servicing their patients at the institution. Information gathering, and analytical abilities need to be adequately

complemented by innovative solutions as part of the decision-making process. It becomes important here to take into account, the diverse perspectives across all stakeholders, and draw a balance in an attempt to arrive at a win-win solution for all, especially bearing in mind, that the followers' or the employees' interests are not compromised unfairly. Given the direct linkage of this dimension of servant leadership to improved customer service, this establishes the significance of the research question RQ1 in Chapter 1.

Flexibility and the ability to deal with complexity. The ideal servant leader is one that can exercise extreme amounts of adaptability in his endeavor to serve others, his followers, customers and the society at large. He would also be able to maintain his poise and deal with non-standard situations, serving his followers and leading by example on how to deal with complexity. This is especially useful in the healthcare industry, where the very nature of the work undertaken by healthcare professionals including the leader and the followers is highly non-routine in nature. By equipping oneself and one's followers with the flexibility and ability to handle complexities, the servant leader could consistently deliver high-quality service to patients at the institution. This highlights the need to explore the research question RQ2 on the link between the application of servant leadership and the relationship between quality of care and patient's satisfaction.

Cultural awareness. One of the complexities mentioned in the previous point that servant leaders have to deal with is interaction with colleagues, followers and consumers from multiple cultural backgrounds. In their endeavor to serve their employees as their primary role, servant leaders also need to be aware of cultural diversities according to Ledlow (2017), especially in the contemporary context, where

globalization has led to the rise in immigration and deportation of staff overseas. This requires an up-to-date appreciation of value systems, norms and beliefs of their followers from different cultures to ensure these sensitivities are not ignored. This appreciation demonstrated by leaders goes a long way in building trust among followers as well.

In the healthcare space, this is even more pivotal to the role of the healthcare professional, since patients could also be multicultural. Some of them might need to be mollycoddled as part of their treatment based on their cultural background, while others, especially the Western patients might be highly individualistic, and hence fiercely independent, and not wanting to be viewed as weak. Since cultural diversity is also another form of complexity faced by servant leaders and handling these diversities ensures ongoing high quality of service.

Leading, motivating and influencing others. As mentioned previously in this chapter, the servant leader performs the dual function of serving his followers as well as leading them. To work towards building a truly autonomous and self-dependent team of employees, the servant leader is required to lead his followers, motivate them to constantly give their best at the workplace (Dierendonck & Patterson, 2018), thereby building an interaction mechanism that fosters mutual influence. This could be done through a combination of formally structured training programs run or organized by leaders for his followers, and informal interactions with them.

Managing emotions and conflicts. This represents the softer dimension of servant leadership and underlines the need for the servant leader to appreciate diverse viewpoints put across by his followers and working to redress these potential conflicts using persuasive skills as opposed to authority (Davis, 2017). It is a constant challenge faced by organizations since an employee working under duress due to emotional conflicts, would be less motivated, and may result in a decrease in quality of customer service. This is even more pronounced in the healthcare space, where service providers work very closely with service consumers or patients. Over a period of time, patients tend to become comfortable with certain service providers, and if these employees were to leave the firm due to emotional detachment, perceived customer service would drop. This again maps back to research question RQ1 in Chapter 1 of this dissertation report.

Technical skills. Leaders are required to train themselves across multiple disciplines and functions, to ensure that they themselves are equipped with adequate expertise in administering service to their consumers (Blanchard & Broadwell, 2018). This would ensure that they are in a position to present themselves as role models, whom their followers would be keen to emulate, thereby building a team or a community of experts at the organization. The criticality of this is magnified in healthcare, since patient wellbeing and safety is often influenced positively or otherwise, by actions taken and decisions made by healthcare providers.

The subsections thus far have dealt with introducing and delving in detail into the explicit dimensions and nuanced aspects of servant leadership. The above discussion also established how use of this approach to leadership has a salient influence on the service

levels accorded to patients at healthcare institutions by the servant leader and his followers. The next subsection assesses how these institutions, their servant leaders and followers can ensure that these improved customer service quality levels are acknowledged by consumers (patients) and translate to patient satisfaction.

Upcoming Trends in Servant Leadership

Effective servant leadership encompassing the above inherent leader attributes and skill sets would ultimately lead followers of the leader to scale up performance beyond expectations. The importance of these results would especially be true during contemporary times, characterized by deregulation, globalization, restructuring, and escalating competitive pressures. In the face of these challenges, the ability of the servant leader to work tirelessly to serve followers and inspire them towards autonomy to improve their self-reliance, would be key to long-term sustenance and growth of healthcare institutions.

To summarize, servant leaders are instrumental in imparting clarity to high service standards that the institution would like to set for its patients. Clarity of direction, adopting a holistic view of any given problem and situation will inspire novel solutions, and drawing a balance between serving followers, leading and stewardship from the front.

Literature Review – Key Dependent Variables Addressed in the Study

The main dependent variable outlined here is patient satisfaction as experienced by the patient because of applying the mediating variable, which is the servant leadership approach.

Quality – Definition and Detailed Description

At the outset, it becomes important to define what the term quality essentially mean. According to Lewis (2015), quality is a state in which value entitlement is realized for the customer and provider in every aspect of the business relationship. One of the main implications of this definition is that quality is a way of forging a relationship between the provider and the consumer of the product or service in question. Further, this relationship needs to stand for value to the consumer (the terms customer and consumer are used interchangeably here) to establish quality, thereby representing a positive user experience. Transposed to the context of healthcare institutions, the above conceptualization of quality establishes patient experience as the center stage when it comes to delivery of quality service by healthcare professionals. This is in line with the primary research goals outlined in Chapter 1, which exhorts that patient satisfaction should be viewed as the litmus test to assess servant leadership and its effect on quality of service delivery.

Distinguishing factors of services and their quality. This section describes in detail the factors that make the quality of services in general, and healthcare services in particular, even more critical than that of tangible products by outlining the differences between services and products. It also provides an anchor for further discussions in this chapter on patient satisfaction, and the proposed research approach that will be outlined in the next chapter.

Services are intangible.

Services, as compared with products essentially represent an abstract undertaking from the provider that certain tasks and processes will be executed by the provider to the satisfaction of the person consuming these services. This undertaking will thus represent value to the customer for the price paid for these services. This is unlike a product that can be experienced in a more tangible way (Desselle, Zgarrick & Alston, 2016). Specific to healthcare services, the above statement emphasizes the fact that the delivery of services needs to be to the satisfaction of the consumer or the patient receiving these services. This goes a long way in underlining the relevance and criticality of patient satisfaction, as defined in the aims and objectives of this research study.

Further, the patients who are to receive treatment or healthcare at an institution would have no way of comparing one institution against another. This is the reason why most patients and their families, when deciding upon a healthcare institution rely predominantly on word-of-mouth recommendations, rather than any other form of promotion undertaken by these healthcare outfits. Since such word-of-mouth publicity would mainly have to originate from other patients who have undergone treatment or received care at the institution in question, it is imperative that their own experiences are registered as positive for them to recommend the institution in the first place (Pheng & Rui, 2016). This concept again makes a strong case for the effectiveness of service quality as best represented by satisfaction levels experienced by the patient.

While not directly related in the case of non-profit healthcare firms, it should be emphasized that for private healthcare institutions to price their services is much trickier than for product companies. This is because product firms can adopt a cost-plus pricing

strategy based on their raw material costs, but such an approach cannot be used for services where raw materials or manufacturing activities are non-existent.

Due to this intangibility, patients would find it hard to express what exactly they expect from healthcare institutions upfront. Patient satisfaction would, on the other hand, be better assessed after consuming the services with comments on how their experience measured up to how they had visualized being treated by the healthcare firm. This also means that patient satisfaction can only be measured in absolute terms and is not as easily measurable relative to their expectations before service by the healthcare institution. This lack of tangibility also leads to a relative inability to measure customer expectations and experience with services (Elms, Hassani & Low, 2017). As an illustration, bed or dorm occupancy might present a tangible measure for the commercial performance of a clinic or a healthcare firm, but the quality of services cannot be represented in such a metric.

Services are produced and consumed simultaneously. There is, in most cases, a delay from the point where a product is manufactured and packaged to the point when it is consumed by the end-user. This is not the case in services, which tend to always be produced and consumed at the same time, a critical facet of services (Dahlgaard-Park,2015). Whether it is a flight booked, a hotel stays, or a massage parlor appointment, services are produced and consumed simultaneously. For the healthcare institution, the service commences when the patient or his relatives or friends call in to book their first appointment and lasts until the patient is discharged from care. Every experience from dealing with the nurse for regular checks, to the attendant working to address ancillary

needs of the patient, form part of the service rendering by the institution and use experience by the patient.

Products also have adequate preparation time to design and create the product as close as possible to what would generate a better-quality use experience for the consumer, while this window is not available for services. For healthcare services especially, this is even more critical. This is because patients dealing with severe illnesses could already be emotionally drained, and as such, any negative experience with healthcare could be multiplied in their perception. Moreover, while product batches found to be deficient in quality can be recalled, a service once provided to a patient cannot be recalled remaining in the experience of the patient to either benefit or hurt the impression of the healthcare firm in question (Lai & Cheng, 2016).

This experience also places a premium on the "moments of truth" as elaborated earlier when a representative of the care institution interacts with the patient (Ross, 2017). These interactions, if negative, could result in a poor patient experience. This is where the altruistic nature of the servant leader is pivotal to transform these interactions into an opportunity to improve customer service quality. By setting sound examples in how stellar quality service can be accorded to the patients in the humane manner that comes naturally to servant leaders, they not only influence patient satisfaction positively but also serves their followers as they serve the patients more effectively.

Delivery of services is provider-dependent. This follows the above point highlighting the significance of the moments of truth interactions between service provider and consumer (Kapoor, Paul & Halder, 2017). Since human beings are

fundamentally a heterogeneous set of individuals, none of them completely similar to another, their individual interpretation of what constitutes good quality service also varies. This variation is further exacerbated by the cultural diversity present among employees of a healthcare institution, as well as among patients coming in for care. To instill consistency in services provided by these individuals would be next to impossible, thereby subjecting the quality of services and patient satisfaction to major extraneous influences. Further, since the patient would use his or her own experience as a benchmark for evaluating the quality of healthcare, not only would such inconsistency affect patient satisfaction, but also the negativity or positivity of the word-of-mouth publicity it receives (Nee, 2016). The qualities identified in the quintessential servant leader in the previous subsection of this literature review could help address this inconsistency to a great extent, by ensuring that the servant leader leads by example and adopts processes and practices in interactions with patients that are emulated by followers.

However, it is also important here to acknowledge that consistency alone does not translate to quality or patient satisfaction (Osaro & Charles, 2012). If the servant leader is found lacking in appreciation of cultural diversity or lack of basic technical knowledge or analytical skills in dealing with complex situations, then the leader could be setting the wrong examples for followers to internalize. This confusion would result in the healthcare firm providing consistently poor quality services, which in turn would negatively affect patient satisfaction. Here is where the personality traits and skills identified in the previous section assume significance since these include technical skills, cultural awareness, ability to deal with complexity, and problem-solving skills (Mumford

et al, 2000). These traits would ensure that consistency in service delivery is accompanied by an underlying ethos of continuous improvement, to deliver patient satisfaction through stellar quality service.

Service Delivery – The Chasm Between Provider and Patient Perspectives

The literature review thus far has corroborated patient satisfaction to be the most significant factor in assessing the quality of services being provided by healthcare service providers. However, most service providers tend to look inward to measure their own service standards, typically through measurement against key performance indicators, or internal standards that have been set within the institution as demonstrative of high-quality service. As has been previously explained, this does not always necessarily coincide with how the patient views the quality of healthcare services provided (Martelo-Landroguez et al., 2015). This subsection defines service quality as well as its components, as related to the patient's perspective regarding the extent to which high-level satisfaction has been achieved. This perspective will then be juxtaposed against service quality from the viewpoint of healthcare providers to identify areas of alignment and other areas where significant gaps exist between these two perspectives.

Patient perspective on behavior and intention.

The structural relationship between service quality and patients' satisfaction is being examined here. The focus will be specifically on service quality and how patients value the care provided to them.

At the outset, the first point when a prospective patient seeks help from a healthcare center is where one can start assessing the patient behavioral processes and

intentions. While this is before the actual rendering of care services, the outward or customer-centric viewpoint should alert those attending to telephone inquiries that even their preliminary interactions with prospective patients constitute the “moments of truth” mentioned earlier in this chapter. These telephone attendants should hence demonstrate empathy and understanding towards patients during their conversation. Further, once a new patient has confirmed the need for services, the head nurse or those responsible for the onboarding process should conduct an orientation and endeavor to put all patient concerns to rest about the duration for dealing with the healthcare center. This window of opportunity should also be used by a servant leader or followers to assess the influence of illness or injury and the behavior and motivation levels of the patient. They should assess such areas as adherence and commitment to follow prescriptions, precautions and dietary recommendations, and the drive and inclination to recover from his or her illness.

In extreme cases, the patient concerned might also have been through bouts of depression as a direct or indirect result of the illness or injury. The dimensions of service quality here should expand to consider these developments and align the care provider’s one-to-one interactions with the patient, to minimize the prospect of upsetting the patient (Foley, 2018). This especially becomes germane where the patient is suffering from a terminal condition, and the treatment and care being provided by the institution is primarily palliative in nature.

Patient Perspective of Service Quality and Satisfaction

This relates to the different dimensions of how patients perceive the quality of healthcare accorded by the institution. To reiterate, one would expect the patient’s

perceptions to differ from those of the healthcare providers. For most patients, especially the elderly suffering from illnesses or who are more prone to injuries, the emotional low that they experience could be as severe as the medical condition itself (Tierney, 2017). This could be because they experience loneliness with nobody to turn to for a conversation including family and close friends. Since providers at the healthcare firm are the only potential conversationalists, these patients may look forward, in most cases, to these interactions. This need for contact needs to be borne in mind, and quality caring needs to incorporate giving, understanding, and listening. However, at the same time, should the patients exhibit withdrawn behaviors, the best approach could be to gradually draw the patients out of their shell, instead of trying to burden them with unnecessary banter.

Another aspect of patient perspective is patient safety, especially for residential in-patients, for whom the healthcare center functions as a place of residence while they are undergoing treatment and care. Here again, the patient's perspective may emphasize feeling safe and secure in the new residential environment (Vaughan, 2013). Accordingly, the healthcare providers would be required to take even the most trivial or seemingly silly concern expressed by the patient with utmost seriousness. Degrading a patient because of seemingly insignificant issues would have the effect of making them reticent in their treatment, which would affect their ability to improve their health and their emotional equanimity (Nelson et al, 2015).

Finally, according to Giovanis & Pierrakos (2015), health education is also critical to patients, especially those who display a conscious enthusiasm for improving health. For

these individuals, the more information they receive on a regular basis, the more they are driven towards recovering from their illnesses. This motivation is because they come to view the care center attendants as partners in their recovery process and count the involvement of healthcare staff as a positive influence on their own inclination to recover (Giovanis and Pierrakos, 2015).

On the other hand, for the patients who are not as motivated to improve their health, the healthcare staff could ensure that they provide positive information on a periodic basis, to try and elicit cooperation in taking their treatment seriously and working actively towards full recovery. In either of these scenarios, regular feedback and educating the patient about their health status and future steps towards complete recovery are viewed as contributors to patient satisfaction from his or her perspective (Giovanis and Pierrakos, 2015).

Patient Satisfaction in a Hospital Setting

Patient satisfaction in a hospital setting as a process is even more involved, as compared to satisfaction of outpatients. Here, the moments of truth simply multiply because of the extended 24-hour stay of the patient throughout the duration of treatment, as emphasized by Al-Neyadi, Abdallah and Malik (2018). The healthcare firm having as much information about the patient as possible and acting on this information would contribute significantly to patient satisfaction. For instance, important information to obtain includes the patient's daily routine, their dietary preferences, their favored visit timings, to their favorite flowers for their room. An understanding of these patient

preferences could be used to generate customer delight among patients, thus enhancing patient satisfaction (Al-Neyadi, Abdallah & Malik 2018).

The Service Provider Perspectives on Patient Satisfaction – Behaviors and Intentions

In the conventional approach to healthcare, these institutions often take on a more inward-looking way of working as they go about providing healthcare services to their patients. As a result, while these personnel were often well-intentioned, the behavior would be more process-oriented and target-oriented rather than patient-centric. By focusing more on internal processes and achieving targets in terms of hospital bed occupancy, the number of patients consulted per month and revenues (especially for private healthcare clinics), the focus on the patients would at best be diffused. This has been documented as a threat to achieving customer (patient) satisfaction, as the career's job is often straitjacketed into a set of duties that they must perform, thereby losing the empathy and cohesiveness with the patient, which is the cornerstone of patient satisfaction (Ali, 2018). The spirit of inclusivity is lost in conventional methods of healthcare delivery, which in turn exacerbates the patient's emotional uneasiness and feeling of loneliness (Ali,2018).

Providers Perceptions of Patient-Centered Care

The previous subsection highlighted the pitfalls of the use of traditional measures of care, which were more inward-looking and considered the patient as an entity external to the whole patient-provider process. According to Grisaffe et al (2016), the contemporary servant leadership driven school of thought makes the treatment process

more outward looking and patient-centric. In effect, it views all the activities performed by the servant leader and followers as something that entirely involves the patient. This automatically enables the staff at the healthcare center to weed out any unnecessary bureaucracy and red tape in its internal processes that do not result directly or indirectly in some form of benefit to the patients' treatment. By focusing more on outcomes which include how patients feel towards the service care delivery, servant leadership adopts the ethos of continuous improvement (Rake, 2017), which in turn leads to increases in patient satisfaction due to continuously improving quality of service from the healthcare providers (Rake, 2017).

Providers Perceptions of Value- Based Care

This section elaborates further on the way healthcare delivery has been shaped by moving from volume based to value-based care, improving the quality of care systemwide while reducing cost and making healthcare more accessible to patients (Matyseiwicz, 2016). While the traditional approach to healthcare has been to maximize the reach of these institutions, predominantly run by the State, this has since focused less on maximizing the patients that the institution serves and more to rendering highest quality service possible to a limited number of patients. Limiting the number of patients allows for a more empathetic and closer relationship between the care staff and the patient. This, in turn, precipitates an emotional bond with the patient, as he or she feels genuinely cared for, thereby aligning the provider's perspective of quality with that of the patient (Porter, 2009).

The transition from volume-based care to value-based care is one that is in harmony with the concept of servant leadership and the attributes and skills developed by the servant leader and emulated by the followers. This is another argument in favor of deploying servant leadership techniques in healthcare centers as a tool to enhance patient satisfaction and their perceived level of service quality accorded to them by the healthcare staff.

Review of Research on Service Quality and its Relationship to Quality in Healthcare

Previous subsections have discussed research studies conducted in the past on the effect of servant leadership, which forms the predictor variable of this research. Here, the research exercises conducted on service quality and their influence on patient-perceived well-being and patient satisfaction are reviewed.

In their seminal study, Gupta et al (2014) examined the relationship between patient-reported satisfaction and service quality and survival in breast cancer. The study acknowledges the increased importance among service providers of a healthcare institution of the extent to which the quality of their services is perceived favorably by patients. This elevated importance accorded to patient perception of service quality and the ensuing satisfaction levels among patients has resulted in service providers using these parameters to demonstrate both patient focus and differentiation in the health-care community, as well as enhance the patient experience (Gupta et al 2014). Furthermore, providers are also using this information to make important decisions regarding operational and treatment plans. The results of this research reassert how pivotal it is for

providers to adopt the practice of looking outward when they conduct a self-assessment of their service quality.

Similar to increasing awareness among providers of the salience assumed by patient perception of healthcare service levels and patient satisfaction, the consumers are also becoming increasingly cognitive of their rights and privileges when dealing with healthcare service providers. In their research work on the subject, Gupta and Rokade (2016) viewed customer satisfaction as the most significant factor to access information regarding the quality of the services provided by a healthcare provider. As mentioned above, this has become even more pronounced in recent years as patients know their rights in terms of health care services. Patient awareness of patient rights and responsibilities makes the quality of care being provided to them most important. In defining quality, Gupta & Rokade (2016) stated that according to the Institution of Medicine (IOM), the quality of healthcare could be represented by "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (p.84).

The authors highlighted (a) the relationship between quality and healthcare, (b) customer satisfaction as a quality parameter, (c) the models developed by researchers, and (d) quality indicators given by health organizations (Gupta & Rokade, 2016). Since this study further reinforces the customer perceived level of service quality accorded by healthcare providers, it makes an even more compelling case supporting the focus of the proposed study.

Kondasani and Panda (2016), in a separate study sought to establish how customer service quality perception leads to positive behavioral intentions towards service providers. The previous subsection outlined how it is important for servant leaders within healthcare institutions to invoke a positive behavioral response and an optimistic intent among patients to cooperate and recover from their ailment. Kondasani and Panda (2016), used the service quality model (SERVQUAL) to provide insightful perspectives as an instrument to measure perceived service quality and provide pragmatic implications. The findings concluded that any relationship between a service provider and service seeker in healthcare is characterized by positive patient perception and satisfaction, where the provider ensures the humane and empathetic quality of both the facilities and the interactions with support staff. In terms of the practical implications of these findings, healthcare providers would be able to better design and implement measures that would enhance the patient-perceived value of these services. This, in turn, would have a positive effect by inducing patient loyalty to the healthcare firm, and propensity to spread the word through word-of-mouth positive publicity, thereby benefiting the growth of the healthcare firm's operations by retaining existing patients and attracting new ones (Kondasani and Panda, 2016).

The findings from the above study were further corroborated by Tsai et al. (2015) in their study on the delivery of patient-centered care as an important component of a high-quality healthcare system. The authors stated that little is known about the relationship between patient satisfaction with two important aspects of surgical care—efficiency and quality. The authors, therefore, focused on U.S. hospitals that perform major surgical procedures to address their research questions. The authors' primary

predictor was the influence of hospital performance on patient satisfaction as measured by the percentage of patients that would “definitely recommend” a hospital. The findings from this study again go to underline how high-quality services as viewed by the patient through the implementation of patient-centric efficiency measures could benefit healthcare institutions by attracting even more patients through recommendations made by positively inclined patients (Tsai et al., 2015).

Finally, Lonial and Raju (2015) examined the role of perceived characteristics of provided services in the development of overall customer satisfaction (OCS) and customer loyalty (CL) in a healthcare setting. In their study, the authors used a telephone survey to gather data from insurance participants of a major Health Maintenance Organization (HMO) who were currently hospitalized patients. Structural equations modeling (SEM) was used to confirm the overall relationship between perceived service quality (PSQ), overall customer satisfaction (OCS) and customer loyalty (CL). The results of the study by Lonial and Raju (2015) are supportive of the earlier subsections of this literature review, which have underlined the criticality of patient loyalty as a metric for evaluating patient satisfaction.

Reaffirming the Research Questions Based on the Literature Review Findings

Finally, having conducted an elaborate review of available literature on the subject of servant leadership, quality of healthcare services as perceived by the patient, and resultant patient satisfaction levels, this subsection reiterates the research questions set out in Chapter 1 to ratify the relevance and salience of the factors examined.

Research Question #1. Does the servant leadership style of management, as measured by SLQ, positively influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

The first half of this literature review has been dedicated to defining the concept of servant leadership and outlining in detail, the various attributes of the concept, including the positive effect on quality of services extended by healthcare providers to their patients. The logical next step would be to corroborate these findings from secondary data by incorporating the assessment of this relationship through the application of primary research techniques and corresponding analytical tools. This would enable evidentiary support for the hypothesized relationship, or potentially highlight areas of conflict between secondary and primary data collected, thereby enriching the existing knowledge base on the subject.

Research Question #2. Does the servant leadership style of management, as measured by SLQ, influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

The literature review unearthed the questionable premise of service providers internally determining parameters of service quality emphasizing process compliance and task orientation. Since a compelling argument for patient satisfaction and loyalty driven more by how the patient perceives service quality, as opposed to how the provider perceives service quality (Dabholkar, P. A. (2015), it is imperative that this finding is

subjected to further study as part of primary data collection and analysis. This explains the need for the research question to be addressed by this study.

Research Question #3. Does the servant leadership style of management, as measured by SLQ, influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

Typically, services tend to incorporate a much higher degree of involvement between the provider and consumer, as compared to products. This is even more pronounced when the services in question correspond to healthcare services rendered to patients by staff at the institution. Healthcare professionals are required to build a bond with patients as part of providing their services. The first is at a relatively superficial level, which involves regular interactions, checkups, and servicing the ancillary needs of the patient. The second is a deeper emotional bond that the ideal health provider, either the servant leader or one the followers would forge with the patient. Both levels of bonding involve communication; however, the latter requires forging a connection with the patient, which is best accomplished by attentive and empathetic listening on the part of the healthcare professional (Nelson et al 2015). As a result, it becomes necessary that the research study is used to establish exactly what degree of significance is assumed for communication by servant leaders and their followers in invoking patient satisfaction.

Research Question #4. Does the servant leadership style of management, as measured by SLQ, influence the relationship between the effectiveness of health

education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

The previous sections of this review have established the importance of communication by the health care professionals through regularly educating patients about the progress they are making with their treatment, specific measures and actions they can adopt to expedite the recovery and advising them on other aspects of health education. Learning about the progress in their recovery motivates patients to strive towards greater improvements in health and is suitably catalyzed by the perceived emotional bond that they come to share with the healthcare staff. This in turn, drives providers to take ownership of the recovery process and be an explicit stakeholder in this initiative, which further inspires the patient towards recovery in a positive feedback loop mechanism (Castro, Van Regenmortel, Vanhaecht, Sermeus, & Van Hecke, 2016).

Research Question #5. Does the servant leadership style of management, as measured by SLQ, influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

The emotional bond mentioned above could either have a positive influence on the patient if due attention and empathy is forthcoming from the providers. However, if the providers are apathetic towards those seeking treatment at the healthcare institution, this could have an equally debilitating effect on the patients. This research question also will be addressed by the present study.

Summary and Conclusions

A comprehensive review of academic texts, journals, and reports of prior studies conducted on the areas of servant leadership, services quality and patient satisfaction was conducted, and the relationships between (a) servant leadership and service standards, and (b) patients' perception of service quality, and (c) patient satisfaction were assessed. The concept of servant leadership was explained in elaborate detail and was compared against conventional approaches to leadership including transactional, transformational and laissez-faire styles of leadership. The review also sought to abstract servant leadership in a definitive set of personality traits and skills developed by the leaders employing this approach to leadership. These traits and skills were in turn linked directly to how they could result in the improvement of the quality of services provided.

The literature review also evidenced how service providers could fall into the trap of overestimating the quality of the services they provide by looking inward, a task-oriented or process-oriented approach, instead of taking a customer-centric view of how these services are perceived. This dichotomy between provider and patient viewpoints was assessed in detail, and a case was made to ensure maximum overlap between these two perspectives, to bring about patient satisfaction in the true sense of the term. The benefits of bringing about such satisfaction among patients through enlisting loyalty for the healthcare institution were listed, and the criticality of recording customer loyalty as a metric was well established. These facets of servant leadership, service quality, and patient satisfaction would add immense value to the existing knowledge repository on these areas that have been hitherto documented in subject-relevant texts and journals.

Having concluded the literature review, the next chapter provides an in-depth explanation of the research design, philosophy, and methodology adopted for the present study. It sets out the various options that were available to the researcher for each of these decision points, debates the pros and cons of each option, and provides the rationale for the final decisions that were made, and the options preferred by the researcher for the study. Chapter 4 thereafter conducts a thorough analysis of the data collected from the primary research and juxtaposes these findings and the results of their analysis against the findings from the analysis of the secondary data collected as part of this literature review. Areas of congruence between the findings are highlighted, and any conflicts between the two sets of findings are subjected to critical assessment thereafter. These, in turn, form the basis for inferences and recommendations, which are documented in the final chapter of this dissertation report.

Chapter 3: Research Method

Introduction

The purpose of this quantitative, correlational study was to determine the impact of the servant leadership style of management on the relationship between the different areas of customer service and patient satisfaction. I examined the mediating effect of servant leadership style between the different areas of customer service (i.e., quality of care, communication, health education, and patient safety) and patient satisfaction. The independent variables were the different areas of customer service, the dependent variable was patient satisfaction, and the mediating variable was the servant leadership style of management. Participants for the study were healthcare managers in the Inland Empire region. Data were collected using Barbuto and Wheeler's (2006) SLQ and the CAHPS survey. A regression analysis was conducted to investigate the relationship between these variables.

The following section will provide an overview in this chapter. First, the research design and rationale will be summarized. Second, the methodology will be outlined, including a description of the population; procedures for recruitment, participation, and data collection; and instrumentation and operationalization of constructs. Third, planned data analysis will be summarized. Fourth, threats to validity and ethical procedures will be discussed. Finally, a summary of the important details about the methodology will be included.

Research Design and Rationale

A quantitative method was employed for the study. Quantitative methods require the use of mathematical techniques to provide statistical inferences about the

relationships or differences between numerically measured variables (Camm, 2012; Hancock & Mueller, 2010; Wisniewski, 2016). Quantitative methodology is used with studies that have research questions pertaining to who, what, and how many (Leavy, 2017). The purpose of the current study was to examine the impact of the servant leadership style of management on the relationship between the different areas of customer service and patient satisfaction. The research questions and hypotheses were directed towards determining the predictive relationship between variables. The independent variable (i.e., areas of customer service), dependent variable (i.e., patient satisfaction), and mediating variable (i.e., servant leadership style of management) were measured numerically using a survey. Therefore, based on all the aforementioned considerations, a quantitative method was appropriate for the current study.

In qualitative studies, interviews, observations, and case studies are used to gather information about a certain phenomenon from identified individuals or group of people under study (Barczak, 2015; Park & Park, 2016). Qualitative methods include inductive logic to determine explanations and insights from different sources of information such as interview transcripts, recordings, documents, case studies, and observations (Barczak, 2015; Park & Park, 2016). Qualitative researchers emphasize answers for how and why questions, and the data are collected under natural circumstances (Peters & Halcomb, 2015).

A correlational research design was employed for this study. Correlational researchers seek to determine relationships between numerically measured variables (Curtis, Comiskey, & Dempsey, 2016; Goodwin & Goodwin, 2013). The correlational research design provides an opportunity for the researcher to evaluate both the magnitude

and behavior of the relationships between variables (Leedy & Ormrod, 2012; Whitley, Kite, & Adams, 2013). Through the use of the correlational research design, insights can be made on how servant leadership styles of management (i.e., mediating variable) impact the relationship between areas of customer service (i.e., independent variable) and patient satisfaction (i.e., dependent variable). I used regression analysis to measure the impact of these variables to address the research questions and hypotheses of this study.

I only focused on one group of participants who were tracked over the years. An experimental approach was not be appropriate for the study because I did not conduct any treatment or experiment with the selected participants and only focused on existing characteristics.

Methodology

Population

The target population for the study was healthcare managers in the Inland Empire region. Study participants consisted of 82 managerial staff within the University Health System, which is comprised of a teaching hospital, five behavioral health centers, 10 federally qualified health centers, and a public health division. The employees included in this study consisted of nurse managers, quality assurance managers, psychiatrists, licensed social workers, departmental heads, physicians, vice presidents, chief operating officers, and chief executive officers. The age range was from 30 -50 years old of both men and women in managerial positions.

Sampling and Sampling Procedures

Study participants were randomly chosen from the pool of healthcare managers in the Inland Empire region to ensure equal representation for all healthcare managers in the

cohort. All participants were assigned a number using the random number generator feature in Microsoft Excel; healthcare managers were selected randomly. To be eligible for this study, the participants must have held holding a position as a healthcare manager in a healthcare institution in the Inland Empire region.

An a priori power analysis was conducted to determine the required minimum sample size for the study. Four factors were considered in the power analysis: significance level, effect size, the power of the test, and statistical technique. The significance level (i.e., Type I error) refers to the chance of rejecting a null hypothesis given that it is true (Haas, 2012). The effect size refers to the estimated measurement of the relationship between the variables being considered (Cohen, 1988). Cohen (1988) categorized effect size into small, medium, and large. Berger, Bayarri, and Pericchi (2013) purported that a medium effect size is better as it strikes a balance between being too strict (small) and too lenient (large). The power of a test refers to the probability of correctly rejecting a null hypothesis (Sullivan & Feinn, 2012). In most quantitative studies, an 80% power is used (Sullivan & Feinn, 2012). The statistical test used for this study was correlation analysis. Therefore, using G*Power 3.1.9.2 (Faul, Erdfelder, Buchner, & Lang, 2009), the computed required minimum sample size for a regression analysis with two predictors (one independent and one mediating variable) with alpha set to .05, power set to .80, and medium effect size was 68 (see Appendix A). To account for missing data and the number of possible participants available for recruitment, 82 healthcare managers was recruited.

Procedures for Recruitment, Participation, and Data Collection

An institutional review board (IRB) approval from Walden University was secured before any data collection activities commence. Once the IRB approval was secured, I then asked permission from the administrators of healthcare institutions to provide a listing of healthcare managers who could be included in the study. I then e-mailed the healthcare managers asking for their participation. Participation was voluntary, and an informed consent form was provided before the actual survey was administered.

All potential participants were e-mailed with a link to the study survey (i.e., comprising of the SLQ and CAHPS) in Survey Monkey. Survey Monkey was the survey host of choice because it works well with the import of data to Microsoft Excel and Statistical Package for the Social Sciences (SPSS), which were the platforms used for data preprocessing and data analysis. The e-mail invitation included a description of the study along with the active link. Each link to the survey was only valid for one survey submission and was not able to be reused. The e-mail informed healthcare managers that participating in this study was strictly voluntary and that no loss of privileges may occur by not participating or withdrawing from the study. Confidentiality was explained in the e-mail. It was made clear to participants that their participation, or lack thereof, would not impact their employment in their respective healthcare institutions. Numbers were assigned to survey participants based on the numeric order of participant submission on Survey Monkey, starting with number one up to the total number of research participants for tracking purposes. Once the required number of participants was reached, the responses of all participants were exported from Survey Monkey to Microsoft Excel for data preprocessing and to SPSS for data analysis.

Instrumentation and Operationalization of Constructs

The primary data for this research came from Barbuto and Wheeler's (2006) SLQ and CAHPS survey. The SLQ was developed to measure the frequency with which an individual believes he or she exhibits servant-leader qualities. The SLQ has 23 survey items measuring five factors: altruistic calling, emotional healing, wisdom, persuasive mapping, and organizational stewardship. The SLQ is a self-report questionnaire where individuals rate themselves on a 5-point Likert-type scale from 0 (*not at all*) to 4 (*frequently, if not always*).

Xu, Stewart, and Haber-Curran (2015) tested the validity of the SLQ using a sample of 956 principals. As a major indicator of the discriminant validity of constructs, the average variance extracted (AVE) estimates ranged from 40% for organizational stewardship to 55% for emotional healing (Xu, Stewart, and Haber-Curran (2015). The AVE estimates for males ranged from 43% for organizational stewardship to 60% for emotional healing (Xu, Stewart, and Haber-Curran (2015). The altruistic calling and organizational stewardship subscales had lower than 50%, a generally accepted level of adequate convergence (Hair, Black, Babin, & Anderson 2010). In terms of reliability, Xu et al. showed that the reliability coefficients in this study of school principals were above the minimally acceptable level of 0.70: altruistic calling ($\alpha = .74$), emotional healing ($\alpha = .84$), wisdom ($\alpha = .83$), persuasive mapping ($\alpha = .83$) and organizational stewardship ($\alpha = .79$). Xu et al. established the internal reliability of the SLQ.

The CAHPS survey is an integral part of the CMS's efforts to improve healthcare in the United States by paying for high-quality services. The CES is then used to measure the customer service experienced by the respondents. To improve customer

experience, it is important for service providers to effectively measure and model customer experience in healthcare settings (Spiess et al., 2014). These Likert scale measures of 1= *unsatisfied*, 2= *neutral*, 3 = *satisfied*, 4 = *very satisfied* were administered to healthcare managers of a county hospital in the Inland Empire region. The respondents completed the measures by providing a numerical score to indicate their choices.

Data Analysis Plan

The data analysis for this study was performed using SPSS for Windows to provide a range of descriptive as well as inferential statistics, including statistical correlations. SPSS software is used by researchers in educational, social, and behavioral sciences (Hinton, McMurray, & Brownlow, 2014). SPSS is user-friendly, and it enables the researcher to export data from Microsoft Excel easily (Kulas, 2009). All required statistical tests for this study were conducted using SPSS.

All data were preprocessed using Microsoft Excel. Preprocessing of data aims to ensure a clean data set by excluding data outliers and missing data. Only those participants who had complete information on both the independent and dependent variables were included in the data analysis. Once a complete, clean data set was achieved, it was be exported to SPSS for data analysis.

Research Questions and Hypotheses

1. Does the servant leadership style of management, as measured by SLQ, positively influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$1: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$1: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

2. Does the servant leadership style of management, as measured by SLQ, influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$2: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$2: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

3. Does the servant leadership style of management, as measured by SLQ, influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$3: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$3: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

4. Does the servant leadership style of management, as measured by SLQ, influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$4: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$4: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

5. Does the servant leadership style of management, as measured by SLQ, influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$5: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$5: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

Two types of statistical analysis were conducted that included descriptive statistics and inferential statistics. Descriptive statistics was conducted to characterize the data that were gathered from the survey. Specifically, the frequency distribution and percentages was used to describe the data that were gathered (see Hoe & Hoare, 2012). In addition, inferential statistics was conducted to draw conclusions about the target population regarding how servant leadership mediates the relationship between customer service and patient satisfaction. Regression analysis was conducted to provide insights on the research questions of the study. Regression analysis served three purposes: description, control, and prediction (Nimon & Reio, 2011). In this study, I described the relationship between areas of customer service and patient satisfaction and how the servant leadership style of management influences these relationships.

Regression analysis is a parametric test, and it must adhere to certain data assumptions. The assumptions employed for parametric tests included normality, linearity, and homogeneity. The normality assumption assumes that the distribution of the test is normally distributed with a mean of 0 for a standard normal distribution, 1

standard deviation, and a symmetric bell-shaped curve (Finch, 2005). A normal probability plot was generated to examine if a violation of the normality assumption exists. The assumption of linearity indicates the relationship between variables (i.e., the predictor and criterion variables) follows a straight line (Bücher, Dette & Wieczorek, 2011). A scatter plot with standard regression output was generated to examine if a violation of the linearity assumption exists. The assumption of homoscedasticity refers to the equal variance of all values of the independent variables around the regression line (Finch, 2005). A residual scatter plot was generated to examine if a violation of the linearity assumption exists.

Threats to Validity

The validity of the results of quantitative research is heavily based on the instruments used in gathering data. As mentioned in the previous sections, data for this study will be collected from validated survey instruments and thus ensures that the data to be collected will effectively measure the constructs of this study. To ensure that data will be relevant, the researcher will ensure that healthcare managers selected to participate in the study currently hold a position in a healthcare institution at the Inland Empire region.

Ethical Procedures

The proposed study will begin with IRB approval from Walden University, to ensure ethical standards are met. After receiving IRB approval, the researcher will secure permission from the administrators of healthcare institutions in the Inland Empire region to collect data from potential participants in their respective institutions. The research is

not expected to pose any harm to participants for several reasons. First, the nature of anonymous quantitative data collection is such that no identifying information is collected that can be linked back to the participants. Pseudo codes will be used to designate each participant (P01 for participant number one and so on). Secondly, the participants are not a vulnerable population. The data to be collected in this study is not in any way confidential, meaning that were anonymity somehow compromised, the risk of harm would remain minimal.

Hard copies of raw data and other documents pertinent to the study will be securely kept in a locked filing cabinet inside the personal office of the researcher. Soft copies of raw data and other documents will be saved in a password-protected flash drive. All data and documents related to the study will be destroyed seven years after completion. Following the conclusion of the study, all hard copies will be shredded while soft copies will be deleted.

Summary

The purpose of this quantitative correlational study is to determine the impact of the servant leadership style of management on the relationship between the different areas of customer service and patient satisfaction. The data for the study will be gathered from the use of Barbuto and Wheeler's (2006) SLQ and the CAHPS survey. The former will be used to measure servant leadership while the latter will be used to measure the areas of customer service and patient satisfaction. A total of 80 healthcare managers will be recruited for the study.

Data will be subjected to descriptive and inferential analysis that includes regression analysis to identify whether significant association and causation exists among the independent, dependent, and mediating variables. The chapter included detail about the research questions and corresponding hypothesis, population, sample size, data collection procedures, and data analysis procedures. Chapter 4 will present the findings of the possible relationships between variables.

Chapter 4: Results

Introduction

The purpose of this study was to determine the impact of servant leadership style of management on customer service, as measured by patient satisfaction. The impact of servant leadership on quality of care, communication, health education, and patient safety as well as levels of patient satisfaction were investigated. Specifically, the following research questions and hypotheses were investigated:

1. Does the servant leadership style of management, as measured by SLQ, positively influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$1: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$1: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

2. Does the servant leadership style of management, as measured by SLQ, influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$2: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$2: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

3. Does the servant leadership style of management, as measured by SLQ, influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$3: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$3: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

4. Does the servant leadership style of management, as measured by SLQ, influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$4: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$4: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

5. Does the servant leadership style of management, as measured by SLQ, influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$5: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$5: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

In this chapter, I include a description of the data collection process involved in the analysis. Baseline descriptive and demographic characteristics of the sample will be provided. Additionally, the results of the statistical analysis for each research question

will be presented as well as the testing of statistical assumptions. The chapter will conclude with a summary of the results of the analysis.

Data Collection

Participants for the study were healthcare managers in the Inland Empire region. Data were collected using Barbuto and Wheeler's (2006) SLQ and the CAHPS survey. Study participants consisted of 82 managerial staff within the University Health System, which is comprised of a teaching hospital, five behavioral health centers, 10 federally qualified health centers, and a public health division. The employees included in this study consisted of nurse managers, quality assurance managers, psychiatrists, licensed social workers, departmental heads, physicians, vice presidents, chief operating officers, and chief executive officers. Study participants were randomly chosen from the pool of healthcare managers in the Inland Empire region to ensure equal representation for all healthcare managers in the cohort. All participants were assigned a number; using the random number generator feature in Microsoft Excel, healthcare managers were selected randomly. To be eligible for this study, the participants must be currently holding a position as a healthcare manager in a healthcare institution in the Inland Empire region. Out of the N=82 participants, 49 (59.8%) were females and 33 (40.2%) were male. Most people had a master's degree, 36(43.9%). This was followed by 26 (31.7%) with a bachelor's degree, 13(15.9%) with a doctorate's degree, and seven (8.5%) with an associate's degree. Most people were European American, 24 (29.3%). This was followed by African American, 19 (23.2%), Hispanic American 15(18.3%), and eight (9.8%) Native American. Thirteen (15.9%) identified as another race. Most people were registered nurses, 14 (17.1%). This was followed by vice presidents (11or13.4%),

managers (nine or 11.0%), nurse managers (nine or 11.0%), administrators (eight or 9.8%), chief executive officers (six or 7.3%), licensed social workers (six or 7.3%), medical directors (five or 6.1%), psychiatrists (three or 3.7%), and quality assurance managers (three or 3.7%). Some participants' role was another category (eight or 9.8%). Most people were employed from 10-13 years (36 or 43.9%). This was followed by 6-9 years (25or 30.5%), 2-5 years (16 or 19.5%), and less than 1 year (four or 4.9%). One person did not provide a response (one or 1.2%).

Results

A sample of $N = 82$ people completed the study survey, which included demographic questions, SLQ, and the CAHPS survey. Demographic statics were reported in the previous section. Customer satisfaction ranged from 0 to 3 ($M = 2.29$, $SD = 0.58$); servant leadership ranged from 0 to 4.00 ($M = 2.86$); patient satisfaction ranged from 1.00 to 3.00 ($M = 2.21$, SD = 0.47); quality of care ranged from 2 to 4 ($M = 2.90$, $SD = 0.49$); communication ranged from 2 to 3.75 ($M = 2.85$, $SD = 0.39$); safety ranged from 2 to 4 ($M = 2.94$, $SD = 0.58$); and health education ranged from 1 to 2 ($M = 1.82$, $SD = 0.39$). This information is depicted in Table 3 below.

Table 3
Descriptive Statistics

	N	Min	Max	*M*	*SD*
Customer Satisfaction	82	0	3	2.29	.577
Servant Leadership	82	.00	4.00	2.86	.82
Patient Satisfaction	82	1.00	3.00	2.21	.47
Quality of Care	82	2.00	4.00	2.90	.49
Communication	82	2.00	3.75	2.85	.39
Safety	82	2.00	4.00	2.94	.58
Health Education	82	1.00	2.00	1.82	.39

Multiple regression was conducted to address each research question. Prior to the analysis, testing of parametric assumptions was performed. The assumptions tested were normality of residuals, outlier detection, independence of observations, multicollinearity, and homoscedasticity. The testing of parametric assumptions were first tested for RQ1.

Normality of the residuals was established by visual inspection of the histogram of residuals presented below. The histogram suggests an approximate normal distribution (Figure 2).

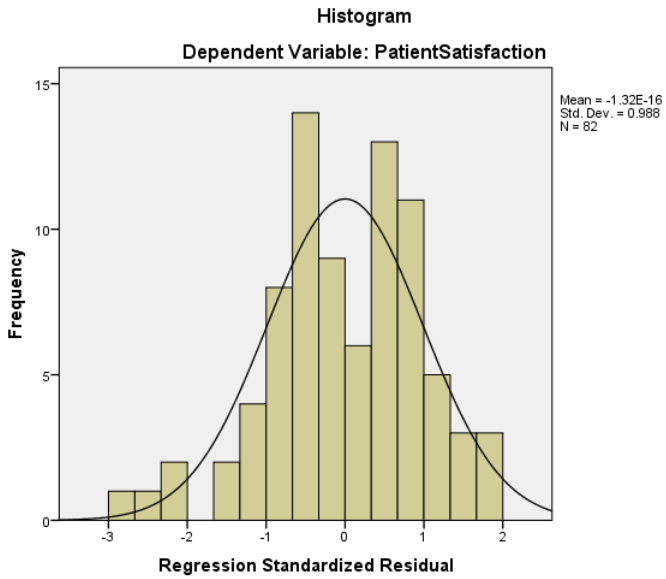

Figure 2. Histogram of residuals for RQ1.

Outliers were assessed by calculating the standardized residuals of the model. There were no residuals beyond -/+ 3 standard deviations thus no outliers to be concerned about (Table 4).

Table 4
Range of Standardized Residuals for RQ1

	N	Min	Max
Standardized Residual	82	-2.90	1.87

Independence of observations was assumption was tested by examination of the Durbin-Watson statistic. The Durbin-Watson statistic of 2.104 was within the 1.5 to 2.5 range, thus indicating independence of observations. Multicollinearity was tested by examination of the variance inflation factor (VIF). The VIF of 1.00 was below 5.0 suggesting no issue with multicollinearity. Lastly, homoscedasticity was tested by

examination of a scatter plot of predicted versus standardized residuals. The plot showed no apparent pattern which indicated homoscedasticity.

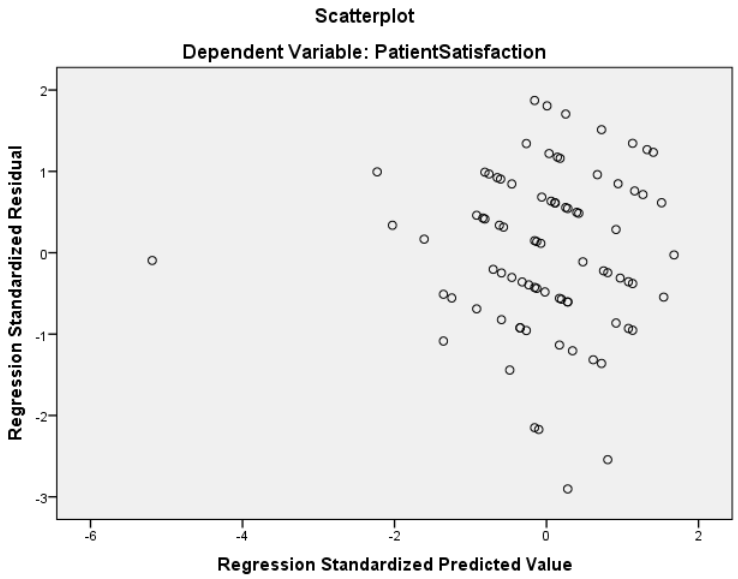

Figure 3. Scatter plot of predicted values and standardized residuals for RQ1.

Next, the testing of parametric assumptions was tested for RQ2. Normality of the residuals was established by visual inspection of the histogram of residuals presented below. The histogram suggests an approximate normal distribution (Figure 4

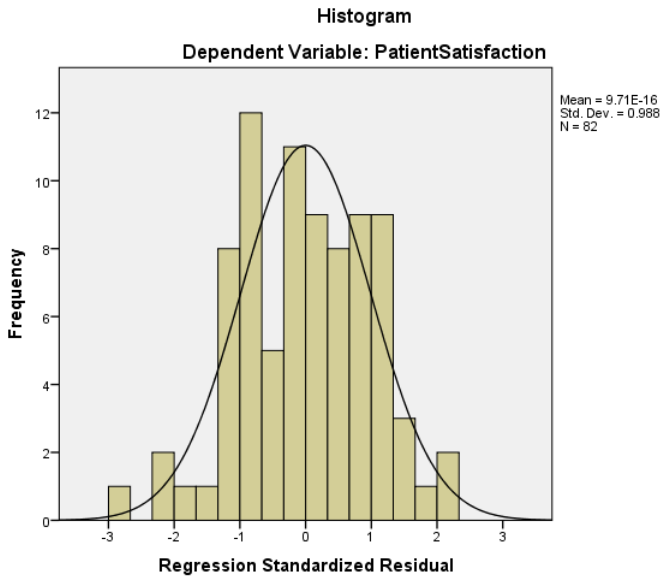

Figure 4. Histogram of residuals for RQ2

Outliers were assessed by calculating the standardized residuals of the model. There were no residuals beyond -/+ 3 standard deviations thus no outliers to be concerned about.

Table 9
Range of Standardized Residuals for RQ2

	N	Min	Max
Standardized Residual	82	-2.71	2.09

Independence of observations was assumption was tested by examination of the Durbin-Watson statistic. The Durbin-Watson statistic of 2.026 is within the 1.5 to 2.5 range thus indicating independence of observations. Multicollinearity was tested by examination of the variance inflation factor (VIF). The VIF of 1.005 was below 5.0

suggesting no issue with multicollinearity. Lastly, homoscedasticity was tested by examination of a scatter plot of predicted versus standardized residuals. The plot showed no apparent pattern which indicated homoscedasticity (Figure 3).

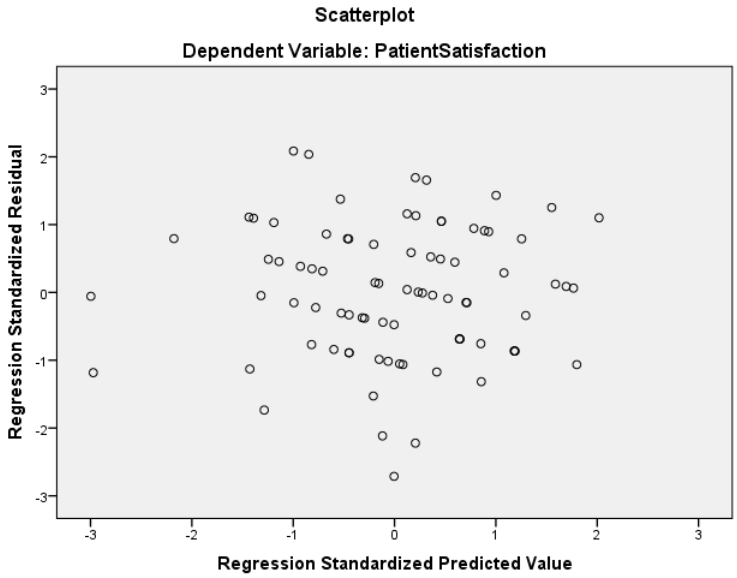

Figure 5. Scatter plot of predicted values and standardized residuals for RQ2

Next, the testing of parametric assumptions was tested for RQ3 restated below:

RQ3: To what extent does the servant leadership style of management, as measured by SLQ, influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

Normality of the residuals was established by visual inspection of the histogram of residuals presented below. The histogram suggests an approximate normal distribution (Figure 4).

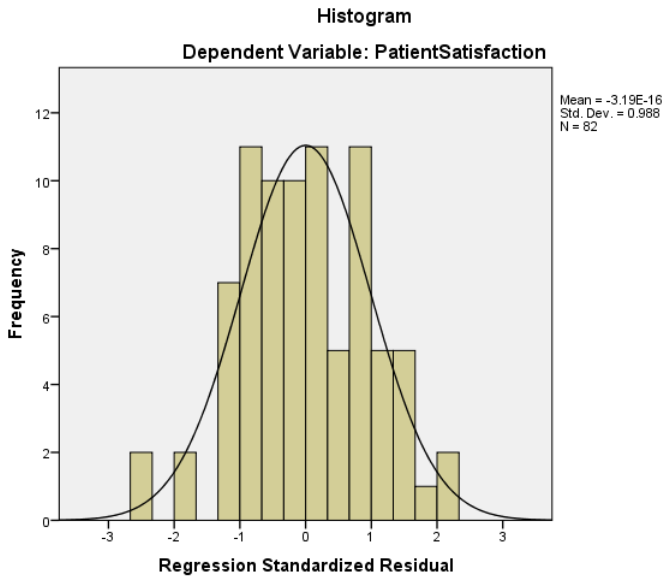

Figure 6. Histogram of residuals for RQ3

Outliers were assessed by calculating the standardized residuals of the model. There were no residuals beyond -/+ 3 standard deviations thus no outliers to be concerned about (Table 9).

Table 10
Range of Standardized Residuals for RQ3

	N	Min	Max
Standardized Residual	82	-2.59	2.17

Independence of observations was assumption was tested by examination of the Durbin-Watson statistic. The Durbin-Watson statistic of 1.962 is within the 1.5 to 2.5 range thus indicating independence of observations. Multicollinearity was tested by examination of the variance inflation factor (VIF). The VIF of 1.004 was below 5.0 suggesting no issue with multicollinearity. Lastly, homoscedasticity was tested by

examination of a scatter plot of predicted versus standardized residuals. The plot showed no apparent pattern which indicated homoscedasticity (Figure 5).

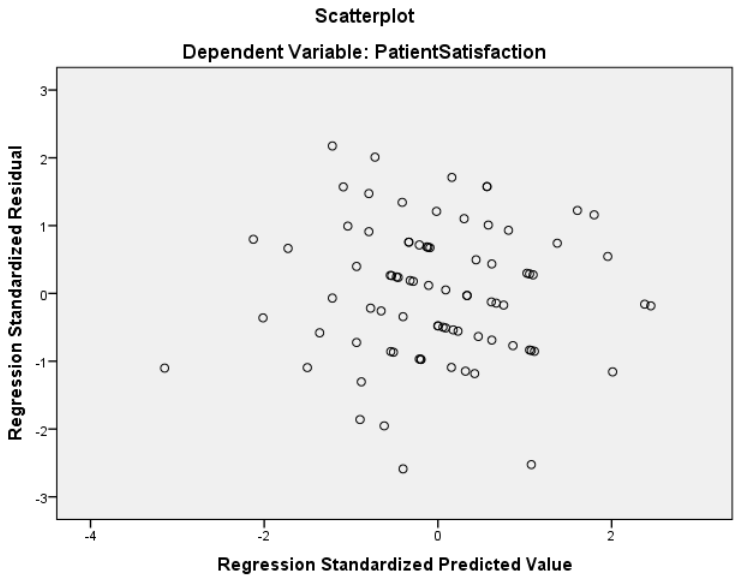

Figure 7. Scatter plot of predicted values and standardized residuals for RQ3

Next, the testing of parametric assumptions was tested for RQ4 restated below:

RQ4: To what extent does the servant leadership style of management, as measured by SLQ, influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

Normality of the residuals was established by visual inspection of the histogram of residuals presented below. The histogram suggests an approximate normal distribution (Figure 6).

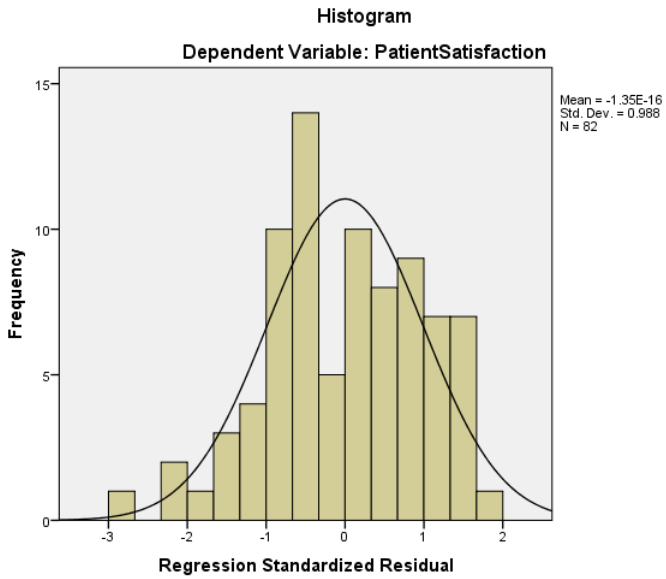

Figure 8. Histogram of residuals for RQ4

Outliers were assessed by calculating the standardized residuals of the model. There were no residuals beyond -/+ 3 standard deviations thus no outliers to be concerned about (Table 10).

Table 11
Range of Standardized Residuals for RQ4

	N	Min	Max
Standardized Residual	82	-2.89	1.85

Independence of observations was assumption was tested by examination of the Durbin-Watson statistic. The Durbin-Watson statistic of 1.862 is within the 1.5 to 2.5 range thus indicating independence of observations. Multicollinearity was tested by examination of the variance inflation factor (VIF). The VIF of 1.001 was below 5.0

suggesting no issue with multicollinearity. Lastly, homoscedasticity was tested by examination of a scatter plot of predicted versus standardized residuals. The plot showed no apparent pattern which indicated homoscedasticity (Figure 7).

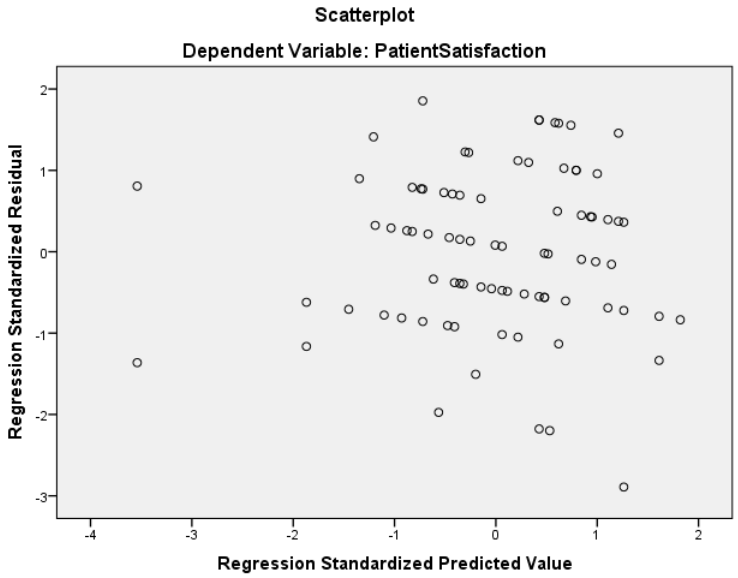

Figure 9. Scatter plot of predicted values and standardized residuals for RQ4

Next, testing of parametric assumptions was tested for RQ5 restated below:

RQ5: To what extent does the servant leadership style of management, as measured by SLQ, influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

Normality of the residuals was established by visual inspection of the histogram of residuals presented below. The histogram suggests an approximate normal distribution (Figure 8).

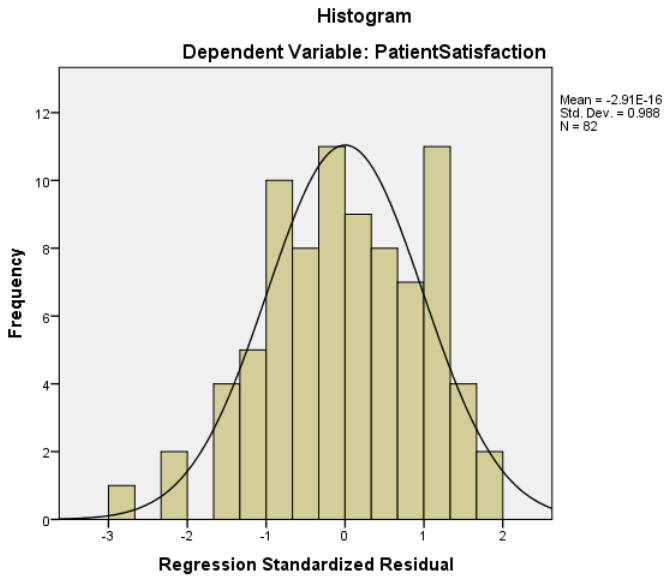

Figure 10. Histogram of residuals for RQ5

Outliers were assessed by calculating the standardized residuals of the model. There were no residuals beyond -/+ 3 standard deviations thus no outliers to be concerned about (Table 11).

Table 12
Range of Standardized Residuals for RQ5

	N	Min	Max
Standardized Residual	82	-2.78	1.95

Independence of observations was assumption was tested by examination of the Durbin-Watson statistic. The Durbin-Watson statistic of 2.001 is within the 1.5 to 2.5 range thus indicating independence of observations. Multicollinearity was tested by

examination of the variance inflation factor (VIF). The VIF of 1.004 was below 5.0 suggesting no issue with multicollinearity. Lastly, homoscedasticity was tested by examination of a scatter plot of predicted versus standardized residuals. The plot showed no apparent pattern which indicated homoscedasticity (Figure 9).

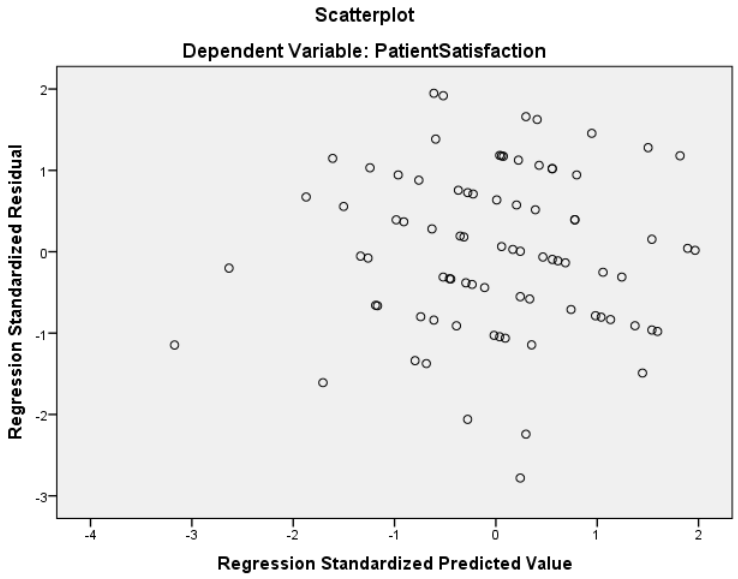

Figure 11. Scatter plot of predicted values and standardized residuals for RQ5

What now follows are the results of the multiple regression conducted in order to answer and test each research question and hypothesis. Rejection of each null hypothesis will be assessed at the 5% level of significance. The chapter will conclude with a summary of the results.

Results of Hypothesis Testing

Multiple regression was conducted in order to test this first null hypothesis:

Ho_1: Servant leadership style of management, as measured by SLQ, does not significantly positively influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H1_1$: Servant leadership style of management, as measured by SLQ, significantly positively influences the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

Baron and Kenny's (1986) steps for mediation were used in order to test for mediation. These steps include:

Step 1:

Regress the dependent variable on the independent variable to confirm that the independent variable is a significant predictor of the dependent variable

Step 2:

Regress the mediator on the independent variable to confirm that the independent variable is a significant predictor of the mediator. If the mediator is not associated with the independent variable, then it couldn't possibly mediate anything.

Step 3:

Regress the dependent variable on both the mediator and independent variable to confirm that the mediator is a significant predictor of the dependent variable, and the previously significant independent variable in Step #1 is now greatly reduced, if not non - significant.

The association between customer service and patient satisfaction was statistically significant ($B = 0.264$, $t = 3.105$, $p = .003$), thus step 1 was satisfied (Table 12).

Table 13
Coefficients Table for RQ 1 (Customer Service and Patient Satisfaction)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.608	.201		7.992	.000
	Customer Service	.264	.085	.328	3.105	.003

a. Dependent Variable: Patient Satisfaction

The association between customer service and servant leadership was not significant ($B = 0.011$, $t = 0.067$, $p = .946$). Since servant leadership is not associated with customer satisfaction, it cannot mediate anything. Thus, the first null hypothesis is not rejected and conclude that there is no mediation of servant leadership on the relationship between customer service and patient satisfaction.

Table 14
Coefficients Table for RQ 1 (Customer Service and Servant Leadership)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.839	.375		7.568	.000
	Customer Service	.011	.159	.008	.067	.946

a. Dependent Variable: Servant Leadership

Multiple regression was conducted in order to test this second null hypothesis:

$H0_2$: Servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H1_2$: Servant leadership style of management, as measured by SLQ, significantly influences the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

The association between quality of care and patient satisfaction was statistically significant (B = -0.218, t = 2.094, p = .039), thus step 1 was satisfied (Table 14).

Table 15
Coefficients Table for RQ 2 (Quality of Care and Patient Satisfaction)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.843	.305		9.323	.000
	Quality of Care	-.218	.104	-.228	-2.094	.039

a. Dependent Variable: Patient Satisfaction

The association between servant leadership and quality of care was not significant ($B = 0.123$, $t = 0.655$, $p = .514$). Since servant leadership is not associated with quality of care, it cannot mediate anything. Thus, the second null hypothesis is not rejected and conclude that there is no mediation of servant leadership on the relationship between quality of care and patient satisfaction (Table 15).

Table 16

Coefficients Table for RQ 2 (Quality of Care and Servant Leadership)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.508	.550		4.557	.000
	Quality Of Care	.123	.187	.073	.655	.514

a. Dependent Variable: Servant Leadership

Multiple regression was conducted in order to test this third null hypothesis:

$H0_3$: Servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H1_3$: Servant leadership style of management, as measured by SLQ, significantly influences the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

The association between communication and patient satisfaction was statistically significant (B = -0.290, t = -2.222, p = .029), thus step 1 was satisfied (Table 16).

Table 17
Coefficients Table for RQ 3 (Communication and Patient Satisfaction)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.040	.375		8.098	.000
	Communication	-.290	.131	-.241	-2.222	.029

a. Dependent Variable: Patient Satisfaction

The association between servant leadership and communication was not significant (B = 0.123, t = 0.655, p = .514). Since servant leadership is not associated with communication, it cannot mediate anything. Thus, thus the third null hypothesis is not rejected and conclude that there is no mediation of servant leadership on the relationship between communication and patient satisfaction (Table 17).

Table 18
Coefficients Table for RQ 3 (Communication and Servant Leadership)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.469	.680		3.631	.000
	Communication	.138	.236	.065	.585	.560

a. Dependent Variable: Servant Leadership

Multiple regression was conducted in order to test this fourth null hypothesis:

$H0_4$: Servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H1_4$: Servant leadership style of management, as measured by SLQ, significantly influences the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

The association between the effectiveness of health education and patient satisfaction was not statistically significant (B = -.045, t = -.335, p = .738), thus step 1 was not satisfied (Table 18). Thus, there is no significant relationship to mediate and this fourth null hypothesis cannot be rejected.

Table 19
Coefficients Table for RQ 4 (Health Education and Patient Satisfaction)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.295	.248		9.249	.000
	Health Education	-.045	.134	-.037	-.335	.738

a. Dependent Variable: Patient Satisfaction

Multiple regression was conducted in order to test this fifth null hypothesis:

$H0_5$: Servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between patient safety and patient satisfaction, as

measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H1_5$: Servant leadership style of management, as measured by SLQ, significantly influences the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

The association between patient safety and patient satisfaction was statistically significant (B = -0.290, t = -2.222, p = .029), thus step 1 was satisfied (Table 19).

Table 20
Coefficients Table for RQ 5 (Patient Safety and Patient Satisfaction)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.724	.260		10.478	.000
	Patient Safety	-.174	.087	-.218	-2.001	.049

a. Dependent Variable: Patient Satisfaction

The association between servant leadership and patient safety was not significant (B = 0.123, t = 0.655, p = .514). Since servant leadership is not associated with patient safety, it cannot mediate anything. Thus, thus the fifth null hypothesis is not rejected and conclude that there is no mediation of servant leadership on the relationship between patient safety and patient satisfaction (Table 20).

Table 21

Coefficients Table for RQ 5 (Patient Safety and Servant Leadership)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.612	.468		5.575	.000
	Safety	.086	.156	.061	.548	.585

a. Dependent Variable: Servant Leadership

Summary

This study sought to investigate the possible mediating effect of servant leadership on the relationships between patient satisfaction with customer service (RQ1), quality of care (RQ2), communication (RQ3), effectiveness of health education (RQ4), and patient safety (RQ5). Results of the study found significant negative relationships between patient satisfaction and quality of care, communication, and patient safety. Patient satisfaction was significantly positively related with customer service. However, mediation could not be supported since the proposed mediator was not significantly related to any of the predictor's quality of care, communication, patient safety, health education, and customer satisfaction.

What follows in Chapter 5 is a discussion as to how the results of this study are interpreted in the context of the theoretical framework. Any limitations of the results of the study will be provided. Additionally, recommendations for future research will be discussed.

Chapter 5

Introduction

The purpose of this study was to determine the impact of servant leadership style of management on customer service, as measured by patient satisfaction, as there is a gap in research regarding this influence of servant leadership in healthcare. A quantitative method was employed for the study. The primary data were derived from Barbuto and Wheeler's (2006) SLQ and CAHPS survey. The possible mediating effect of servant leadership on the relationship between patient satisfaction with customer service, quality of care, communication, effectiveness of health education, and patient safety were investigated. A multiple regression approach was used to answer and test the following research questions and hypotheses:

1. Does the servant leadership style of management, as measured by SLQ, positively influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$1: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$1: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between customer service and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

2. Does the servant leadership style of management, as measured by SLQ, influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$2: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$2: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between quality of care and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

3. Does the servant leadership style of management, as measured by SLQ, influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$3: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$3: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between communication and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

4. Does the servant leadership style of management, as measured by SLQ, influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$4: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$4: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between the effectiveness of health education and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

5. Does the servant leadership style of management, as measured by SLQ, influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California?

$H_0$5: The servant leadership style of management, as measured by SLQ, does not significantly influence the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

$H_1$5: The servant leadership style of management, as measured by SLQ, significantly influences the relationship between patient safety and patient satisfaction, as measured by CAHPS among healthcare managers in Inland Empire region of Southern California.

I found significant negative relationships between patient satisfaction and quality of care, communication, and patient safety. Patient satisfaction was significantly positively related with customer service. However, mediation could not be supported because the proposed mediator was not significantly related to any of the predictor's quality of care, communication, patient safety, health education, and customer satisfaction.

Interpretation of the Findings

According to Trastek et al. (2014), servant leaders concentrate on ensuring that healthcare providers are fully equipped to enact changes to meet the needs of the diverse stakeholders affiliated with healthcare providers. However, Trastek et al. argued that further research is needed to establish the elements of servant leadership that lead to increased satisfaction of patients as customers to the healthcare industry. Neubert et al. (2016) demonstrated that servant leadership is directly related to nursing helping and creative behaviors to improve patient satisfaction through improved nurse job satisfaction. The results of this current study supported this finding at the 10% level of significance by detecting a small to medium positive correlation between servant leadership and patient satisfaction ($p = .073$).

Proponents of servant leadership claim that servant leadership improves customer satisfaction by creating cultural shifts in the workplace (Liden et al., 2014). When staff, employees, and leaders feel that they are contributors to organizational success and intellectual assets of their workplace, there is a direct impact on the quality customer service delivery (Flynn et al., 2016). However, the results of this current study did not support this relationship. There was no significant correlation found between servant

leadership and customer service (p = .946). Additionally, there was no significant relationship between servant leadership and quality of care (p = .514).

One of the characteristics of servant leadership includes communication with employers. Scholars who addressed tangible outcomes of servant leadership found associations with improved quality of care, communication, reduced costs, and procedural justice (Aij & Rapsaniotis, 2017). The servant leadership characteristics of listening, empathy, awareness, healing, and persuasion contribute to healthy relationships between administrators and clinical staff, as well as between providers and patients (Aij & Rapsaniotis, 2017). These interpersonal skills also form the core of patient-centered communication, which has been linked to increased patient satisfaction and adherence and better health outcomes (Aij & Rapsaniotis, 2017). I found no significant correlation between servant leadership and communication (p = .560).

Scholars have discussed the importance of communication by the healthcare professionals through regularly educating patients about the progress they are making with their treatment, measures and actions they can adopt to expedite the recovery, and advising them on other aspects of health education. Learning about the progress in their recovery motivates patients to strive towards greater improvements in health and is suitably catalyzed by the perceived emotional bond that they come to share with the healthcare staff. This drives providers to take ownership of the recovery process and be a stakeholder in this initiative, which further inspires the patient towards recovery in a positive feedback loop mechanism (Castro, Van Regenmortel, Vanhaecht, Sermeus, & Van Hecke, 2016). I, however, found no significant correlation between servant leadership and health education communication (p = .765).

The emotional bond between the patient and healthcare provider could either have a positive or negative influence on the patient if due attention and empathy is forthcoming from the providers. However, if the providers are apathetic towards those seeking treatment at the healthcare institution, this could have an equally debilitating effect on the patients. Apathy towards patients could cause patient anxiety and deprive them of the reassurance that they are safe and secure at the clinic. This would affect how the patients feel about the quality of services they receive at the healthcare center, thereby lowering patient satisfaction. I, however, found no significant correlation between servant leadership and patient safety (p = .585). Table 21 below summarizes these correlations.

Table 22
Correlations with Servant Leadership

		1	2	3	4	5	6	7
Servant Leadership (1)	r	1						
	N	82						
Patient Satisfaction (2)	r	.199	1					
	p	.073						
	N	82	82					
Customer Satisfaction (3)	r	.008	.328	1				
	p	.946	.003					
	N	82	82	82				
Quality of Care (4)	r	.073	-.228	-.154	1			
	p	.514	.039	.167				
	N	82	82	82	82			
Patient Safety (5)	r	.061	-.218	-.111	.844	1		
	p	.585	.049	.320	.000			
	N	82	82	82	82	82		
Health Education (6)	r	.034	-.037	-.144	.029	.005	1	
	p	.765	.738	.198	.796	.967		
	N	82	82	82	82	82	82	
Communication (7)	r	.065	-.241	-.161	.658	.621	-.020	1
	p	.560	.029	.148	.000	.000	.860	
	N	82	82	82	82	82	82	82

Although there were no significant mediating effects of servant leadership on the relationship between patent satisfaction with customer service, quality of care, communication, effectiveness of health education, and patient safety, there were significant relationships between patient satisfaction and the independent variables. I detected a small to medium positive correlation between patient satisfaction and servant

leadership (p = .073). Additionally, I found significant relationships between patient satisfaction and quality of care (p = .039), communication (p = .029), and patient safety (p = .049).

Gupta et al (2014) examined the relationship between patient-reported satisfaction and service quality and survival in breast cancer and acknowledged the increased importance among service providers of a healthcare institution of the extent to which the quality of their services is perceived favorably by patients. Additionally, patient satisfaction has been linked to word of mouth communication and repurchases intention, both of which have been associated with improved customer service (Kitapci et al., 2014). Patient satisfaction contributes to high levels of adherence to prescribed treatment regimens, better patient safety measures, and overall reduced costs through decreased healthcare use (Anhang et al., 2014).

Limitations of the Study

Limitations of the study included (a) a small spatial area that does not allow for generalizability; (b) there are many potential response biases of healthcare managers; and (c) quantitative survey data does not allow for the exploration of how and why servant leadership does or does not improve customer service, just whether or not it does (see Creswell, 2009; Moser & Kalton, 2017). The small spatial area under investigation in this study does not wholly limit the generalizability of the results. The research purpose was to determine the impact of servant leadership style of management on customer service as measured by patient satisfaction, through the lenses of providers (healthcare managers) a purpose and methodological design that can be replicated by researchers across the United States, and rest of the world. Therefore, this research may prompt other

researchers to test whether they find similar results in other social demographics and unique geographic areas where servant leadership is practiced within healthcare settings.

Secondly, response bias, a general term used to describe conditions or factors that occur while responding to surveys, which may impact on the way responses are provided (McPeake et al., 2014). When response bias occurs, it is generally viewed as a deviation, so anomalies within the response data will be investigated and noted during the analysis process of this paper. To mitigate instances of response bias, research questions have been honed for specificity while communicated clearly to the respondents. In addition to this, respondent screening has taken place to ensure that all respondents hold appropriate positions, knowledge, literacy, and understanding of the themes for required responses.

Finally, the quantitative design of the research does limit the understanding of the "how" and "why" of Servant Leadership style management. However, the results derived from this study will lay the foundation for future qualitative research on the topic of customer service as measured by patient satisfaction with servant leadership. It is hoped that future researchers will continue to seek to fill this gap in knowledge.

Recommendations

Future recommendations include larger spatial areas as well as applying a mixed methodology where both quantitative and qualitative analysis can be conducted. Larger spatial areas would increase the generalizability of the findings. In qualitative studies, interviews, observations, and case studies are used to gather information about a certain phenomenon from identified individuals or group of people under study (Barczak, 2015; Park & Park, 2016). Qualitative approaches make use of inductive logic to arrive with explanations and insights from different sources of information such as interview

transcripts, recordings, documents, case studies, and/or observations (Barczak, 2015; Park & Park, 2016). In qualitative analysis, exploration of *how* and *why* Servant Leadership does or does not improve customer service, just whether or not it does, could be accomplished. Qualitative analysis emphasizes to answer "how" and "why" questions and the interpretation of data as collected in their natural circumstances (Peters & Halcomb, 2015). Moreover, a mixed method approach is a methodology that involves the collecting, analyzing, and integrating of quantitative and qualitative techniques (Halcomb & Hickman, 2015; Terrell, 2012). A mixed method approach study makes use of the qualitative analysis to support the quantitative results.

Implications

In terms of the social change implications of the findings of this current study, healthcare providers would be able to better design and implement measures that would enhance the patient-perceived value of the healthcare services. This, in turn, would have a positive effect by inducing patient loyalty to the healthcare firm, and propensity to spread the word through word-of-mouth positive publicity, thereby benefiting the growth of the healthcare firm's operations by retaining existing patients and attracting new ones.

Establishing true metrics for evaluating the effectiveness of the servant leadership style of management in the Inland Empire Region of Southern California will allow healthcare managers across the United States to replicate research and develop actionable plans for improved customer service and care quality. The results of this study could provide insight into understanding, promoting, and improving overall patient satisfaction within healthcare organizations. Furthermore, the social change implications of this study focused on patient satisfaction which has been directly linked to patient survival, so any

research aimed at improving overall patient satisfaction also has the potential to save lives, while improving the lived experienced of all those employed in the healthcare industry.

Conclusion

The purpose of this quantitative correlational study was to determine the impact of the servant leadership style of management on the relationship between the different areas of customer service and patient satisfaction. Although this study did not discover any mediating effects of servant leadership on the relationship between patient satisfaction and customer service, quality of care, communication, effectiveness of health education, and patient safety, it did support other findings as discussed earlier. Neuber et al. (2016) found that nurse job satisfaction is tied to servant leadership practices through stimulating collaboration and creativity, engaging employees, and various other positive outcomes for organizations and their members. The results identified by Neubert et al. are likely a result of the principles of servant leadership, such as humility, empathy, and agape love, which ultimately develop a social identity of service for those practicing the leadership style (Sun, 2013). Perceptions of leader identity as one of service has also been associated with improved service quality in healthcare settings (Kondasani & Panda, 2016; Tsai et al., 2015). Despite the inherent ties between customer services, as measured by patient satisfaction, there is a significant gap in the literature relating to how servant leadership can help improve customer service in healthcare settings through improvements to the quality of care. It is imperative that this gap is narrowed by conducting future studies. It is necessary to explore how servant leadership practices can

continue to improve patient satisfaction as a social change implication across healthcare service environments, and whether a customer service approach guided by servant leadership styles is the ultimate means of improving patient satisfaction.

Further research can be extended to additional categories and geographic areas of the United States to determine how servant leadership, patient satisfaction, and HCAHPS are related. Hospital administrators should examine the findings of this study for possible implications to their leadership style and practice in determining how it may impact the organization they lead. Additionally, managers and leaders of United States hospitals can benefit from this study. According to the Garman & Lemak (2011) and the American College of Healthcare Executives (2012) the challenges that healthcare managers face are financial, quality, and compliance issues. Healthcare manager objectives are to achieve high patient satisfaction and maximize profitability by using the leadership style that best allows them to achieve these objectives.

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Appendix A: Invitation to Participate

I respectfully request your participation in a research study I am conducting as part of the requirement for completing my doctoral degree at Walden University.

The title of the study is “The Impact of Servant Leadership on Customer Service as measured by Patient Satisfaction in the Inland Empire Region of Southern California”. This study intends to improve the lived experience of patients as consumers in healthcare centers of the Inland Empire, California, as well as the leadership practices of those staff employed in these facilities.

Participants are contacted via email to complete a survey. This survey will take approximately 30 minutes to complete.

Participation in this study is voluntary and the participant is free to withdraw from this survey at any point in time. Study participants are healthcare professionals who currently hold a leadership position or have a healthcare organization in the Inland Empire region of Southern California.

The direct benefit of this study will be the awareness of leadership strategies to impact customer service and the application of the identified measures of servant leadership styles to influence patient satisfaction.

To participate in this study, kindly click the link below:

https://bit.ly/2Ky5P6W

Thank you for your time and assistance.

Chibunna Nwaobia

PhD Student Researcher.

Appendix B: Survey Questionnaires

SECTION I: Demographics (Check the applicable).

1. **What is your gender? (select one):**

○ Male

○ Female

○ Transgender

○ Other

2. **What is your level of education? (select one):**

○ No or some high school

○ High School

○ Associate degree

○ Bachelor's degree

○ Master's degree

○ Doctorate degree

3. **What is your race/ethnicity (select one)?**

○ White

○ African-American

○ Latina

- ○ Naïve American
- ○ Other

4. What is your current role? (select one):

- ○ Psychiatrist
- ○ Medical Director
- ○ Program Manager
- ○ Nurse Manager
- ○ Quality Assurance Manager
- ○ Licensed Social Worker
- ○ Chief Executive Officer
- ○ Vice President
- ○ Chief Operating Officer
- ○ Other _____

5. How long have you served in your current clinical role/profession?

- ○ Less than 1 year
- ○ 2-5 years
- ○ 6-9 years
- ○ 10-13 years

SECTION II: These questions ask about patient satisfaction. Do not include care given when patient stayed overnight in a hospital or times for dental care visits.

6. In the last 6 months, when your patient contacted this provider's office to get an appointment for care they needed right away, how often did they get an appointment as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

7. In the last 6 months, how often did your staff listen carefully to their patients?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

8. In the last 6 months, how often did your staff show respect for what you their patients had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

9. In the last 6 months, how often did your staff spend enough time with their patients?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

SECTION III: These questions ask about communication, quality of care, effectiveness of health education and patient safety.

10. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

- ○ Never

- ○ Sometimes
- ○ Usually
- ○ Always

11. In the last 6 months, how often did this provider explain things in a way that was easy to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

12. In the last 6 months, how often did this provider listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

13 In the last 6 months, how often did this provider seem to know the important information about your medical history?

- ○ Never

- ○ Sometimes
- ○ Usually
- ○ Always

14. In the last 6 months, how often did this provider show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

15 In the last 6 months, how often did this provider spend enough time with you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

16. In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

17. In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

18. In the last 6 months, how often was it easy to get appointments with specialists?

- ○ Never
- ○ Sometimes

- ○ Usually
- ○ Always

19. In the last 6 months, did you and anyone on your health care team talk about a healthy diet and healthy eating habits?

- ○ Yes
- ○ No

20. In the last 6 months, did you and anyone on your health care team talk about the exercise or physical activity you get?

- ○ Yes
- ○ No

21. In the last 6 months, how often did you and anyone on your health care team talk about all the prescription medicines you were taking?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

SECTION IV: Servant Leadership Questionnaire. In this section, you are requested to use the drop-down key to rate each statement based on the following categories: **0 = not at all to 4 = frequently, if not always.**

22. This person puts my best interests ahead of his/her own.
23. This person does everything he/she can to serve me.
24. This person sacrifices his/her own interests to meet my needs.
25. This person goes above and beyond the call of duty to meet my needs.

Emotional Healing

26. This person is one I would turn to if I had a personal trauma.
27. This person is good at helping me with my emotional issues.
28. This person is talented at helping me to heal emotionally.
29. This person is one that could help me mend my hard feelings.

Wisdom

30. This person seems alert to what's happening.
31. This person is good at anticipating the consequences of decisions.
32. This person has great awareness of what is going on.

33. This person seems in touch with what's happening.
34. This person seems to know what is going to happen.

Persuasive Mapping

35. This person offers compelling reasons to get me to do things.
36. This person encourages me to dream "big dreams" about the organization.
37. This person is very persuasive.
38. This person is good at convincing me to do things.
39. This person is gifted when it comes to persuading me.

Organizational Stewardship

40. This person believes that the organization needs to play a moral role in society.
41. This person believes that our organization needs to function as a community.
42. This person sees the organization for its potential to contribute to society.
43. This person encourages me to have a community spirit in the workplace.
44. This person is preparing the organization to make a positive difference in the future

SECTION V: In this section, you are requested to rate your experience with the company…

Customer Effort Score

45.How satisfied are you with your subordinate staff performance towards patient satisfaction?

- ○ Very Unsatisfied
- ○ Unsatisfied
- ○ Satisfied
- ○ Very satisfied

46. What was it that makes it possible for your subordinate staff performance towards patient satisfaction?

- ○ Inclusion of staff decision-making
- ○ Use of incentives
- ○ Staff appraisal
- ○ Staff training

Thank you for participating in this survey.