Leadership in Health Services

Servant leadership and job satisfaction within private healthcare practices

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Abstract

Purpose – The purpose of this study is to investigate the influence of servant leadership on job satisfaction within private healthcare practices.

Design/methodology/approach – Criterion sampling has been used to draw a sample of private healthcare practitioners and their employees. The data collected from 241 useable questionnaires have been statistically analysed. Factor analysis and Cronbach's alpha coefficients have been used to assess the validity and reliability of the measuring instrument, and multiple regression analyses have been performed to test the influence of the dimensions of servant leadership on job satisfaction.

Findings – The findings show that private healthcare practitioners display the dimensions of servant leadership investigated in this study. Furthermore, a significant positive relationship between developing others and job satisfaction for both sample groups, but only between caring for others and job satisfaction for the employee sample group, was reported. Acts of humility and servanthood by practitioners were not found to influence job satisfaction.

Practical implications – Educators can use the findings of this study to identify gaps in the leadership training of healthcare practitioners, and healthcare regulators can use the recommendations provided to implement appropriate interventions to ensure that healthcare practitioners fulfil their mandate of practising in an appropriate manner.

Originality/value – This study contributes to the limited understanding of servant leadership among private healthcare practitioners and it provides recommendations on how private healthcare practitioners can improve their servant leadership behaviour.

Keywords Servant leadership, Job satisfaction, Healthcare practitioner

Paper type Research paper

Introduction and background

Entering the healthcare profession is often viewed as a calling (Kilner and Kilner, 2004) and many consider the "traditional calling concept" as the ethical basis for the profession (Spencer *et al.*, 1999). Some have a religious or spiritual calling to serve (Wheeler, 2011), whereas others simply have an intense desire to serve others (Northouse, 2011). According to Trastek *et al.* (2014, p. 372), "this desire to serve others is at the heart of the healthcare providers' motivation". Similarly, servant leaders perceive leadership as an act of service (Blanchard and Hodges, 2003); providing a service and serving others is at the heart of this leadership style (Jafai *et al.*, 2016). Barbuto and Wheeler (2006) stressed that having a calling is central to servant leadership, where it refers to the desire to serve and sacrifice one's self-interests for the gain of others. Servant leadership is thus most effective in service-orientated organisations (Ekundayo, 2013), including healthcare. Servant leadership is well suited to

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leadership in healthcare because "health care providers' work and their life calling is to serve" (Trastek *et al.*, 2014, p. 380), and servant leaders are devoted to their service because of their calling (Wheeler, 2011). According to Schwartz and Tumblin (2002, p. 1426), the servant leadership model is necessary in healthcare organisations because such care "has an inherent servant nature".

Employee job satisfaction is as much a concern in the healthcare sector as it is in other business sectors (Rad and Yarmohammadian, 2006). Persistently low healthcare worker morale has been noted as a weakness in the management of healthcare in South Africa (Harrison, 2009). Alloubani *et al.* (2014) contended that the leadership style of a manager influences the job satisfaction of employees and several studies show this also to be the case in healthcare (Rad and Yarmohammadian, 2006). A study among professional nurses in South Africa revealed that those working in the public sector were generally dissatisfied, specifically with their pay, workload and available resources. Although nurses working in the private sector were generally satisfied, they were still dissatisfied with their pay and opportunities for career development (Pillay, 2009). Given that job satisfaction is an important part of ensuring high-quality healthcare and that dissatisfaction among healthcare workers leads to poor quality and less efficient service delivery (Pillay, 2009), the importance of addressing low levels of job satisfaction in the South African healthcare sector is highlighted.

Leadership is a concept that has been widely studied (Cunha and Manuela, 2013; Reed *et al.*, 2011), but little attention has been paid to leadership in healthcare (Nay *et al.*, 2014; Parkin, 2009) and not much is known about how medical leaders lead (Chapman *et al.*, 2014). According to Garber *et al.* (2009), servant leadership is particularly relevant to the healthcare context. Research suggests that practitioners who display servant and people-orientated styles are more effective (Chapman *et al.*, 2014; Jafai *et al.*, 2016). However, although, servant leadership appears to be a potentially useful style of leadership in healthcare, more research is needed on how it is perceived by those working in the field (Garber *et al.*, 2009). It is thus important to understand to what extent healthcare practitioners demonstrate servant leadership. Apart from enhancing the performance of healthcare practices, appropriate leadership could enable these practitioners to practise in a manner that demonstrates servant behaviour towards both their patients and employees. Furthermore, an increased understanding of leadership in healthcare settings, and of the personal characteristics evident among successful leaders in these professions, would make a significant contribution to leadership training in the field (Chapman *et al.*, 2014).

Against this background, the purpose of the current study is to investigate the influence of servant leadership on job satisfaction within private healthcare practices. More specifically, the following research question was posed: Does the level of *servant leadership* displayed by private healthcare practitioners influence the level of *job satisfaction* experienced by both the practitioners and their employees? To address this research question, the study draws on the needs theories of job satisfaction as well as on servant leadership theory. Of all the leadership theories, servant leadership most strongly emphasises the needs of others. Therefore, given the nature of healthcare and the needs of stakeholders, servant leadership is considered an appropriate leadership style for healthcare practitioners. In the current study, "servant leadership" refers to a healthcare practitioner displaying humility, servanthood, caring for others and striving to develop employees.

Inefficient leadership has been recognised as a weakness in the management of healthcare in South Africa (Harrison, 2009). This study contributes to an understanding of leadership and its inefficiencies among private healthcare practitioners in South Africa by examining the extent to which they practise servant leadership, and how this influences job

satisfaction in their practices. In addition, this study provides recommendations on how private healthcare practitioners can improve their servant leadership behaviour.

Literature overview and development of hypotheses

Job satisfaction

Job satisfaction has been studied in various disciplines and geographical areas over many years (Belias and Koustelios, 2014; Eyupoglu and Saner, 2009; Grigoroudis and Siskos, 2009). It is defined as the positive feeling or attitude that individuals have towards their jobs, that results from balancing their wants from a job with their expectations of it (Robbins and Judge, 2009; Werner, 2011). Buitendach and De Witte (2005, p. 28) contended that "job satisfaction has to do with an individual's perception and evaluation of his or her job". In this study, *job satisfaction* refers to an individual perceiving their involvement in a healthcare practice as rewarding, enjoyable, fulfilling and satisfying (Eybers, 2010; Farrington, 2009).

Job satisfaction is important because it influences organisational success (Voon *et al.*, 2011), enhances employee morale (Griffin and Ebert, 2003), creates enjoyable relationships with co-workers, promotes creativity and innovation (Bushra *et al.*, 2011) and encourages organisational citizenship behaviour (Nelson and Quick, 2013). In addition, job satisfaction leads to increased employee retention, lower levels of absenteeism, higher productivity and better quality service (Kusluvan, 2003). Satisfied employees are also more committed to their organisations (Jex, 2002).

Several theories have been proposed to understand job satisfaction and its antecedents. These theories can be categorised into process theories and needs theories (Amos *et al.*, 2008). The process theories of job satisfaction postulate that managers or leaders need to understand the process of motivation and know what to do to influence the choices individuals make in the process (Hellriegel *et al.*, 2012). The choices individuals make can be influenced by positive reinforcement of good behaviour (Skinner, 1969), treating them equitably (Adams, 1963), setting challenging but achievable goals (Locke, 1968) and meeting their expectations (Vroom, 1964). Needs theories emphasise the uniqueness of individuals based on their needs and values (Hellriegel *et al.*, 2012). Thus, a manager or leader must be aware of and satisfy the unique needs of employees. These needs can be categorised as lower-order needs (such as affiliation, job security, good remuneration and favourable working conditions) and higher-order needs (such as growth, achievement, esteem and self-actualisation) (Amos *et al.*, 2008). Furthermore, Hackman and Oldham's (1976) job characteristics model suggests that certain job characteristics (such as skill variety, task identity, task significance, autonomy and feedback), critical psychological states (such as experiencing meaningfulness of work, responsibility for work outcomes and knowledge of actual results) and high growth needs strength (i.e. desire for personal challenges, a sense of accomplishment and learning) are necessary to achieve personal and work outcomes (such as performance and job satisfaction).

The underlying assumption of the needs theories of job satisfaction is that when the needs of employees are met, job satisfaction occurs (Buitendach and De Witte, 2005). Similarly, the underlying assumption of servant leadership theory is that "if leaders focus on the needs and desires of followers, followers will reciprocate through increased teamwork, deeper engagement and better performance" (Burkus, 2010). Servant leadership theory emphasises the needs of followers more than any other leadership theory (Patterson, 2003) and is considered particularly relevant to the healthcare context (Garber *et al.*, 2009).

Servant leadership

The concept of servant leadership was introduced by Robert Greenleaf in 1970 (Van Dierendonck, 2011). Greenleaf envisioned a profound and seemingly counterintuitive notion that there exists a sense of leadership that arises from a natural yearning to want to serve first, and maintain a conscious choice to do so (Sendjaya *et al.*, 2008). On this basis, Greenleaf developed a leadership style where leaders focus their efforts on serving first and with skill, understanding and spirit, and where followers respond to capable servants assigned to lead them (Adjibolosoo, 2000, p. 79). Among the many leadership styles, servant leadership best represents the ideals embodied in the human factor (Daft, 2005; Doraiswamy, 2012). According to Page and Wong (2000), the human factor refers to "a spectrum of personality characteristics and other dimensions of human performance that enable social, economic, and political institutions to function, and remain functional over time".

Greenleaf (1970) described a servant leader as an individual with a desire to serve others and to make sure their needs are taken care of. Servant leadership is a style of leadership where the leader transcends self-interest to serve the needs of others, to help others grow and to provide opportunities for others to gain materially and emotionally (Daft, 2005). According to Page and Wong (2000), servant leadership "incorporates the ideals of empowerment, total quality, team building, participatory management and a service ethic into a leadership philosophy". A servant leader prioritises the needs of followers and ensures that they are served first (Day, 2014; Gopee and Galloway, 2013). They seek growth, improved health, increased wisdom and the liberation of followers (Greenleaf, 2012). Servant leaders also promote ethics, care for others and develop followers (Spears, 2010). They inspire followers by role modelling, and build relationships with them to attain goals (Baron, 2010). Servant leaders take responsibility for their followers and other stakeholders (Page and Wong, 2000) by offering them emotional support and showing them empathy (Jenkins and Stewart, 2013). Servant leadership emphasises the personal integrity and ability of a leader to serve others including employees, customers and communities (Liden et al., 2008).

Over time, Greenleaf's theory of servant leadership has increased in popularity, and standard leadership practices have rapidly begun to reflect the concepts associated with servant leadership (Spears, 2004). Despite this, however, there is no consensus on a definition or theoretical framework for servant leadership. Many interpretations have resulted, demonstrating a wide range of characteristics and behaviours (Van Dierendonck, 2011). Several of these frameworks are summarised in Table I.

From Table I, it is evident that a variety of attributes are used to describe servant leaders. Although the frameworks use different vocabulary for similar concepts, there are clear overlaps between the various attributes in the different frameworks (Kalshoven *et al.*, 2011; Van Dierendonck, 2011). Table I groups these attributes into six clusters; however, there remain "quite a number of different servant-leader attributes" (Van Dierendonck, 2011, p. 1232). Furthermore, the different frameworks describe servant leaders using different numbers of attributes. For example, Page and Wong (2000) measured twelve attributes of servant leadership, whereas Barbuto and Wheeler (2006) measured five, Liden *et al.* (2008) measured seven and Focht and Ponton (2015) measured eleven. Van Dierendonck (2011) further highlighted that all models have strengths and weaknesses.

For the purpose of this study, the framework of Page and Wong (2000) was adopted because it integrates the four main domains of leadership in general (personality, relationship, task and process) into a conceptual framework of servant leadership. The first domain relates to a character orientation (personality), which demonstrates a nurturing servant attitude and is associated with values such as integrity, humility and servanthood. The second domain refers to a people orientation (relationship), which aims for human

Table I.
Common attributes associated with servant leadership

Cluster	Laub (1999)	Page and Wong (2000)	Patterson (2003)	Spear (2004)	Ehrhart (2004)	Barbuto and Wheeler (2006)	Wong and Davey (2007)	Liden et al (2008)	Van Dierendonck and Nuijten (2011)	Mittal and Dorman (2012)	Focht and Ponton (2015)
Humility		Humility	Humility		Puts followers first			Putting subordinates first	Standing back, humility	Humility	Humility, serves others need before own
Inter-personal		Servanthood	Altruism, service			Altruistic calling					Service
	Values people	Caring for others	Agapao love, trust						Forgiveness		Values people, trust, caring, unconditional love
				Listening, empathy, healing		Emotional healing		Emotional healing		Empathy	Listening
					Relationships with followers						
Growth of people	Develops people	Developing others		Commitment to growth of people	Help followers to grow and succeed		Serving and developing others	Helping subordinates grow and succeed		Developing others	Learning
	Shares leadership	Empowering others, shared decision-making	Empowering others		Empowering followers		Consulting and involving others	Empowering	Empower-ment	Empowering others	Empowering
Authenticity	Displays authenticity	Integrity					Modelling integrity and authenticity		Authenticity	Moral integrity	Integrity
Provides direction	Provides leadership	Visioning, goal-setting, leading, modelling, team-building	Vision	Persuasion, conceptuali-sation, foresight	Demonstrate conceptual skill	Persuasion mapping	Inspiring and influencing others		Courage	Egalitarianism	

(*continued*)

Table I.

Cluster	Laub (1999)	Page and Wong (2000)	Patterson (2003)	Spear (2004)	Ehrhart (2004)	Barbuto and Wheeler (2006)	Wong and Davey (2007)	Liden et al (2008)	Van Dierendonck and Nuijten (2011)	Mittal and Dorman (2012)	Focht and Ponton (2015)
Steward-ship	Builds communities			Awareness, stewardship, building communities	Behave ethically, Create value for others outside the organisation	Wisdom, organisational stewardship		Creating value for the community, behaving ethically	Accountability stewardship	Creating value for the community	

Sources: Muller, 2017; Van Dierendonck, 2011

capital advancement, and is linked to values such as caring for, empowering and developing others. The third domain refers to a task orientation, which focuses on the attainment of business success and is related to visioning, goal-setting and leading. The fourth dimension is a process orientation, which pursues the improvement of organisational processes, and is associated with the values of modelling, team-building and shared decision-making (Page and Wong, 2000). Page and Wong's model distinguished between human-related attributes (personality and relationship) and those that are related to the organisation (task and process). In addition, Page and Wong's (2000) model is one of the first servant leadership models and it has been in use for several years (Van Dierendonck, 2011).

In striving to isolate the true nature of servant leadership and ensure model parsimony, only four of the twelve attributes from the model of Page and Wong (2000) were selected for investigation in this study. The attributes associated with task and process, namely, visioning, goal-setting and leading, as well as modelling, team-building and shared decision-making, are necessary for all types of leadership and are not specific to servant leadership. Similarly, empowering others (relationship) and integrity (personality) are the premise for all good leaders (Yukl *et al.*, 2013,, p. 38). For this reason, the aspects of servant leadership investigated in this study were humility, servanthood, caring for others and developing others. It is these aspects of servant leadership that embody the human factor of servant leadership and relate to the high-order needs of employees, in terms of the needs theories of job satisfaction (Amos *et al.*, 2008).

Van Dierendonck (2011, p. 1233) defined *humility* as the:

> Extent to which a leader puts the interest of employees first, facilitates their performance, provides them with essential support [. . .] [and] is willing to step aside so as to allow employees to work independently.

According to Van Dierendonck (2011), a servant leader with humility is modest and does not take credit for achievements. Such leaders prioritise and are open to the ideas of others, and provide others with support when needed (Thornton, 2004; Van Dierendonck, 2011). Humility requires courage for intentional vulnerability, and the surrendering of pride voluntarily for the benefit of others and the organisation (Sipe and Frick, 2009). Humility is a characteristic that influences leadership effectiveness (Sipe and Frick, 2009). According to Liden *et al.* (2008), *servanthood* characterises someone who prioritises serving others and makes personal sacrifices to do so (Page and Wong, 2003), who is aware of the needs of others and does everything possible to help them (Sendjaya, 2015). Servanthood develops a working environment that values employee feelings and empowerment (Liden *et al.*, 2008). *Caring for others* involves concern for the well-being and success of others (Daft, 2008; Liden *et al.*, 2008). Caring for others is also known as affection and entails expressing personal care, concern and support for other people (Ebener and O'Connell, 2010, p. 326). Caring leaders are those who take time to show empathy and listen to the personal issues of followers (Barbuto and Wheeler, 2006). Leaders who show a high level of concern and genuine interest in their followers build trust and commitment that motivate followers to exert more effort in the workplace for both their leader and the organisation (Ebener, 2010). *Developing others* involves providing assistance to improve performance in areas related to task effectiveness, community stewardship, self-motivation and future leadership capabilities (Liden *et al.*, 2008). Servant leaders have an interest in realising the career goals of others, and are genuinely concerned about the career growth of their followers (Liden *et al.*, 2008). A servant leader is actively involved in the development of others, which in turn assists in building organisational capabilities (Liden *et al.*, 2008; Page and Wong, 2003).

Although the vocabulary of Page and Wong (2000) was used in this study to label the attributes of servant leadership investigated, their measures were not used as is.

Servant leadership and job satisfaction

Several studies (Jaramillo *et al.*, 2009; Jones, 2012; Mehta and Pillay, 2011) provide empirical evidence of a positive relationship between servant leadership as a single construct and employee job satisfaction. Jaramillo *et al.* (2009) reported that servant leaders positively influence the working environment, strengthen a sense of shared values and ultimately increase job satisfaction. Mehta and Pillay (2011) maintained that servant leaders improve job satisfaction through cultivating a shared vision and values, working in teams and by motivating and empowering employees. Jenkins (2008) contended that a servant leader increases trust between leader and follower, which increases job satisfaction. Servant leadership increases not only the effectiveness of followers but also the effectiveness of leaders (Schmidt, 2013). Van Dierendonck (2011) concluded that servant leadership has the potential to foster employee engagement and flourishing organisations.

Numerous studies have also found a relationship between the individual dimensions of servant leadership and job satisfaction (Hajjaj, 2004; Jones, 2012; Mehta and Pillay, 2011). A study among municipal employees found positive relationships between service, humility and shared vision and employee intention to remain working for the organisation, which in turn was influenced by job satisfaction (Hajjaj, 2004). Similarly, Mehta and Pillay (2011) and Jones (2012) found positive relationships between authenticity, sharing leadership, valuing people, providing good leadership and employee job satisfaction. The following hypotheses are proposed:

H1. There is a positive relationship between the levels of (*a*) *humility,* (*b*) *servanthood,* (*c*) *caring for others* and (*d*) *developing others* displayed by private healthcare practitioners and the levels of *job satisfaction* experienced by them.

H2. There is a positive relationship between the levels of (*a*) *humility,* (*b*) *servanthood,* (*c*) *caring for others* and (*d*) *developing others* displayed by private healthcare practitioners and the levels of *job satisfaction* experienced by their employees.

Methodology

For the purpose of this study, a positivistic research paradigm was adopted and a quantitative approach used. The study used the survey methodology and was cross-sectional and deductive in nature. The population consisted of all private healthcare practitioners and their employees in the Eastern and Western Cape provinces of South Africa. The National Health Act No. 61 of 2003 defines a private health establishment as a "health establishment that is not owned or controlled by an organ of state". In addition, the Health Professions Council of South Africa (HPCSA, 2008, p. 8) defined a private practice as:

> The practice of a health practitioner who practises for his or her own account, either in *solus* practice, or as a partner in a partnership, or as an associate in an association with other practitioners, or as a director of a company established.

In this study, private healthcare practitioners are healthcare practitioners who own or control a healthcare practice for their own account. Private healthcare practitioners (also known as self-employed healthcare practitioners) include doctors, dentists and psychologists who are the owners of an independent trade, business or profession, and who

offer services to the public at a fee (Internal Revenue Services, 2014). Other private healthcare practitioners are pharmacists, midwives, nurses and other clinical professions (International Finance Corporation, 2010).

The researchers were unable to access a sample frame for the present study. Thus, purposive sampling was used to identify possible respondents. More specifically criterion sampling was used, which refers to a sample being selected based on certain criteria (Marlow, 2010). The following criteria were used in this study: the private healthcare practitioner had to own his or her own practice, the practice must have been in operation for at least one year and two or more full-time employees had to work in the practice. Individuals who were included in the employee sample had to be employed in a private healthcare practice that met the aforementioned criteria. The sample consisted of 400 private healthcare practitioners and their employees. Possible respondents were identified by fieldworkers and through local telephone directories. A total of 255 healthcare practitioners and employees participated. Only 241 questionnaires were deemed useable, comprising 117 healthcare practitioners and 124 employees. An effective response rate of 60.25 per cent was achieved. Based on the high response rate, non-response bias was not considered problematic, and the sample size was deemed adequate for performing the statistical tests (Hair *et al.*, 2014). However, care should be taken when attempting to generalise the result of this study to the population, as the ideal of 380 respondents was not achieved (Collis and Hussey, 2014).

Two separate, self-administered structured questionnaires were used to collect the data; one was distributed to private healthcare practitioners and the other to their employees. The two questionnaires contained the same statements but were phrased differently for the two sample groups. The questionnaires comprised 19 statements measuring the dimensions of servant leadership as displayed by the healthcare practitioner. The private practitioners were requested to indicate their extent of agreement with the statements describing their own servant leadership style. The employees were requested to indicate their extent of agreement with the statements describing their employer's (the practitioner's) servant leadership style. Examples of these statements are: "Does not seek recognition or reward in serving subordinates", and "Has a desire to serve others and takes time to talk to subordinates on a personal level". Four statements (items) were used to measure the *job satisfaction* of respondents. Examples include: "I experience my involvement in this practice as fulfilling," and "I enjoy working in this practice." The statements were anchored on a five-point Likert scale with (1) denoting *strong disagreement* and (5) denoting *strong agreement*. The items used to measure both the independent and dependent variables were sourced from existing studies and contextualised to the current study (Table II). These items were selected because they were cross-validated among these studies. In addition, satisfactory evidence of validity and reliability was provided.

Variables	Items	References
Humility	6	Page and Wong (2000)
Servanthood	5	Khuntia and Suar (2004), Barbuto and Wheeler (2006), Liden *et al.* (2008), Page and Wong (2000), Yukl, Mahsud, Hassan and Prussia (2013)
Caring for others	4	Barbuto and Wheeler (2006), Kalshoven *et al.* (2011), Liden *et al.* (2008), Page and Wong (2000)
Developing others	4	Liden *et al.* (2008), Page and Wong (2000)
Job satisfaction	4	Dua (1994), Eybers (2010), Farrington (2009)

Table II.
Source of scales

Both private healthcare practitioners and their employees responded – by means of self-reporting – to the independent and dependent variables at the same time, and from the same measuring instrument. As such, concerns relating to common method bias (Meade *et al.*, 2007) and social desirability bias were raised. Several procedural methods were implemented proactively to reduce the possibility of common method bias. The items on the scales were kept simple, specific and concise, and were constructed carefully to avoid ambiguity, vagueness and being double-barrelled (Podsakoff *et al.*, 2003). In addition, respondents were assured of anonymity and that no answers were right or wrong (Podsakoff *et al.*, 2003). Assurances of confidentiality were also provided and items were randomised in an attempt to reduce socially acceptable responses. Potential respondents were approached by fieldworkers and requested to participate in the study. Questionnaires were distributed in person to those who agreed, and when completed, were personally collected by fieldworkers.

STATISTICA 13 was used to perform the statistical analyses of the study. Factor analysis was used to conduct tests of unidimensionality to assess the validity of the various scales. Unidimensional constructs require a set of items to load onto the same factor (Saleh and Khine, 2011). The test of unidimensionality was deemed appropriate as all constructs used in this study are well supported in the literature (Table II) and the researchers intended to create summated scores for each respondent for each construct measured (Hair *et al.*, 2014). Cronbach's alpha coefficients were used to assess the degree of internal reliability of the scales used. Descriptive statistics were calculated to summarise the sample data, and multiple regression analyses were used to test whether the dimensions of servant leadership influence *job satisfaction*. The multiple regression analyses were conducted separately for the healthcare practitioners and their employees.

Empirical results

Sample description

The majority of the private healthcare practitioners who participated in this study were males (75.21 per cent), older than 40 years (76 per cent) and of the white population group (70.09 per cent). Most (28.20 per cent) indicated that they had owned their healthcare practices for 21 years or more. Another 24.79 per cent indicated that they had been running their own practices for five years or less. In terms of the characteristics of the healthcare practices, the majority employed 21 employees or more (28.21 per cent), followed by 24.79 per cent who employed five or fewer employees. The majority of healthcare practitioners who participated in the study were doctors (28.21 per cent), followed by pharmacists (17.95 per cent), optometrists (17.09 per cent), dentists (9.40 per cent) and physiotherapists (9.40 per cent). For the employee sample group, the majority were male (83.87 per cent) and were either 29 years old or younger (25.81 per cent), or between the ages of 40 and 49 years (25.81 per cent). Half of the employee participants were of the white population group (50.00 per cent), followed by coloured (25.00 per cent), black (16.94 per cent) and Asian (4.03 per cent). The majority of the employee respondents (70.17 per cent) indicated that they had worked for the healthcare practice in which they were currently employed for 10 years or less. From the employee sample group, the majority of the practices in which they were employed had five or fewer employees (66.10 per cent). The most prominent professions by whom the employees were employed were doctors (23.39 per cent), optometrists (20.97 per cent) and pharmacists (15.32 per cent). The remaining professions comprised physiotherapists (8.87 per cent), dentists (8.87 per cent) and psychiatrists (4.84 per cent).

Results of the validity and reliability analyses

All the items measuring the independent and dependent variables loaded together as expected (Table III). All factor loadings for the dimensions of servant leadership and *job satisfaction* were above the cut-off point of 0.5 (Hair *et al.*, 2010). All factors returned Cronbach's alpha coefficients greater than the lower limit of 0.7 (Nunnally, 1978). Satisfactory evidence of validity and reliability for the constructs was thus provided.

The operational definitions of the dependent and independent variables are summarised in Table IV.

Data description

Harman's single-factor test (Reio, 2010) was used as the *post hoc* statistical technique to assess the existence of common method bias. All the items measuring all the constructs were included in the analysis. A single factor emerged explaining 40.82 per cent of the variance in the data, well below the threshold of 50 per cent. This suggests that common method bias is not a matter of serious concern in this study. Although the usefulness of Harman's single-factor test has been questioned (Podsakoff *et al.*, 2003), alternative techniques also suffer from limitations and are not recommended until effectiveness has been shown (Conway and Lance, 2010).

Descriptive statistics

From Table IV, it can be seen that, for the dimensions investigated, *caring for others* returned the highest mean score for both the practitioner ($\bar{x}$ = 4.202) and the employee

Variables	Items	Minimum and maximum loadings	CAs
Humility	6	0.628-0.711	0.742
Servanthood	5	0.6680.784	0.779
Caring for others	4	0.764-0.839	0.802
Developing others	4	0.729-0.840	0.791
Job satisfaction	4	0.681-0.862	0.797

Table III. Validity and reliability results

Factor	Operationalisation
Humility	Refers to private healthcare practitioners stepping aside for someone better qualified, allowing others to take credit for performance, not seeking recognition or reward, learning from subordinates, celebrating the accomplishments of others and acknowledging their own dependency on subordinates
Servanthood	Refers to private healthcare practitioners making personal sacrifices for employees, prioritising employee interests ahead of their own, going beyond the call of duty to serve and help employees and showing a desire to serve others
Caring for others	Refers to when private healthcare practitioners genuinely care for the welfare of employees, can be approached to assist with their personal problems, take time to talk to them on a personal level and pay attention to their personal needs
Developing others	Refers to when private healthcare practitioners invest considerable time and energy in equipping employees to perform their duties, contribute to their personal growth, prioritise their career development and ensure that they reach their career goals
Job satisfaction	Refers to an individual perceiving their involvement in the healthcare practice as rewarding, enjoyable, fulfilling and satisfying

Table IV. Summary of operational definitions

sample groups ($\bar{x}$ = 4.000). The majority (89.74 per cent) of practitioners agreed that they displayed *caring for others*, as did the majority of employees (74.19 per cent). *Humility* returned the second-highest mean for the practitioners ($\bar{x}$ = 3.922), with the majority (73.50 per cent) agreeing with the statements measuring this construct. Employees, however, returned the lowest mean for *humility* ($\bar{x}$= 3.752), with only 65.81 per cent of this sample agreeing that their employers displayed *humility*. Private healthcare practitioners returned higher mean scores for *servanthood* ($\bar{x}$= 3.903) than employees ($\bar{x}$ = 3.898). They also returned higher mean scores for *developing others* ($\bar{x}$ = 3.915) than employees ($\bar{x}$ = 3.821). For both *servanthood* and *developing others*, the majority of practitioners and employees agreed with the statements measuring these dimensions. With regard to the dependent variable, practitioners returned a mean score of 4.380 and employees a mean score of 4.250 for *job satisfaction*. The majority of practitioners (94.02 per cent) and employees (88.71 per cent) agreed with the statements measuring *job satisfaction*.

Multiple regression analysis

Before performing the multiple regression analysis (MRA), variance inflation factors were calculated to determine the existence of multi-collinearity. Variance inflation factors of less than five were reported for all independent variables for both sample groups. Multi-collinearity was thus not considered a problem when estimating the multiple regression in the current study (Craney and Surles, 2002).

Residual analysis was performed to test the assumptions associated with undertaking MRA. Case-wise plots of the raw residuals and Cook's distance for both sample groups revealed that no outliers were present in the data. The normal probability plot of the residuals deviated slightly from a linear line, but the histograms of the residuals provided sufficient evidence of normality. To test for autocorrelation of the residuals, Durbin–Watson tests were performed. These tests produced Durbin–Watson statistics of 1.956 for the practitioner sample and 2.071 for the subordinate sample, providing support that autocorrelation was not present (Mendenhall and Sincich, 2003). To test the assumption of equal variances, a scatterplot of the raw residuals relative to each independent variable was created. This process revealed that the variance of the residuals was somewhat evenly distributed, thus confirming the assumption of equal variances. Given that the global *F*-test's *p*-values were significant ($p < 0.000$), the multiple regression models for both the practitioner and employee sample groups were considered adequate for prediction purposes.

The results of the MRA for the practitioner sample indicate that the independent variables (*humility, servanthood, caring for others* and *developing others*) explained 31 per cent of the variance in *job satisfaction* for private healthcare practitioners (Table V).

A significant positive relationship (beta = 0.260; $p < 0.05$) was found between *developing others* and *job satisfaction*. Significant relationships were not found between the other independent variables and *job satisfaction*. Although insignificant, it is interesting to note that *humility* had a negative relationship with *job satisfaction*. Support is thus found for the hypothesised relationships between *developing others* (*H1d)* and *job satisfaction* for the healthcare practitioner sample. However, support is not found for the hypothesised relationship between *humility* (*H1a*), *servanthood* (*H1b*), *caring for others* (*H1c*) and the dependent variable *job satisfaction*.

In Tables VI and VII, the results of the MRA for employees indicate that the independent variables explained 47.97 per cent of the variance in *Job satisfaction*. A significant positive relationship can be seen between *caring for others* (β = 0.197; $p < 0.05$) as well as *developing others* (β = 0.329; $p < 0.05$) and the dependent variable, *job satisfaction*. No significant relationships were reported between the independent variables, *humility* and *servanthood,*

Variables	Mean	SD	Disagree %	Neutral %	Agree %
Humility					
Practitioners	3.916	0.506	0.000	26.496	73.504
Employees	3.752	0.638	2.419	32.258	65.323
Servanthood					
Practitioners	3.903	0.506	0.000	34.188	65.812
Employees	3.898	0.686	2.419	25.806	71.774
Caring for others					
Practitioners	4.202	0.517	0.000	10.256	89.744
Employees	4.000	0.731	4.032	21.774	74.194
Developing others					
Practitioners	3.915	0.523	0.000	26.496	73.504
Employees	3.821	0.726	3.226	29.032	67.742
Job satisfaction					
Practitioners	4.380	0.501	0.000	5.983	94.017
Employees	4.250	0.604	0.806	10.484	88.710

Note: Bold = $p < 0.05$

Table V.
Descriptive statistics

Independent variables	Dependent variable: job satisfaction $R^2 = 0.310$ Beta	*t*-value	Sig. (p)
Intercept	*1.900*	*5.149*	*0.000****
Humility	−0.044	−0.391	0.697
Servanthood	0.208	1.941	0.055
Caring for others	0.195	1.868	0.064
Developing others	*0.260*	*2.298*	*0.023**

Notes: *$p < 0.05$; **$p < 0.01$; ***$p < 0.001$

Table VI.
Influence of independent variable on job satisfaction – practitioners

Independent variables	Dependent variable: job satisfaction $R^2 = 0.477$ Beta	*t*-value	Significance (p)
Intercept	*1.843*	*7.323*	*0.000****
Humility	−0.033	−0.278	0.782
Servanthood	0.125	1.041	0.300
Caring for others	*0.197*	*2.014*	*0.046**
Developing others	*0.329*	*3.057*	*0.003***

Notes: *$p < 0.05$; **$p < 0.01$; ***$p < 0.001$

Table VII.
Influence of independent variables on job satisfaction – employees

and *job satisfaction*. Even though the relationship was insignificant, it is noted that *humility* ($\beta = -0.033$) again returned a negative relationship. Support is thus found for the hypothesised relationships between *caring for others* (*H2c*) and *developing others (H2d)*, and *job satisfaction* for the employee sample. However, support was not found for the

hypothesised relationship between *humility* (*H2a*) and *servanthood (H2b*) and *job satisfaction*.

Discussion

The findings of this study show that the majority of private healthcare practitioners agreed that they displayed the dimensions of servant leadership investigated. The majority of employees also agreed that the private healthcare practitioners for whom they worked displayed these dimensions in their leadership. Worth noting is that both sample groups returned the highest mean for *caring for others*. This finding is in line with the literature that suggests that leaders who display servant behaviour care about the well-being and the success of their followers (Daft, 2008; Liden *et al.*, 2008). It can be concluded that the private healthcare practitioners participating in the current study are practising servant leadership, with *caring for others* being particularly evident.

The findings show that the more private healthcare practitioners perceive themselves as *developing others* by investing time and energy into equipping their employees and contributing to their employees' personal growth, as well as prioritising their employees' career development and ensuring that they reach their career goals, the more practitioners perceive their own involvement in the healthcare practice as rewarding, enjoyable, fulfilling and satisfying. Whether or not they perceive themselves as displaying *humility, servanthood* and *caring for others*, it has no influence on their experience of involvement in their practice as satisfying. When developing others, the outcomes of personal growth and career goal achievement, such as the additional qualifications and promotions achieved by employees, are tangible, visible and long-lasting. Such tangible outcomes are more likely to contribute to practitioners' feelings of satisfaction than are acts of humility, self-sacrifice or caring for others, which as such do not result in tangible outcomes and are often short-lived. In the context of Hackman and Oldham's (1976) job characteristics model, outcomes that are tangible, visible and long-lasting are more likely to fulfil private healthcare practitioners' need for job meaningfulness and ultimately their job satisfaction, than are outcomes which are neither tangible nor visible.

The findings show that the more private healthcare practitioners are perceived by their employees as *caring for others*, the more their employees will experience their own involvement in the healthcare practice as satisfying. This finding is supported Mehta and Pillay (2011) who also found a positive relationship between dimensions relating to valuing others and *job satisfaction*. Furthermore, the more private healthcare practitioners are perceived by employees as leaders who develop others (*developing others*) the more employees will experience job satisfaction working in the healthcare practice. Similarly, Mehta and Pillay (2011) concluded that servant leadership improves *job satisfaction* through empowering employees. However, whether or not private healthcare practitioners are perceived by employees as displaying *humility* and *servanthood*, it has no influence on employees experiencing job satisfaction. These findings contradict those of Hajjaj (2004), who reported positive relationships between humility and service (*servanthood*), and job satisfaction. Different contextual settings could account for the findings in the current study not supporting those of Hajjaj (2004). Hajjaj's sample consisted of municipal workers in a public institution, whereas the current sample consisted of healthcare workers in private institutions.

Both *caring for others* and *developing others* are practitioner behaviours that are experienced physically and/or emotionally by their employees. Opportunities are made available to employees by their healthcare employer to grow and develop careers, and attention is given to their personal needs. As such, employees can take advantage of these

opportunities to advance themselves and a sympathetic ear is available. *Humility* and *servanthood*, however, are behaviours that are not necessarily experienced or seen by employees. The extent to which a healthcare practitioner steps aside for someone else or makes personal sacrifices may be evident to practitioners but less so to employees. The needs theories of job satisfaction are validated in the context of the current study. By fulfilling both affiliation (*caring for others*) and growth needs (*developing others*), job satisfaction is experienced by healthcare employees.

Developing others was found to be most influential on the level of job satisfaction of healthcare employees. Although being genuinely cared for and having an approachable employer are important to job satisfaction, one could argue that for most employees, the likely increase in responsibility and remuneration, as well as personal growth, resulting from an enhanced career, is more important. The job characteristics theory supports this argument, in that by fulfilling the growth needs of employees, task significance and meaningfulness of work are enhanced, leading to greater levels of job satisfaction.

Managerial implications

Given the results of this study, private healthcare practitioners should continually improve their servant leadership style by specifically investing time and energy into providing growth opportunities for their employees. They can achieve this by identifying the skills gaps of employees and investing in relevant skill development training. Private healthcare practitioners could also delegate managerial and leadership roles to employees to develop their skills and accountability. They should also ensure that clear career paths are available in their practices. They could prioritise their employees' career development by mentoring them in their career development journey and providing support for further studies. Through meeting the growth needs of their employees, healthcare practitioners themselves will experience more meaningfulness in work, and subsequently higher levels of job satisfaction. As supported in the literature, heightened levels of job satisfaction for both practitioners and their employees could result in achieving personal and work outcomes.

Private healthcare practitioners should genuinely care for the welfare of subordinates and be approachable to assist with their employees' personal problems. They can achieve this by showing empathy when employees face personal or work-related pressures. Private healthcare practitioners should be emotionally intelligent, able to understand how employees feel and able to sympathise and give advice. They could also attend training courses that will enhance their listening and communication skills. Private healthcare practitioners need to take time to talk to employees on a personal level. To do this, they should be approachable and practise an "open door" policy. They should be sensitive to the personal concerns and well-being of the employees and should respect confidentiality. The result will be the building of trust between the practitioner and the employee.

Servant leadership presents many advantages for healthcare practices and for society in general. Given its positive influence on job satisfaction, servant leadership could play a noteworthy role in providing better-quality services in the healthcare sector. As suggested by Ebener and O'Connell (2010), servant leaders add value to their communities by enhancing the service that is offered for the benefit of their communities. Furthermore, servant leadership promotes organisational citizenship and helping behaviour in general (Roberts, 2015). However, Ekundayo, (2013) and Smith (2012) pointed out that servant leadership can also be regarded as a simplistic, idealistic and naive leadership style. A servant leader can be misused and exploited by people taking advantage of the kindness of such a leader (Ekundayo, 2013; Smith, 2012). Private healthcare practitioners should take cognisance of the aforementioned.

Contribution and limitations

Leadership is considered important for an effective healthcare system (Curry *et al.*, 2012), but only limited research has been conducted in healthcare leadership (Curry *et al.*, 2012). This study has made a contribution to the existing body of knowledge on leadership, particularly servant leadership within a healthcare context. Items from several authors were used to develop the scales adopted in this study. The validity and reliability assessments provide further support for these scales in future studies. The findings of this study have provided insight into the level of servant leadership as well as the influence of this leadership style on job satisfaction. As such, it can be used by educators, trainers and advisors to identify gaps in the leadership of healthcare practitioners, which can be addressed with appropriate education interventions. Healthcare regulators such as the HPCSA could also make use of the findings and recommendations of this study to implement appropriate interventions to ensure that healthcare practitioners fulfil their mandate of practising in an appropriate manner.

Despite these contributions, several limitations need to be highlighted. The study was based on individual responses of private healthcare practitioners and employees. Social desirability bias presents a problem, as the respondents may inflate their responses to be socially acceptable. Social desirability bias affects the validity and the reliability of the results (De Jong *et al.*, 2010; Kim and Kim, 2013; Zikmund and Babin, 2012). Generalisation of the results was limited to private healthcare practitioners included in the sample. The majority of private healthcare practitioner respondents were of the same demographic profile (gender, age and ethnicity). This does not provide appropriate representation for the entire population of private healthcare practitioners in South Africa. Another limitation to the study is that the research conducted focused on healthcare practitioners who owned smaller practices. Larger private healthcare firms such as private hospitals, private clinics and large pharmaceutical companies facing leadership challenges were not included. This study investigated only four attributes of servant leadership. Given the wide range of characteristics and behaviours associated with servant leadership (Van Dierendonck, 2011), other attributes should be investigated in future studies.

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