3 Leadership, job satisfaction and nurses’ commitment

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Introduction
The main issue addressed in this chapter concerns the relationship between managerial practices on the one hand and nurses’ job satisfaction and commitment on the other hand. Assessment of managerial practices and their implications in terms of commitment and job satisfaction appear to be of theoretical and empirical relevance with regard to the performance of employees in the nursing sector.

Leadership, job satisfaction and commitment are closely interrelated. Job satisfaction and commitment are immediate antecedents of intention to leave the workplace and turnover: the higher a nurses’ job satisfaction and commitment, the lower their intention to leave. Among antecedents of job satisfaction and commitment, leadership plays a central role, along with other human resource management practices. Leadership is positively correlated with nurses’ job satisfaction and with commitment towards the institution and its missions (Dunham-Taylor, 2000; Stordeur et al., 2000; Morrison et al., 1997). In the figure below commitment is portrayed as a mediator influencing job satisfaction (Currivan, 1999).

Moreover, leadership has further major implications in the hospital production process: numerous studies demonstrate that sister nurses adopting active leadership behaviours urge nurses to achieve higher standards of quality and to do more than they originally thought to be able to (Stordeur et al., 2000).

Figure 1. Model on relationships between leadership, commitment and job satisfaction.
Leadership

Despite the multitude of ways in which leadership has been conceptualised, the following definition of leadership can be proposed: *leadership is a process whereby an individual influences a group of individuals to achieve a common goal* (Northouse, 1997). The main challenges for leaders are to build a long-term vision, to increase commitment, to build teams and coalitions in order to create required organisational changes. In order to reach their goals they should focus on motivating, inspiring and empowering their employees.

In work settings, the supervisor is often the most salient person and is therefore likely to both represent the organisation's culture and to exert a direct influence upon subordinates’ behaviours. Superiors who enable employees to participate more in decision making and who encourage a two-way communication process tend to generate a favourable climate among their nursing team, characterised by less interpersonal conflict and hostility and fewer non-cooperative relationships (Stordeur et al., 2001). This managerial style can be typified as transformational leadership. On the other hand, assigning tasks, specifying procedures, and clarifying expectations have been shown to result in reduced role ambiguity and increased job satisfaction among employees. Leaders who are perceived to closely monitor their nurses in order to prevent mistakes tend to evoke higher levels of emotional exhaustion among their staff (Stordeur et al., 2001). It is likely that in many circumstances close control by the sister nurse is perceived as an additional pressure to the high work pressure nurses already face. Moreover, close monitoring may be perceived as a lack of trust in the nursing staff. Emotional support and adequate feedback provision about nurses’ performance would be a better strategy and may lead to an increase in nurses’ self-esteem.

Job satisfaction

Job satisfaction is generally defined as an employee’s affective reaction to a job, based on comparing actual outcomes with desired outcomes. It is generally recognised as a multifaceted construct that includes employee feelings about a variety of both intrinsic and extrinsic job elements. Employees expect their job to provide an accumulation of features (e.g., pay, promotion, autonomy) for which the employee has certain preferential values. The range and importance of these values vary across individuals, but when the accumulation of unmet expectations becomes sufficiently large, job satisfaction is lower, and there is a greater probability of withdrawal behaviour (Pearson, 1991).

Numerous factors influence job satisfaction, including: clinical duty/service and type of work, nursing care delivery model, degree of professionalism, organisational climate, supervision and interpersonal relationships, status, autonomy, repetition of duties, the nature of tasks to be performed, job outcomes
and pay (Hinshaw & Atwood, 1984). Irvine and Evans (1995) have also underlined the importance of work characteristics (routine, autonomy, and feedback), characteristics of how the work role is defined (role conflict and role ambiguity) and characteristics of the work environment (leadership, stress, advancement opportunities and participation) in relation to nurses’ job satisfaction. In the Davidson et al. study (1997), effective communication patterns contributed favourably to perceptions about quality of care, time available to accomplish work demands, and overall enjoyment of the job. Studies investigating relationships between type of nursing care delivery and nurses’ satisfaction report low correlations between these two variables (Kangas et al., 1999). The process of implementing a nursing care delivery model is more important than the model itself.

Nurses’ satisfaction is positively linked to patients’ satisfaction (Leiter et al., 1998) and to quality of care (McNeese-Smith, 1995). Dissatisfaction at work leads to absenteeism, expression of grievances, and turnover. Unsatisfied workers report a higher intent to leave, the influence of job satisfaction being as powerful as that of wages (Clark, 1998).

**Nurses commitment**

**Organisational commitment.** The various views on organisational commitment seem to reflect three general components: affective attachment to the organisation (affective commitment), perceived costs associated with leaving the organisation (continuance commitment), and feelings of obligation to the organisation (normative commitment) (Allen & Meyer, 1990). Although each of these components increases the likelihood that the employee will choose to remain within the organisation, the nature of these psychological ties differs from one another. *Affective commitment* refers to the degree to which the employee identifies with, is involved in, and is emotionally attached to the organisation. Affectively committed employees believe in the goals and values of the organisation and enjoy being a member of it. Employees with strong affective commitment remain with the organisation because they *want* to do so.

*Continuance commitment* refers to the degree to which the employee recognizes that costs associated with leaving the organisation tie him or her to the organisation. Such employees remain within the organisation because they *have* to do so. *Normative commitment* refers to the degree to which the employee feels an obligation to the organisation; staying within the organisation is the right and moral thing to do. Employees remain within the organisation because they feel they *ought* to do so (normative commitment will not be investigated in NEXT-Study). All components of commitment are positively related to the decision whether to stay or leave the organisation.
Professional commitment. Commitment to one’s profession has not been studied as extensively as organisational commitment. However, it has been found to be an important component of different types of work-related commitment of nurses (Cohen, 1998). Gardner (1992) emphasised the importance of occupational commitment in nursing because it relates to the attractiveness of nursing as a lifelong occupational choice and valued career option.

The terms 'professional', 'occupational' and 'career commitment' have been used somewhat interchangeably in the literature. Recent research supports a three-dimensional construct of professional commitment that is similar to the one for organisational commitment. According to Meyer et al. (1993), the nature of the person's involvement in the occupation might differ depending on which form of commitment is predominant. A person who is affectively committed may, for example, keep up with developments in the occupation (e.g. by subscribing to trade journals or attending conferences), or join and participate in relevant associations. Individuals who have a strong continuance commitment may, in contrast, be less inclined to involve themselves in occupational activities besides those required to continue membership (Meyer et al., 1993).

Professional commitment is argued to be an even stronger determinant of nurses' turnover than commitment to the organisation and work (Mueller et al., 1992). Lacking professional commitment has been found to be associated with intention to leave the nursing profession in several studies (Bedeian et al., 1991; Cohen 1998), and also with intention to leave the organisation (Cohen, 1998).

Methods
Leadership instrument
Leadership quality was measured with 4 items from the COPSOQ (Copenhagen Psychological Questionnaire). These items concerned how nurses perceive the way their immediate superiors make sure that the individual member of staff has good development opportunities, give high priority to job satisfaction, are good at work planning and at solving conflicts. A high score for this scale indicates a high quality of leadership. The rating scale is a five-point one.

Job satisfaction instrument
The job satisfaction scale was composed of 4 items of the COPSOQ. These items pertain to the way in which employees are satisfied with their work prospects, their physical working conditions, the way their abilities are used, and finally their job as a whole; everything is taken into consideration. A high score for this scale indicates that people are extremely pleased with their job. The rating scale is a five-point one.

Organisational commitment and professional commitment were both measured with a four item job commitment scale adapted from Allen and Meyer.
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(1990). All items reflected the affective dimension of commitment (i.e. ‘I really feel that I belong to this institution/to the nursing profession’). Answers were recorded on a five-point scale (1=totally inaccurate and 5=totally accurate). High scores indicate a strong commitment to the organisation and to the profession.

Data analysis
Data analysis was conducted with SPSS 11.0. Means comparisons were carried out using ANOVA, proportion comparisons with Chi² test.

Table 1. Response rates for the measurement instruments 'leadership', 'job satisfaction', 'organisational' and 'professional commitment' per country. (r.rate = response rate)

<table>
<thead>
<tr>
<th>Country</th>
<th>leadership scale n</th>
<th>n</th>
<th>r.rate</th>
<th>job satisfaction scale n</th>
<th>n</th>
<th>r.rate</th>
<th>organisational commitment scale n</th>
<th>n</th>
<th>r.rate</th>
<th>professional commitment scale n</th>
<th>n</th>
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<td>4,101</td>
<td>96.3</td>
<td>4,188</td>
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<td>4,185</td>
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<td>4,181</td>
<td>98.2</td>
<td></td>
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<td>D</td>
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<td>3,484</td>
<td>97.7</td>
<td>3,525</td>
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<td>3,476</td>
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<td>FIN</td>
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<td>3,909</td>
<td>98.5</td>
<td>3,935</td>
<td>99.1</td>
<td>3,926</td>
<td>98.9</td>
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<td>-</td>
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<td><strong>89.2</strong></td>
<td><strong>37,885</strong></td>
<td><strong>97.6</strong></td>
<td><strong>34,656</strong></td>
<td><strong>89.3</strong></td>
<td><strong>34,610</strong></td>
<td><strong>89.2</strong></td>
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Results

Leadership

Leadership quality was more positively evaluated in Great-Britain, Belgium, Germany and Slovakia, compared with the other participating countries, particularly in Poland and Italy. Nevertheless, the two highest score categories (4 and 5) were not used in most cases; nurses were merely “more or less” satisfied with their superior’s abilities to plan teamwork, to solve conflicts, to give priority to nurses’ development and to job satisfaction.
Moreover, leadership quality appears to vary with work setting; it was more positively rated in home/residential care (m=3.52) compared with nursing homes (m=3.28) and hospitals (m=3.20). Nurses having a higher level of training considered the leadership quality of their superiors (m=3.24) worse compared with their counterparts that had no qualification or a low training level (m=3.33). The difference between males and females was not significant.

Finally, nurses who had often thought about leaving reported low quality of leadership. In Figure 3 the pattern is visualized.

Discussion leadership
Firstly, it is interesting to note that there were more missing values for the leadership scale in comparison with the other scales, probably because respondents are reluctant to give their opinion about their immediate superior by fear of reprisals (Stordeur et al., 2001).

In our European sample, English, Belgian, Slovakian and German nurses reported a significantly higher leadership quality compared with Polish and Italian nurses. Our results reflect differences in the development of nursing
leadership in European countries that may be explained by a constellation of historical and structural factors, by nursing training and corporate culture. In the health care system, the evolution of values, structures and professions is very slow and may vary among countries (Genevieve, 2003).

Leadership abilities of sister nurses were perceived differently according to the work setting. Our outcomes are supported by a study of Leatt and Schneke (1982) who found that structure, size, technology, internal and external environments can influence health care workers’ attitudes and behaviour. The different manners in which the workplace and teamwork are organised might explain our results. When providing home/residential care, for example, nurses work more independently without the permanent control of sister nurses who naturally have to delegate a part of the organisation and coordination of nursing care. Consequently, nurses can feel empowered, having better control over their activity: their perception of leadership quality will be higher under these circumstances.

Highly qualified nurses evaluate the leadership quality of their superiors less positively. Moreover, further training also raises nurses expectations towards their superiors and of the work context in which they evolve (Sheridan et al., 1984). The fact that specialised nurses prefer to work in hospitals might partly account for the previously mentioned outcomes regarding the relatively low evaluations in hospital settings.

Except in Poland, sister nurse leadership is positively related to job satisfaction (r=.38) and to affective commitment towards the organisation (r=.33) and negatively associated to intent to leave (r=−.25). In Poland, leadership quality is not associated with these outcomes.

**Job satisfaction**

*Figure 4. Mean scores for job satisfaction by country. Possible range 1 (low) to 4 (high)*

Substantial differences between the participating countries have been found with respect to job satisfaction. The overall scores may hide more specific information
about potential sources of dissatisfaction. Indeed, we found the lowest score in all countries for 'satisfaction with psychological support' and for 'satisfaction with physical working conditions' and the highest score for 'use of abilities' (DE, BE, FIN, FR, N, SLK) or 'satisfaction with the job as a whole' (IT, NL). In Poland, the high dissatisfaction scores were obtained to 'use of abilities' (m=2.46) and 'opportunity to give to patients the care they need' (m=2.47). Another remarkable result was the low 'satisfaction with work prospects' in Germany and Slovakia (m=2.34 and m=2.23).

Womens’ job satisfaction was found to be significantly higher (m=2.65; n=33,809), compared with men (m=2.55; n=3,967). As regards differences according to age and seniority, we observed a curvilinear relationship: scores were higher for the lowest and highest ages and seniority ranges and lower after 5 to 10 years of experience, which corresponds to an age of 30.

Job satisfaction appeared to vary with work setting: job satisfaction was higher in home/residential care (m=2.81) than in nursing homes (m=2.65) and in hospitals (m=2.58). The dimension 'satisfaction with working conditions' particularly contributed to the differences.

Except for the nursing personnel who had no qualifications in nursing, job satisfaction decreased slightly as educational level increased.

Sister nurses represented 11% of our sample, and deputy nurses 10%. Job satisfaction appeared to increase with hierarchical level, sister nurses and deputy nurses being the most satisfied nurses (m=2.80), and staff nurses the least satisfied (m=2.59).

Finally, there was an obvious relationship between job satisfaction and intent to leave. The lower the satisfaction, the higher the intent to leave.

Figure 5. Mean scores for job satisfaction by intent to leave. Possible range 1 (low) to 4 (high)
Discussion job satisfaction

As expected for health service employees (Tumulty et al., 1994), poor levels of job satisfaction were reported in our European nursing sample. The rather low job satisfaction level can be mainly attributed to the physical working conditions, as observed previously (De Troyer, 2000), but also by the low social support obtained. The nursing occupation is physically demanding as the handling of heavy loads is often involved (moving, repositioning and lifting patients), but also due to the movements and postures that are expected in many work situations. Moreover, in many occasions, the work environment is not well adapted (transformable beds, internal transport of patients, bad architectural structure of the ward, etc). Differences in job satisfaction between countries might be due to differences in working conditions. According to De Troyer, equipment which assists in the handling of patients does exist in Belgium, Denmark, France, the Netherlands, and the United Kingdom, but only in some hospitals.

The design and organisation of the job sometimes imply that many physically demanding tasks are carried out alone and without mechanical assistance for a number of reasons (lack of time at some points of the day, lack of information about patients’ degree of independent motion, stretcher-bearers not available, and so on).

Strikingly, German nurses reported poor satisfaction with work prospects. In fact, even though federal law regulates basic training for nurses, post basic nurse education is left to the 16 federal states. This has resulted in different 16 federal states recognizing different types of specialization. Moreover, the qualification as a specialist nurse does not guarantee any particular competence and work domain to these nurses, except for the nursing teacher. These two aspects of German post-basic training and lack of a specific area of competence for specialist nurses may discourage nurses to continue their training leading to poor satisfaction with work prospects.

Differences in job satisfaction between men and women have to be interpreted according to the low proportion of men in our sample; a high proportion of them were Italian nurses who were particularly unsatisfied with their job. On the one hand, these differences could be explained by differences in professional aspirations. Women’s lower expectations are likely to result from their poorer position in the labour market but also from their higher investment in family sphere. The basis for this argument is the finding that individuals tend to evaluate experiences relative to some kind of norm or reference level (Clark, 1997). Moreover, satisfaction with ones use of abilities was also lower for men, which can reflect unease with the traditional image of nurses (mother’s role and patient dedication) as well as a clash between what men do as nurses and what they think they should do to progress in their career. On the other hand, male nurses
are stereotyped as lazy or as non-achievers who chose nursing rather than medicine, engineering or other "masculine" professions (Chung, 2000). Some male nurses feel that higher performance standards are required from them compared with their female colleagues and that peers may resent them having a traditionally female role (Farella, 2000). One of the misconceptions is that men are not capable of being nurses, nursing being a "woman's job". These unfair misconceptions make it difficult for men to find satisfaction in the nursing profession.

The U-formed relationship between age, seniority and job satisfaction requires two interpretations. Among younger nurses, a higher level of satisfaction may be due to the fact that inexperienced nurses have less responsibilities, less pressure, less demands from colleagues, doctors and the sister nurse. They may also be less exposed to work-to-family conflicts. Among older nurses, higher satisfaction could be explained by a better knowledge of nursing, by benefits linked to seniority (schedules, salary), and by less external demands. It is also possible that older nurses refocus their priorities to factors outside the work setting, such as family and planning for retirement. Nurses older than 50 years of age may also be more able to favourably assess what is possible and available today in the nursing profession as compared to previous years (Ingersoll et al., 2003). In our cross-sectional study, we cannot rule out selection mechanisms: dissatisfied nurses may have already left the profession.

In accordance with Blegen’s meta-analysis (1993), satisfaction is lower among nurses with a higher level of training. As suggested by Price and Mueller (1981), a higher level of training may lead to dissatisfaction if organisational constraints hinder the use or the further development of acquired knowledge and abilities, while these nurses have higher expectations towards management. The amount of dissatisfaction may worsen if they realise that they have no access to opportunities where they could use these abilities.

As expected, satisfaction was higher among nurses with higher occupational positions. This can be attributed to having more control over the job, more decision latitude, along with a more central position between nursing staff and other healthcare professionals (esp. the physicians), a valued position within nursing hierarchy, and more social recognition.

Finally, job satisfaction was higher among nurses working in home/residential care compared with those working in old people homes and hospitals. This could be explained by the characteristics of home care which ensures higher autonomy, higher job control and a narrow, rewarding, relation with chronic patients. Parallel, home care nurses do not experience the tremendous pace and administrative burden that hospital nurses do experience.
Commitment
In this section, the affective dimension of both organisational and professional commitment according to different characteristics of the respondents and according to type of health care institution will be described.

Figure 6. Mean scores for commitment by country. Possible range 1 (low) to 5 (high)

In each country, professional commitment was significantly higher than organisational commitment (paired samples t-test; p<.0001). Indeed, in practice, we observed that nurses can change easily from one health care institution to another without leaving the nursing profession. Although the amount of professional commitment was highest in France, the highest organisational commitment score was seen in Finland.

Figure 7. Mean scores for commitment by setting. Possible range 1 (low) to 5 (high) (out-patient care in Finland and Poland)
Figure 7 shows that both organisational and professional commitment varied between the different types of healthcare institutions. Organisational commitment seemed to be higher in nursing homes and home care compared with the score for hospitals, while the highest professional commitment was found in nursing homes/out-patient care.

Figure 8. Mean scores for commitment by gender. Possible range 1 (low) to 5 (high)

For both types of commitment, the scores for men were lower compared with the scores for women (p<.0001). Please note that nurses having a seniority of up to 1 year reported a higher amount of commitment towards their institution and their profession (Figure 9).

Figure 9. Mean scores for commitment by seniority. Possible range 1 (low) to 5 (high)
The association between intent to leave and the two commitment types is clear (Figure 10). As the frequency in thinking of leaving the profession increased, both levels of organisational and professional commitment decreased.

Figure 10. Mean scores for commitment by intent to leave. Possible range 1 (low) to 5 (high)

Finally, it is of interest to pay attention to the positive relationship between leadership quality and affective commitment (towards institution: \( r = .29; p < .0001 \); towards profession: \( r = .14; p < .0001 \)), and between job satisfaction and affective commitment (towards institution: \( r = .35; p < .0001 \); towards profession: \( r = .18; p < .0001 \)). The relationship between affective commitment and intent to leave was negative (\( r = -.33 \) for commitment towards institution; and \( r = -.38; p < .0001 \) for commitment towards profession).

Discussion commitment
The relatively higher scores for professional commitment can be accounted for by the high degree of dedication and motivation that nurses have towards their profession and their patients. Lowest levels of professional commitment can be found in Great-Britain, Germany, and the Netherlands. This may be due to the fact that nurses, in spite of their devotion towards their job, obtain low recognition and rewards from sister nurses, doctors, and administrators.

Organisational commitment scores are lower in comparison with the scores for professional commitment. This result is important because, in practice, we observe that nurses easily change from one health care institution to another without leaving the nursing profession. The high need for qualified nurses enables them to change frequently and easily but it aggravates the feeling of shortage and the quality of care (continuous recruitment, socialisation of nurses to ward/organisation habits etc.).

Commitment towards smaller organisations such as nursing homes is higher than towards larger institutions (e.g. hospitals), where doctors’ decisiveness is more dominant and the organisation is more bureaucratic and hierarchical. The highest scores for professional commitment can be found in nursing homes,
where prolonged and continuous care is needed. In this work setting, the amount of opportunities to take care for patients’ welfare are higher. This matches the task orientation of nurses, which seems to be based on the fundamental concern for patient welfare (Borghans & De Steur, 1999).

It should not be surprising that men obtain lower scores for the two types of commitment than women, probably because men attribute more importance to professional and social success (even if this success implies leaving the organisation, or even the profession). Besides, nursing is still regarded as a female profession (except for Italian male nurses).

Scores on commitment controlled for seniority shows that, as expected, nurses having worked for up to one year express higher commitment levels. Affective commitment develops mainly in earlier stages of one’s career. Later on, affective commitment can be high as well, but combined with other types of commitment (like continuance commitment for example). Here too, professional commitment scores higher than organisational commitment. At the beginning of their career, people identify more with their profession and to a lesser degree with the organisation in which they work.

The relationship between both organisational and professional commitment and intent to leave the profession is clear. As commitment influences levels of satisfaction, it is of significance to be monitored in order to prevent premature leaving of nurses. More detailed analysis is needed to gain further insight into cross-cultural differences.

**General discussion**

Research in employee turnover has generated several models of determinants and processes underlying voluntary turnover. In the most recent models, job satisfaction and organisational commitment proved to have empirical relationships with voluntary turnover even in meta-analyses (Gaertner, 1999). Among determinants, leadership is viewed as an important predictor of job satisfaction and commitment, beside the other work setting characteristics. Leadership quality is a core element of management. It is not only strongly related to the amount of employee commitment but it is also logically linked to organisational performance and patient satisfaction (Rogg et al., 2001).

In our European sample, nurses from Great-Britain, Belgium, Slovakia and Germany reported higher scores for leadership quality compared with Polish and Italian nurses. Nevertheless, despite positive correlations between head nurse leadership and global job satisfaction (r=.32) and organisational commitment (r=.29), we observed that, at the country-level, highest scores in leadership were not systematically followed by highest scores in job satisfaction and commitment (see Great-Britain and Belgium). Conversely, in the Netherlands, we obtained low scores in leadership, but high scores in job satisfaction and, for Finland, in
commitment. Our correlations between leadership quality and job satisfaction vary from the lowest result in Slovakia ($r=.33$) to the highest result in Great-Britain ($r=.46$). Therefore, we cannot conclude that relationships between leadership, job satisfaction and commitment are automatic. For each country, it must be recognised that individual, organisational and task characteristics exist which may act as moderators on leadership effectiveness. Among these moderators, we can distinguish individual characteristics of subordinates (ability and training; high need for independence; professional orientation; indifference toward organisational rewards), task characteristics (methodologically invariant tasks; task-provided feedback; intrinsically satisfying tasks) and finally, organisational characteristics (organisational formalisation; organisational inflexibility; highly specified and active advisory and staff functions; cohesive work groups; organisational rewards not within the leader's control; spatial distance between a superior and subordinates) (Kerr & Jermier, 1978). Campion et al. (1993) also insisted that characteristics such as job design, interdependence, team composition, environmental context and process (e.g. workload sharing, communication/cooperation within groups, potency and social support) better account for effectiveness criteria (such as productivity and satisfaction). In an international sample, we cannot rule out the influence of cultural factors (Hofstede, 1980).

As nurses’ dominant work orientation is based upon the fundamental concern for patients welfare, it is important to monitor the character of their job in order to guide the amount of organisational and professional commitment. Only if nurses perceive the organisation, and even the profession as a place where they can fulfil work-related desires, the intent to stay will increase. It is hard to understand why, in a period of a huge nurse shortage, their life-long employability is so badly guided. (Van der Heijden, 2002). After all, it is not only the amount of respect and recognition by head nurses, doctors, and administrators, to mention but a few, that is at stake here. Many of the nurses in our sample reported that their job is, in many circumstances, highly physically demanding, and thus endangers their future employability. Since the perception of the quality of leadership is also positively related to the amount of job satisfaction and productivity, it is recommendable that supervising staff in the health care sector pays more attention to individual differences in order to increase the person-job match. As the amount of affective commitment develops mainly in one’s earlier career stages, it is extremely important to start paying attention to the work-related abilities, needs and desires of individual nurses, in order to adjust leadership style, work-related demands and developmental plans. During one’s entire career, the future employability should be considered in order to prevent premature loss of capabilities, knowledge and commitment.
According to Gaertner (1999), it is even possible that all of these determinants do not predict both job satisfaction and organisational commitment. For example, from a theoretical point of view, supervisory support and promotional chances could be directly related to organisational commitment over and above job satisfaction, while other structural determinants could be related to job satisfaction alone. It is also important to point out that, compared to organisational commitment, job satisfaction varies more directly and instantaneously with changing working conditions (Mowday et al., 1982). It is probably why, in countries like Germany, Finland and the Netherlands, we observed a high discrepancy between leadership quality and job satisfaction scores. Drawing in results from the other parts of our baseline questionnaire will be very important to obtain a more complete structural model. Additionally, more data analysis is needed which makes use of appropriate tools such as hierarchical modelling.

From a practical perspective, more needs to be known about how leaders can affect principal working conditions in order to indirectly enhance job satisfaction. Moreover, if managers would conceptualise major work characteristics (i.e. staffing, training, assigning work, appraising performance, allocating rewards, etc) within a human resource framework, it might enhance employees awareness in human resource departments of their responsibilities regarding work groups (Campion et al., 1993); this could favour the decentralisation of power in baseline managers hands (here, sister nurses) who would be more suitable to work as leaders, responsible for their team functioning in well-adapted working conditions.

References


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