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Assessing servant leadership in athletic training clinical education

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ASSESSING SERVANT LEADERSHIP IN ATHLETIC TRAINING CLINICAL EDUCATION

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MASTER'S THESIS

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ABSTRACT

The purpose of this study was to examine 1) if students felt servant leadership was present within the Approved Clinical Instructors (ACI's) of the programs surveyed; and 2) if those students who perceived their ACI's to be servant leaders also had more student satisfaction, and greater student success. Based on the literature search conducted, there was little to no research found on servant leadership in athletic training clinical education, especially from the athletic training students' perspective. Responses were obtained from 11 of the 27 Athletic Training Education Programs that were randomly selected for participation. Bivariate correlations were run on the thirty five student surveys that were collected and deemed complete. Regression analyses were run if a strong correlation was identified among any of the variables. Servant leadership had a strong influence on satisfaction in student athletic trainers whether from the ACI or the clinical site (n= 35, r=.877, p=.000; n= 35, r=.601, p=.000). Regression analysis was run showing that 83.4% of variance in student satisfaction is accounted for by variation in servant leadership qualities of approved clinical instructors (Y=-2.53+.583x). Student success, as defined in this study, was not influenced by servant leadership qualities regardless of the ACI or clinical affiliation (p>.05).

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Content Page

Chapter I
Introduction

Clinical education is a common educational practice in the health care professions. Clinical education generally involves students learning from professionals (i.e. clinical instructors) in a real life environment. Some common health care fields that utilize clinical education include dentistry, physical therapy, occupational therapy, nursing, and athletic training. According to Platt-Meyer (2002) the goals of clinical education are to (a) "reinforce didactic learning by applying the knowledge and psychomotor skills to real-life patient-care situations in traditional and non-traditional settings", (b) "to allow for multiple repetitions and practice of psychomotor skills in a supervised environment, to enhance the proficiency of the learned skills", and (c) "to provide a stage where students can use information from the affective domain to apply their newly formed attitudes, values, and beliefs to assist in patient-care management" (p. 34).

Meleca, Schimpfhauser, Witterman, and Sachs (1981) identified clinical education as a significant and essential component of professional education in health care services. Clinical education allows students to consolidate knowledge, acquire professional values, and socialize into the professional role (McCabe, 1985). One of the most critical aspects of clinical education is the clinical instructor (Lauber, Toth, Leary, Martin, and Killian, 2003). A review of the literature indicated that there has been considerable debate related to the effective behaviors of clinical instructors. One of the characteristics discussed in the literature is the area of leadership and healthcare clinical instructors (Howatson-Jones, 2004; Horwitz, Horwitz, Daram, Brandt, Brunicardi, & Awad, 2008; Kerfoot, 2003; Neill, Hayward, & Peterson, 2007; Platt-Meyer, 2002;

Swearingen & Liberman, 2004). Clinical instructors not only serve as role models and teachers, but also as leaders (Platt-Meyer, 2002). Students directly and indirectly learn professional and leadership skills through observation of their clinical instructors. Leadership training among medical residents has led to improvements in overall health care, increased team building and increased coordination among medical teams (Horwitz et al., 2008). Nursing in particular has pushed for clinical instructors who are considered to be servant leaders (Howatson-Jones, 2004; Kerfoot, 2003; Swearingen & Liberman, 2004).

Servant Leadership

Robert Greenleaf (1977) introduced servant leadership into the organizational context while working as an AT&T executive. Greenleaf (1977) recognized the need for a leadership model that was based on trust, teamwork and community. Greenleaf observed that the top people of truly great organizations displayed servant leader characteristics. Greenleaf (1977) stated that servant-leadership "begins with the natural feeling that one wants to serve, to serve first" (p. 27). Individuals led by servant leaders should "grow as persons, become healthier, wiser, freer, more autonomous, and more likely themselves to become servants" (Greenleaf, 1977, p. 14). Although Greenleaf was the first to conceptualize servant leadership in today's context, its principles can be found in ancient texts such as the Bible. In the Gospel of Mark, "Jesus says whoever wants to be a leader among you must be your servant, and whoever wants to be first must be the slave of all. For even, I, the Son of Man, came here not to be served but to serve others." (NLT Bible, Mark 10:43-45). Servant leadership advocates a group-oriented approach to

analysis and decision making as a means of strengthening institutions and improving society (Spears, 1998).

The Growing Impact of Servant Leadership

Greenleaf (1977) believed that servant leadership should be applied in profit and non-profit organizations, churches, universities, health care, and foundations. Institutions have discovered that internal training and education on servant leadership can truly improve how business is developed and conducted, while still successfully turning a profit (Spears, 1998). Several companies that have adopted servant leadership as part of their corporate philosophy include Toro Company, Service Master Company, Southwest Airlines, TDIndustries and the Men's Warehouse (Sendjaya & Sarros, 2002; Spears, 2004). Servant leadership has been recognized as an avenue to transform hospitals, churches and school administrations (Anderson, 2003; Kezar, 2001; Spears, 2004; Swearingen & Liberman, 2004; Wong, 2004).

Several authors have studied Greenleaf's original works and have tried to identify the most important aspects of servant leadership. Larry C. Spears (1998), CEO of the Greenleaf Center from 1990 to 2007, studied Greenleaf's original writings for many years and identified the essential characteristics of a servant leader. These include: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community. Spears (1998), stated that the primary purpose of servant leadership should be to create a positive impact on its employees and community, rather than using profit as the sole motive. Other published authors such as Ken Blanchard, Peter Block, Max DePree, and

Peter Senge, have identified servant leadership as a concept that enhances other leadership and management models (Spears, 1998).

Educational systems have begun to see the importance of servant leadership. Colleges and universities have offered servant leadership as part of leadership and management courses (Spears, 1998). Servant leadership has also emerged in experiential education. This concept is also known as service learning, in which students learn by doing (Spears, 1998). The National Society for Experiential Education (NSEE) has adopted servant leadership as the philosophical basis for experiential learning programs (Spears, 1998).

Although many institutions claim the significance of servant leadership, there is little empirical evidence to back it up. Experts on servant leadership are concerned that reducing servant leadership to a set of characteristics will defeat its true meaning and purpose (Page & Wong, 2000). Greenleaf (1977) admitted that his ideas regarding servant leadership may contain concepts that may be difficult to apply and are not easily operationalized. "The requirements of leadership impose some intellectual demands that are not measured by academic intelligence ratings. The leader needs two intellectual abilities that are usually not formally assessed in an academic way: he needs to have a sense for the unknowable and be able to foresee the unforeseeable" (Greenleaf, 1977, p. 21-22). Despite this belief, others feel that servant leadership needs to be measurable in order to claim it as an emerging leadership model (Laub, 2000; Page & Wong, 2000). Page pointed out that people are looking for meaningful work where they can contribute to the larger good of society and servant leadership provides just that.

Servant Leadership in Clinical Education. Health care professionals tend to be the types of people Page describes who want to find meaningful work. They naturally want to serve others and in return are able to contribute to society. However, there has been a large decline in the retention of nurses and other medical professionals (Swearingen & Liberman, 2004). Swearingen and Liberman attributed this to the poor work environments that focus on production rather than patient care. They believed along with Anderson (2003) that servant leadership could be a solution to this problem. Servant leadership shifts the focus from production, to building community and empowering people (Greenleaf, 1977; Spears, 1998). Retention of certified athletic trainers and student athletic trainers in the athletic training profession is also an ongoing problem (Clapper & Harris, 2008; Hendrix, Acevedo & Hebert, 2000; Stilger, Etzel & Lantz, 2001).

Athletic trainers do not generally bring revenue into the institutions where they work. However, there is a significant amount of pressure put on them to return athletes to participation after an injury as soon as possible. Athletic training rooms are often chaotic leaving little time for teaching student athletic trainers (Foster & Leslie, 1992; Mensch, 2006). Student athletic trainers often feel they are in a working environment (i.e. transactional) rather than a learning environment (Mensch, 2006). Recent literature has tried to identify effective clinical instructor qualities necessary to improve positive learning environments for student athletic trainers (Barnum, 2008; Foster & Leslie, 1992; Lauber et al., 2003; Laurent & Weidner, 2001; Mensch, March 2006; Mensch, July 2006; Pitney & Ehlers, 2004; Weidner & Henning, 2002; Weidner & Henning, 2004; Weidner & Henning, 2005). Many of the effective clinical instructor qualities are similar to those

of servant leadership characteristics (Lauber, Toth, Leary, Martin & Killian, 2003; Spears, 1998). Certified athletic trainers (ATC) and student athletic trainers disagreed on which were the most effective clinical instructor qualities (Lauber et al., 2003; Laurent & Weidner, 2001; Pitney & Ehlers, 2004). From the literature, it was apparent that students felt that interpersonal relationships were the most important (Pitney & Ehlers, 2004). They wanted to feel that their supervising ATC cared about them personally. This is a vital issue that needs to be addressed to continue the development of future athletic trainers. Fifty-three percent of athletic training professional development is perceived by athletic training students to come from clinical education (Laurent & Weidner, 2002).

Servant leadership has been found useful in business, education, and church organizations. There was not any literature on servant leadership in clinical education. However, clinical education incorporates both an educational setting and a working environment. Servant leadership has shown to be effective in both of these settings; therefore, the study of servant leadership in clinical education seems warranted. This study investigated the effectiveness of servant leadership in clinical educational settings.

Problem Statement

While many health care fields are pushing for servant leadership, there is not any literature on its applicability or effectiveness. Could servant leadership be useful in athletic training clinical education? Do servant leader clinical instructors lead to more satisfied student athletic trainers? Do servant leader clinical instructors lead to higher student success? This study aimed to provide some evidence on these unknown relationships.

Purpose

The purpose of this study was to examine 1) if students felt servant leadership was present within the Approved Clinical Instructors (ACI's) of the programs surveyed; and 2) if those students who perceived their ACI's to be servant leaders also had more student satisfaction, and greater student success.

Research Hypotheses

1) ACI's that are perceived as servant leaders will produce athletic training students with a higher grade point average than non-servant leader ACI's.
2) ACI's that are perceived as servant leaders will produce athletic training students who are more satisfied with their clinical education than non-servant leader ACI's.

Operational Definitions

1. Subscales of the Organizational Leadership Assessment (OLA) were operationally defined as Values People, Develops People, Builds Community, Displays Authenticity, Provides Leadership, and Shares Leadership.
2. Program directors (PD's) were operationally defined as full-time faculty members of the host institution and a Board of Certification Certified Athletic Trainer responsible for the administration and implementation of the ATEP (Commission on Accreditation, p. 15).
3. Approved clinical instructors (ACI's) were operationally defined "as an appropriately credentialed professional identified and trained by the program Clinical Instructor Educator to provide instruction and evaluation of the Athletic Training Educational Competencies and/or Clinical Proficiencies. The ACI could not be a current student within the ATEP" (Comission on Accreditation, p. 19).

4. Certified athletic trainers (ATC's) were operationally defined as individuals who "work with physicians and other medical personnel, employers, patients, parents, guardians, and athletic personnel in the development and coordination of efficient and responsive health care delivery systems. Athletic trainers are integral members of the health care team in secondary schools, colleges and universities, professional sports programs, sports medicine clinics, corporate /industrial, and other health care settings" (Commision on Accreditation, p.2). For the purposes of this study ATC's were also defined as approved clinical instructors who have undergone the proper training requirements for clinical instruction and who provide direct supervision and instruction to students in the clinical aspect of athletic training education.
5. Athletic training students (ATS's) were operationally defined as students who were formally accepted into the undergraduate athletic training education program and who were in their final or penultimate year of the athletic training education program (Laurent & Weidner, 2001).
6. Student success was operationally defined by the students overall grade point average and clinical experience grade point average.

Assumptions

For this study the researcher assumed that all participants followed the survey directions explicitly and that all participants answered each question carefully, seriously, honestly, and to the best of their knowledge.

A second assumption was that average grade point could be affected by leadership style. Herbst (2003) discovered that schools where higher degrees of servant leadership

were practiced by the staff led to higher levels of student achievement in mathematics, reading, and annual learning gains. Greenleaf (1977) argued that leadership in the educational system was necessary, but rarely recognized by educators as important. Servant leadership is about meeting individual needs, so it is therefore assumed that servant leaders are more likely to meet individual learning styles of students (Greenleaf, 1977). Two meta-analytic studies on the Dunn and Dunn model of learning-style preferences provided evidence that matching the students' learning-style preferences with educational interventions increased student achievement and improved attitudes toward learning (Dunn, Griggs, Olson, Beasley, & Gorman, 1995; Lovelace, 2005). Farkas (2003) found that using a learning styles approach compared to a traditional method significantly improved student achievement, attitude, and empathy when teaching about the Holocaust. It was also assumed that classroom results such as in Herbst's study would yield the same results in the clinical education setting.

A third assumption was that grade point average would be a good measure of student success. Based on the literature, student success can be measured by grade point average (G.P.A.) (Korvick, Wisener, Loftis, & Williamson, 2008; Noble, Flynn, Lee, & Hilton, 2008). Overall grade point average and clinical experience grade point average provided the basis for student success scores for this study.

And last, was that student satisfaction in the clinical education setting would be affected by leadership style. Servant led individuals become happier, more satisfied and more productive (Greenleaf, 1977, Spears, 1998). In 1996, TDIndustries, a servant led organization, had almost 100% employee satisfaction from its 900 employees (Lowe, 1998). It was assumed that servant leadership would have the same impact on

satisfaction in the clinical education setting as it did in other organizations. Platt-Meyer (2002) points out the similar characteristics shared by effective leaders and effective clinical instructors. She suggests that in order to be an effective clinical instructor, one must be an effective leader.

Limitations

There are a few limitations in this study that need to be addressed. Due to the cross-sectional nature of this study the directionality of these relationships between servant leader, approved clinical instructors and the variables of interest cannot be shown. No cause and effect statements can be determined from this data set.

Delimitations

The design and structure of this study delimited the sample to only 88 athletic training education programs out of 346. The intention of this study was to target athletic training education programs across the nation. However, some states only had one program and responses were not received, limiting the generalizability of the results. Second, only athletic training clinical education was studied, limiting the generalizability to only clinical education within the athletic training profession. A third delimitation was that only athletic training students were asked to fill out the Organizational Leadership Assessment.

Significance

When this study was conducted it was one of the first to examine servant-leadership in clinical education. The potential impact it could have on student athletic trainers, certified athletic trainers and athletic training education programs are listed below.

1) It is important for the athletic training profession to understand how approved clinical instructors with a servant leadership style influences the many variables associated with student learning; unfortunately there is little to no information addressing this issue in clinical education. This investigation will be one of the first to identify the nature of these relationships.
2) For students and approved clinical instructors, the role that servant leader clinical instructors have on student success has not been defined. Data is needed to help understand the moderating effect servant-leader clinical instructors have on the variables important for clinical education success.
3) Many of the dimensions of servant leadership such as listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community (Spears, 1998) seem to closely match those of effective clinical instructor behaviors. Therefore, servant leadership research and its effects on student success and student satisfaction can be valuable information to improving clinical education in athletic training education programs.
4) Effective clinical instructor behaviors and leadership behaviors for athletic training education programs have been identified by program directors and clinical instructors, but little has been done assessing student perceptions. It is important to have an understanding of what characteristics students feel are important for learning as well. This study will be one of few to assess the perceptions of students.

Chapter II
Literature Review

Education systems are emphasizing the importance of service learning for their students. Service learning involves students applying their learned classroom skills through community service (Sitter, 2006). This allows students to gain experience and contribute to the community. If students are being encouraged to serve others through their abilities, it is important to have a role model that displays this same behavior. The National Society for Experiential Education, (NSEE), which includes service learning has adopted servant leadership as the philosophical basis for experiential learning programs (Spears, 1998). Clinical education is a common educational practice in the health care professions that implements this idea of service learning. Clinical education generally involves students learning from professionals (i.e. clinical instructors) in a real life environment. Some common health care professions that utilize clinical education include dentistry, physical therapy, occupational therapy, nursing, and athletic training. Students learn from professionals and have the ability to apply learned skills in exchange for providing free services.

Learning Styles in Education

According to a survey of American Association of School Administrators, learning styles are very important (Lewis, 1991). Lewis stated that all children can learn, but all students learn in different ways. Tileston (2005) discussed important aspects of creating an environment that facilitates learning. In order for students to learn optimally, Tileston emphasizes that the information must have importance to the individual, which can be accomplished by 1) meeting the student's immediate and long term learning goals; and 2) creating situations in which the student can be successful to increase self-efficacy.

Two meta-analytic studies on the Dunn and Dunn model of learning-style preferences provided evidence that matching the students' learning-style preferences with educational interventions increased student achievement and improved attitudes toward learning (Dunn, Griggs, Olson, Beasley, & Gorman, 1995; Lovelace, 2005). Farkas (2003) found that using a learning styles approach compared to a traditional method significantly improved student achievement, attitude, and empathy when teaching about the Holocaust. Perhaps learning styles need to be addressed when teaching in the clinical setting as they are in the classroom.

Clinical Education in Nursing and Allied Health Care

Extensive research has been done to determine effective clinical instructor behaviors in nursing and other allied health care fields (e.g. physical therapy, dentistry). Teaching and learning is much different in the clinical setting than in the classroom. In a clinical setting the learning environment is often realistic, and one that cannot be repeated (Wong & Wong, 1987). There are discrepancies between what the students perceive as effective teaching and what the clinical instructors (CI) believe is effective (Brown, 1981; Fong & McCauley, 1993; Jarski, Kulig & Olson, 1990; Wharton, 1985). Research dating back to 1981 has shown the same theme of discrepancies as current research (Brown, 1981; Fong & McCauley, 1993; Jarski, Kulig & Olson, 1990; Wharton, 1985).

The common clinical teaching behaviors evaluated in nursing include communication skills, professional skills, interpersonal skills, and adult education skills, in which clinical instructors believe that knowledge and displaying professionalism are the most critical for effective learning (Brown, 1981; Fong & McCauley, 1993; Jarski, Kulig & Olson, 1990; Wharton, 1985). Students think the most effective teaching

behaviors have to do with positive feedback and positive interpersonal relationships with the students, patients and other personnel (Brown, 1981; Fong & McCauley, 1993; Jarski, Kulig & Olson, 1990; Wharton, 1985). This lack of consensus between CI's and students poses a threat to the quality of healthcare provided to patients and to the learning process of students (Fong & McCauley, 1993). It is therefore critical to provide a favorable learning environment for the student.

Clinical Education in Athletic Training

These same incongruities exist in the athletic training profession, perhaps at a greater level. Certified athletic trainers (ATC's) spend over 30% of their clinical time teaching students as opposed to other health care professionals who spend 10-40% of their time teaching (Foster & Leslie, 1992). Athletic trainers may be in charge of supervising up to six students at any one given time (Foster & Leslie, 1992). Clinical instructors in other fields generally only supervise a few students at a time during patient care (Foster & Leslie, 1992).

Lauber, Toth, Leary, Martin and Killian (2003) identify effective clinical instructor behaviors in athletic training as instructional, interpersonal, evaluative, professional, and personal. Instructional skills include: explanation, demonstration, answering questions and stimulating learning. Interpersonal skills involve: support and encouragement of student; genuine interest and respect for student; encourages questions and opinions; and is available to the student. Evaluative skills are when the ATC provides: tactful correction; constructive feedback and suggestions; and observation and assessment of student performance. Professional skills include: demonstrating interest in athletes, clinical knowledge, competence, judgment, acting as a professional role model,

and making students aware of their personal professional responsibility. The personal category evaluates the ATC's personality and interactions. These include: honesty, sense of humor, flexibility, self-control and patience, enthusiasm, and friendliness. Throughout the literature, researchers name the behavioral categories slightly different, but the underlying characteristics remain the same.

Program directors, students, and certified athletic trainers all disagree on which behavior category is the most important for learning. Program directors think the evaluative category is significantly more important than do the ATC's (Lauber, et al., 2003). The certified athletic trainers think being professional is the most important (Lauber, et al., 2003). The research on students' perceptions varies. Some believe professionalism or modeling are the most important characteristics (Laurent & Weidner, 2001), whereas others think trust, congruent values and personal relationships are important (Pitney & Ehlers, 2004).

After reviewing all of the literature, it is apparent that certified athletic trainers and other clinical instructors (e.g. nurses) are unaware of the effect that interpersonal relationships have on learning. All of the literature points out that clinical instructors' need to be more genuinely interested in their students' personal and professional development.

Several reasons exist for this ongoing issue. First, clinical instructors may have a difficult time accomplishing daily tasks, let alone trying to build relationships with students (Mensch, 2006). A more pressing issue, however, is a lack of teaching experience (Wong & Wong, 1987; Weidner & Henning, 2002). Clinical instructors lack formal preparation in education (Jarski, et al., 1990; Wong & Wong, 1987). Many are

chosen based on their professional skills, not their teaching skills (Jarski, et al., 1990). This lack of teaching preparation carries over from generation to generation, because individuals often teach how they were taught (Meleca, Schimpfhauser, Witterman, & Sachs, 1981). A new focus for improving an effective learning environment in clinical education is developing leadership skills.

Leadership Styles

Effective leadership is vital to the integrity of organizations and to the individuals involved. Education and healthcare systems are not free of this responsibility. A significant amount of research has been done on effective leadership skills necessary for a productive and successful organization. Health care and educational systems are recently realizing the importance of leadership. The traditional leadership styles that are commonly employed by leaders are transactional, transformational, and passive-avoidant (i.e. laizzez-faire). Transactional and transformational leadership are the most common leadership styles used and researched.

Transactional Leadership

Transactional leadership has to do with the exchange of extrinsic rewards (e.g. money) for expected outcomes (e.g. high production) (Burns, 1978). Transactional leaders work to develop individuals for the success of the organization, not to better them as a person (Burns, 1978). They are able to identify ways to fulfill the current needs of their followers; so long as the organizations goals are met (e.g. pay raise for high production) (Bass, 1985). In this type of leadership, the relationship between the leader and follower does not go beyond the mere purpose of the transaction (Burns, 1978). This

traditional style of leadership is not effective for today's society (Laurent & Bradney, 2007; Hater & Bass, 1988).

Transformational Leadership

Transformational leadership has been found to be more effective in creating individuals who are more satisfied and productive within their organizations (Hater & Bass, 1988; Laurent & Bradney, 2007). Transformational leadership is a form of transactional leadership, in which both aspire to attain a certain goal or outcome (Hater & Bass, 1988). Transformational leaders differ from transactional leaders, in that they lead through charisma (House, et al., 1988). Charismatic leaders are visionary, practical, and inspirational (Graham, 1991). They know where to go, how to get there and posess the ability to motivate others to go above and beyond the call of duty for a shared vision (Bass, 1985; Bass & Hater, 1988; Graham, 1991; House, et al., 1988). Transformational leaders provide followers with a vision of the future that promises a better and more meaningful way of life (Burns, 1978; Bass, 1985; House, Woycke, & Fodor, 1988; Kanungo, 1988). They demonstrate confidence and respect for their followers and challenge them to reach their potential (House et al., 1988). Although research has shown that transformational leadership is effective, Graham (1991) argues that it lacks a moral component. She argues that Hitler was a charismatic leader, but one without morals. Robert K. Greenleaf identified this lack of morality in leaders in his book A Journey into the Nature of Legitimate Power and Greatness (1977). He recognized the need for a leadership style that was based on trust and community. Robert K. Greenleaf identified this as servant leadership, in which the leader serves first.

Servant Leadership

The 21st century calls for a leadership model that focuses on people rather than production. Businesses are suffering the consequences of unethical conduct (e.g. theft) as a result of poor leadership (Kaptein, Huberts, Avelino, & Lasthuizen, 2005). Medical professionals are experiencing high burnout rates due to the pressures of production, leading to poor healthcare systems (Swearingen & Liberman, 2004). Several companies that have adopted servant-leadership into their corporate philosophy have found it to be very rewarding for the organization as a whole and for its constituents (Spears, 2004). Although some educational and healthcare systems have identified the need for servant leadership, little empirical research has been done demonstrating its effectiveness in these settings. It is critical to have an understanding of the underlying principles that make up servant leadership for further advancement in these areas.

History of Servant Leadership. Greenleaf (1977) states that servant-leadership "begins with the natural feeling that one wants to serve, to serve first" (p. 27). Greenleaf was the first to come up with the concept servant-leadership, but the principles have strong Biblical roots. Jesus Christ was a leader who displayed this servant mentality when he washed the feet of his disciples; one of the most demeaning tasks a human could perform (NLT Bible, John 13). In the Gospel of Mark, "Jesus says whoever wants to be a leader among you must be your servant, and whoever wants to be first must be the slave of all. For even I, the Son of Man, came here not to be served but to serve others" (NLT Bible, 10:43-45).

Greenleaf's Concept of Servant Leadership. Greenleaf (1977) introduced servant leadership into the organizational context while working as an AT&T executive. He

identified two types of leaders; leader-first and servant-first. To be a servant-first is a choice to ensure that other people's highest needs are met before all else. Greenleaf observed that the top people of truly great organizations displayed servant leader characteristics. He identified them as "the most humble, the most reverent, the most caring, and the most determined" (p.12). They were ones who used reasoning, persuasion, kindness, empathy, and trust rather than authority and power. Individuals led by servant leaders should "grow as persons, become healthier, wiser, freer, more autonomous, and more likely themselves to become servants" (Greenleaf, 1977, p. 14). Greenleaf clarifies that servant leadership is not just a set of specific leadership techniques, but a result of personal characteristics.

Servant Leadership Characteristics. Larry C. Spears (1998), CEO of the Greenleaf Center from 1990 to 2007, studied Greenleaf's original writings for many years and identified the essential characteristics of a servant leader. These include: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community. Spears points out that these 10 attributes are critical, but not exhaustive. Russell and Stone (2002) describe similar results. They found nine functional (i.e. necessary) attributes and eleven accompanying attributes (i.e. complementary) after an exhaustive review of the literature. In the recent literature, some of the original ten characteristics have been combined into broader categories. For example, conceptualization and foresight have been grouped under vision (Farling, Stone, & Winston, 1999; Page & Wong, 2000; Russell & Stone, 2002). The characteristics that are cited as the most critical throughout

all of the literature are vision, trust, and service (Farling, et al., 1999; Page & Wong, 2000; Russell & Stone, 2002).

There have been several attempts to create a model for servant leadership that can be applied or used for research purposes. All of the models include the original ten attributes in some form or another except for one. Farling et al. (1999) argued that servant leadership is a form of transformational leadership and only incorporated vision, influence, credibility, trust and service into their conceptual model.

Page and Wong (2000) developed a model based on Greenleaf's theory that servant leadership is a result of personal characteristics. They recognized that "motives stem from our character, which dictates what we do and how we lead" (p. 71). Page and Wong included four categories within their conceptual model that encompassed the ten characteristics of servant leadership identified by Spears. The four categories were: 1) character, 2) relationship, 3) leadership task, and 4) leadership process. Character is the core, which involves a commitment to serving others with integrity and humility and influences all of the other categories. The relationship component involves the transactions that occur between the leader and the follower. This category includes caring for others, empowering others, and developing others. Leadership tasks involve doing the work of a leader such as creating a vision, goal setting and leading. The leadership process includes improving the organizational processes through modeling, team building, and shared decision-making. Lastly, servant leaders act as role models through demonstration and follow-through. Servant leaders lead by example and impact society and culture through the process.

After creating this model for servant-leadership, Page and Wong (2000) developed a twelve category instrument to measure it. This instrument measures the servant leadership characteristics along with the broad categories of effective leadership. The twelve categories include: integrity, humility, servanthood, caring for others, empowering others, developing others, visioning, goal setting, leading, modeling, team-building, and shared decision-making.

Servant Leadership Research

Wong pointed out that many modern management theorists have identified that authoritative leadership needs to be replaced by leadership that empowers people (Avolio, 1999; Bennis, 1990; Hammer & Champy, 1993; Senge, 1990). Even with the growing interest and application of servant leadership there is very little quantitative evidence supporting its effectiveness. This is partly due to the fact that servant leadership is a lifelong process that involves soul searching and deep identity. Experts on servant leadership argue that the "profound, mystical meaning of servant-leadership may be lost once it is reduced to a set of easily transferable skills" (Page & Wong, 2000 p. 85). Servant leadership has brought success to many companies that have adopted it (e.g. TDIndustries, Southwest airlines) (Lowe, 1998; Sendjaya & Sarros, 2002; Spears, 2004). In 1996, TDIndustries had almost 100% employee satisfaction from its 900 employees (Lowe, 1998).

Kezar (2001) presented a case study on servant leadership applied to an academic administration of a community college. He argued that this form of participatory leadership style created animosity among the members. However, servant leadership was forced on the individuals of the institution. People were even forced out of their positions

and restricted from voicing their opinions if they did not adapt the servant leadership style. As Greenleaf (1977) and other experts on servant leadership stated, servant leadership has to come from the heart (Page & Wong, 2000; Spears, 1998). It is not something that can be forced upon people. Drury (2004) found differing results in which college employees' perceptions of organizational commitment positively correlated with servant leadership.

Although there is not a significant amount of empirical research on servant leadership, there is some on the effectiveness of transformational leadership (Hater & Bass, 1988; Laurent & Bradney, 2007). Farling et al., (1999) argued that servant leadership is a form of transformational leadership. Larkin (1995) confirmed this theory when examining the leadership characteristics of male and female transformational business leaders. Larkin found that many of the most effective leaders possessed characteristics similar to those of servant leaders. Irving (1999) discovered that team effectiveness in churches, non-profit organizations, and businesses significantly correlated with servant leadership characteristics.

Servant Leadership in Organizations. Servant leadership is being recognized as an avenue to transform hospitals, businesses, churches and school administrations (Anderson, 2003; Kezar, 2001; Spears, 2004; Swearingen & Liberman, 2004; Wong). Several companies that have adopted servant leadership as part of their corporate philosophy include Toro Company, Service Master Company, Southwest Airlines, TDIndustries and the Men's Warehouse (Sendjaya & Sarros, 2002; Spears, 2004). Southwest Airlines, TDIndustries and Synovius Financial have consistently been ranked

in the top ten of Fortunes 100 Best Companies to work for in America for several years (Sendjaya & Sarros, 2002; Spears, 2004).

Servant leadership has been the foundational construct of TDIndustries since the 1970's when introduced by founder Jack Lowe Sr. (Lowe, 1998). TDIndustries is employee owned by its 1,273 partners (i.e. employees). All employees are given Greenleaf's servant leadership essay and supervisors receive servant-leadership training. TDIndustries attributed their success to trust, a key component in servant leadership. Partners' opinions are valued and company information (e.g. revenues) is shared openly.

Synovius Financial Corporation demonstrated servant leadership through a strong commitment to family-oriented policies by encouraging a work/life balance (Sendjaya & Sarros, 2004). Southwest Airlines has been recognized as one of the most admired companies and airlines in the world for their caring approach and service to others (Sendjaya & Sarros, 2004). The Chairman of The SerivceMaster, which has been a Fortune 500 firm for the past 10 years, asserted that a leader is not the one with a distinguished title, but the one who is a role model and promoter of others (Sendjaya & Sarros, 2004).

Servant Leadership in Educational Settings. Greenleaf (1977) argued that leadership in the educational system was necessary, but rarely recognized by educators as important. He professed that servant leadership opportunities needed to be provided for educators and students at the secondary and college levels. The need and implementation of servant leadership in educational settings today is dramatically increasing. Servant leadership is being implemented by teachers, advisiors, superintendents, and principals (Bowman, 2005; Chonko, 2008; Crippen, 2005; Herman & Marlowe, 2005; McClellan,

2007; Tate, 2003; Taylor, 2007; Wenig; Wheaton, 1999). Bowman (2005) explains the impact that servant leadership can have on creating and sustaining teacher-student relationships in the educational system. He asserted that implementing servant leadership into the educational system would reframe the educator's professional obligation to focus on the developmental needs of all learners. Grothaus (2004) used a servant leadership program to teach at-risk youth how to make a positive difference in their community by increasing their resiliency, self-esteem, leadership abilities, and life skills. Manitoba educational systems provided training and education on servant leadership to their institution (Crippen, 2005). Over 1200 educators realized the value of servant leadership in teaching and began to apply it (Crippen, 2005). Taylor (2007) found that principals who were servant leaders were viewed by their teachers as more effective in challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart. Wheaton (1999) found similar results where school superintendents who demonstrated servant leadership characteristics were more effective and were preferred by their subordinates. Herbst (2003) discovered that schools where higher degrees of servant leadership were practiced by the staff led to higher levels of student achievement in mathematics, reading, and annual learning gains.

Servant Leadership in Clinical Education. Nursing and other allied health care fields have pushed for servant leadership in clinical education settings (Kerfoot, 2003; Howatson, 2004; Neill, Hayward, & Peterson, 2007). There is not any empirical evidence to back up the effectiveness of servant leadership in clinical education. However, clinical education incorporates both an educational setting and a working

environment. Servant leadership has shown to be effective in both of these settings; therefore, the study of servant leadership in clinical education seems warranted.

Platt-Meyer (2002) pointed out the similar characteristics shared by effective leaders and effective clinical instructors. She suggested that in order to be an effective clinical instructor, one must be an effective leader. Other allied healthcare education programs have implemented this new shift to leadership as well (Horwitz, Horwitz, Daram, Brandt, Brunicardi & Awad, 2008). Undergraduate nursing programs have emphasized a servant leadership mentality for clinical instructors (Howatson, 2004; Kerfoot, 2003; Neill, Hayward & Peterson, 2007, Swearingen & Liberman, 2004). Nursing, physical therapy, occupational therapy, health and nutrition sciences, physician assistant and pharmacy students who were led by servant leader instructors and who were able to apply servant leadership qualities found it helpful in the learning process (Neill et al., 2007).

The rapid decline in retention of nurses and physicians has been attributed to poor work environments (Swearingen & Liberman, 2004). Hospitals and medical clinics have placed so much emphasis on production that the quality of healthcare is decreasing and the burnout rate is increasing (Anderson, 2003). Anderson states that physicians need an environment where they can bring healing to their patients. Anderson, and Swearingen and Liberman, have identified that servant leadership could be a long-term fix to this problem (Anderson, 2003, Swearingen & Liberman, 2004). Servant leadership shifts the focus from production, to building community and empowering people (Greenleaf, 1977, Spears, 1998).

Burnout for student athletic trainers and certified athletic trainers in accredited ATEP programs is also very common (Clapper & Harris, 2008; Hendrix, Acevedo & Hebert, 2000; Stilger, Etzel & Lantz, 2001). Stilger, Etzel, and Lantz (2001) found high stress levels in student athletic trainers, which can be detrimental to overall health and learning. It is important for the supervising athletic trainer to be empathetic, understanding, and sensitive to student's struggles to decrease dropout rate (Stilger, et al., 2001). Student athletic trainers often feel they are in a working environment (i.e. transactional) rather than a learning environment. This has been viewed as unethical treatment and could discourage good students from entering or completing current athletic training education programs (Mensch, March 2006). This problem exists because of the differences in learning environments between the approved clinical instructors (a.k.a. certified athletic trainers) and the current student athletic trainers. In the past, student athletic trainers went through an internship program where they were used as a workforce by athletic departments to help with medical coverage of athletic teams in return for the ability to become certified by the Board of Certification (BOC). In the last ten years, however, the internship route to BOC was eliminated and the education programs have been reformed. Approved clinical instructors continue to teach how they were taught, however, leaving current student athletic trainers unsatisfied with their educational experience.

Recent literature has tried to identify effective clinical instructor qualities necessary to improve positive learning environments for student athletic trainers (Barnum, 2008; Foster & Leslie, 1992; Lauber et al., 2003; Laurent & Weidner, 2001; Pitney & Ehlers, 2004; Mensch, March 2006; Mensch, July 2006; Weidner & Henning,

2002; Weidner & Henning, 2004; Weidner & Henning, 2005). Many of the effective clinical instructor qualities are similar to those of servant leadership characteristics. A shift from transactional leadership to servant leadership could potentially eliminate the feeling of a working environment and therefore decrease dropout rate.

If current certified athletic trainers adopt a servant attitude, it could help decrease stress in student athletic trainers (Stilger, et al., 2001). The student athletic trainers could then potentially adopt this servant attitude and apply it as future professionals, starting a new generation of servant leaders. As stated earlier, students teach how they were taught (Meleca, et al., 1981). Servant-led individuals become happier, more satisfied and more productive (Greenleaf, 1977, Spears, 1998). However, there is a lack of empirical evidence in education supporting these theories.

Measures of Servant Leadership Behavior

Experts on servant leadership are afraid that reducing servant leadership to a set of characteristics will defeat its true meaning and purpose (Page & Wong, 2000). Despite this belief, others feel that servant leadership needs to be measurable in order to demonstrate its effectiveness (Page & Wong, 2000; Laub, 2000). Several authors have attempted to measure what servant leadership is, how it is measured, and its positive outcomes. The measures include (a) the Revised Servant Leadership Profile (Page & Wong, 2000), and (b) the Organizational Leadership Assessment Instrument (Laub, 2000).

Revised Servant Leadership Profile (RSLP). Page and Wong (2000) developed the Servant Leadership Profile to measure servant-leadership characteristics. This original instrument measured integrity, humility, servanthood, caring for others,

empowering others, developing others, visioning, goal setting, leading, modeling, team-building, and shared decision-making. These twelve characteristics were based on servant-leadership characteristics found in the literature and other broad categories of effective leadership. Despite the validity and reliability of the Servant Leadership Profile, it lacked a factor analysis of the above twelve characteristics. In 2004, Wong developed the Revised Servant Leadership Profile to address this problem. This new instrument measures only seven components of servant leadership, which include: empowering and developing others, serving others, participatory leadership, inspiring leadership, visionary leadership, and courageous leadership.

Organizational Leadership Assessment (OLA). Laub (2000) developed the Organizational Leadership Assessment after extensive review of the literature and consultation with a panel of fourteen experts on servant leadership. After all of the servant leader characteristics were found in the literature, the panel of experts rated them as essential, necessary, desirable, and unnecessary. The OLA assesses the organization as a whole, as well as the leadership of the organization, and assesses both from the perspective of the respondent's personal experience. The categories measured included (a) values people, (b) develops people, (c) builds community, (d) displays authenticity, (e) provides leadership, and (f) shares leadership.

Chapter III
Methods

The purpose of this study was to determine the effect that servant leadership had on athletic training student success and student satisfaction. Approved Clinical Instructors were evaluated by their athletic training students to determine the level of servant leadership qualities they displayed. In addition, students were asked to take a survey to determine their level of satisfaction with their Approved Clinical Instructor (ACI's), and provided their GPA scores. This chapter describes the components that make up the methodology of this research. First, the participants and selection of participants are discussed. Second, surveys and reasoning for the survey selection are described. Third, the implementation of the procedures was explained. Fourth, an explanation of the data analysis used will conclude the methods chapter. Before conducting this research, approval was granted by the University's Institutional Review Board (IRB).

Participants

Undergraduate students from selected Commission on Accreditation of Athletic Training Education Programs (CAATE)-accredited, entry-level undergraduate athletic training programs were invited to participate in this study. Athletic training students were asked to complete surveys on their Approved Clinical Instructors and on the respective clinical affiliation. Students were selected from the existing 346 accredited athletic training education programs (ATEP) that were part of ten different national athletic training districts. Students were randomly chosen from 27 programs in three districts: District 1, the Eastern Athletic Trainers' Association; District 5, the Mid

America Athletic Trainers' Association and; District 10, the Northwest Athletic Trainers' Association. These districts were geographically selected in order to represent ACI's across the nation. There are a total of 91 accredited ATEP's within these three districts. Nine programs were randomly selected from each of the three districts. Students (through the program director of each of these 27 programs) were asked to complete a survey to evaluate each of the ACI's. On average there were seven ACI's within each program, equaling a population size of 637. In order to have a margin of error of .05 with a confidence level of 95 percent and a response rate of 80 percent, 178 ACI's would have to be evaluated. This number was chosen by using an online sample size calculator from www.raosoft.com.

Selection

In order to represent the demographics of all the states within the districts; a blocked-quasi random sampling method was used. A list of each CAATE-accredited program within the three chosen districts were listed in Microsoft Excel. An online random sample generator (www.randomizer.org) was used to choose at least one program from each of the states in the district. Some of the states only had one education program, so randomization was somewhat limited. Representing each state increased the accuracy and generalization of the findings (Jarski, Kulig, & Olson, 1990). In order for students to participate in this study, they had to be in the last or second to last year of the athletic training education program.

Instruments

Instruments used for this study measured servant leadership, student satisfaction, and student success. The Organizational Leadership Assessment provided an objective

look at how the students perceived their ATEP and their ACI. A third component of the Organization Leadership Assessment was used to measure the student's satisfaction with the clinical site as a whole. The student satisfaction survey assessed the students' satisfaction with the ACI they spent the most time with in the 2008-2009 academic school year. Student success was based on overall grade point average and clinical experience grade point average. Each of these instruments is defined and described below.

Demographics Questionnaire. The demographics questionnaire included questions about the year in program (i.e. last year or 2nd to last year), gender, overall grade point average, clinical experience grade point average, and the name of the institution. The name of the institution was only used to determine how many programs were represented in the responses. No identifying information about the institution was used in the results or discussion. Based on the literature, student success can be measured by grade point average (G.P.A.) (Korvick, Wisener, Loftis, & Williamson, 2008; Noble, Flynn, Lee, & Hilton, 2008). Overall grade point average and clinical experience grade point average provided the basis for student success scores for this study.

Athletic Training Student Satisfaction Questionnaire. Student satisfaction of the individual ACI was measured using a questionnaire created by the researcher based on other student satisfaction questionnaires from sports, and other allied health care professions (Barris, Kielhofner, & Bauer, 1985; Espeland & Indrehus, 2003; Reimer & Chellandurai, 1998). Questions were chosen from the Athlete Satisfaction Questionnaire and Course Experience Questionnaire and reworded to represent athletic training. After

completion, the survey was reviewed by a panel of experts at Eastern Washington University. Appropriate changes were made as requested by the panel of experts before beginning a pilot study. A pilot study was conducted in February 2009 to determine the validity and reliability of the instrument. Participants for the pilot study included 32 athletic training students from Eastern Washington University who were in their last or second to last year in the program (the results from this pilot study were not included in the data collection for the final research study). Students were asked to read the directions and questions carefully. They were asked to provide comments, questions, and misunderstandings about each individual survey question. Based on the pilot study two questions were reworded; none were eliminated. Each student felt that the questions were reflective of satisfaction with their Approved Clinical Instructor and answered each question as expected, ensuring reliability of the instrument.

Eastern Washington University was selected because of convenience and direct access by the researcher. The student satisfaction questionnaire was designed to measure the students' satisfaction with the approved clinical instructor they had spent the most time with in the 2008-2009 academic school year.

Organizational Leadership Assessment (OLA). The Organizational Leadership Assessment (Laub, 2000) was designed after (1) extensive review of servant leadership characteristics from the literature, and (2) surveying a panel of servant leadership experts. The experts chosen had either written on servant leadership or had taught servant leadership at a university level. The OLA was designed to assess servant leadership in all types of for profit and non-profit organizations. Before testing was done with the instrument, the panel of experts reviewed each item for validity. To ensure validity and

reliability of the OLA instrument, a pre-field test was done with 22 adult learners from two different colleges. Participants were asked to provide comments as to whether the instrument and individual questions were understandable. Item-to-test correlations were run and those with low scores were changed. After adjustments were made from the pre-field test results, a field test was done with 1624 people from 45 different organizations. A total of 828 responses were usable from 41 organizations including religious, business, and educational organizations. The field test revealed a high level of internal consistency with a Cronbach alpha measure of .98. Each of the 66 statements in the OLA represents a characteristic from each servant leader category (values people, develops people, builds community, displays authenticity, provides leadership, and shares leadership). Based on the design of the instrument, participants were unaware of which statement represented which category. The instrument includes a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) in response to the above 66 statements (e.g. people within this organization trust each other).

The Organizational Leadership Assessment was comprised of three different survey components. The first survey measured the student's perception of servant leadership qualities of the clinical site. The second survey measured the student's perception of the ACI's servant leadership qualities. The third survey measured the student's satisfaction of the clinic as a whole.

One of the reasons this instrument was chosen was to help ensure that the integrity of the original servant leader model developed by Robert Greenleaf was maintained in the assessment. After studying Greenleaf's original writings for a number of years, Larry C. Spears, who was one of the OLA panel experts, identified ten key

characteristics of the servant-leader (i.e. listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community (Spears, 1998). The OLA encompasses all ten of these components along with other essential characteristics agreed upon by the panel.

Procedure

The list of the program director's name and email address for each of the CAATE-accredited undergraduate entry-level athletic training programs was obtained from the CAATE web site. Each of the 27 program directors selected through a blocked-quasi random sampling method were contacted via email regarding the study. The program directors were asked to participate in forwarding an email to all of their athletic training students. The program directors were asked to reply to the email stating that they were willing to help and to provide the number of ACI's within their program. The email forwarded to the athletic training students informed the subjects that participation was voluntary and anonymous. It included information about the purpose, benefits, procedures, and risks. A request for the surveys to be returned within two weeks and a link to the web-based survey itself was given at the end of the email. The web-based survey started with demographic questions, then proceeded to the athletic training student satisfaction questionnaire and last the Organizational Leadership Assessment. Participants were asked to read all directions before beginning each section and to fill out all information honestly and accurately. The participants were made aware that by completing the surveys they were consenting to participation. To increase response rate, follow-up emails were sent to all potential participants two and four weeks after initial contact.

The surveys were Web-based surveys created through GoogleDocs.com. This website was chosen by the researcher because it was easy to use and understand. A web-based survey was the chosen method because it is inexpensive, convenient, and provides a good method of guaranteeing anonymity (Laurent & Bradney, 2007). When responses were received in Google Documents, no respondent information (i.e. email or name) was provided. Web-based surveys allow the convenience of immediate results and enhanced survey item completion rates (Schleyer & Forrest, 2000). The disadvantages of using web-based surveys included elimination of responses from computer illiterate participants, and the possibility of technical errors (Jones & Pitt, 1999; Raziano, Jayadevappa, Valenzula, Weiner, & Lavizzo-Mourey, 2001). When provided the option of a web-based survey, email, or postal mail, a significantly greater number of participants respond to web-based surveys (Laurent & Bradney, 2007; Schleyer & Forrest, 2000). Laruent and Bradney (2007) found that athletic trainers and program directors preferred web-based surveys. Due to the large sample size, population, and time constraints, a web-based survey appeared to be the best method. Data gathered from the web-based survey was password protected and was only accessible by the researchers involved.

Data Analysis

Demographic information was analyzed for year in program, gender, cumalative GPA, clinical GPA, and the district of the athletic training education program the student was a part of. The name of the institution was not identified or used for data analysis. The name of the institution was only used to determine how many programs were represented in the responses and to identify which district they were from. Bivariate

correlations were run to determine the relationships between: (1) servant leadership characteristics of the individual ACI and student success (i.e. cumulative grade point average and clinical experience grade point average); (2) servant leadership characteristics of the clinical affiliation and student success (i.e., same as above); (3) servant leadership characteristics of the individual ACI and student satisfaction; and (4) servant leadership characteristics of the clinical affiliation and satisfaction (Kerr, Hall, Kozub, 2002). Regression analyses were run if a strong correlation was identified among any of the above six variables.

Chapter IV
Results

The results of this research are organized into the areas of demographics and the six bivariate correlations that were used to assess the relationships between: (1) perceived servant leadership characteristics of ACI's and student success based on cumulative GPA; (2) perceived servant leadership characteristics of ACI's and student success based on clinical experience GPA; (3) perceived servant leadership characteristics of ACI's and student satisfaction; (4) perceived servant leadership characteristics of the clinical site and cumulative GPA; (5) perceived servant leadership characteristics of the clinical site and clinical experience GPA and: (6) perceived servant leadership characteristics of the clinical site and student satisfaction. After analyzing the descriptive statistics of each variable, it was clear the data was skewed, so the best measure of central tendency was the median (see Table A1). Therefore a Spearman rank correlation was used to account for more variability.

Demographics

In April 2009 surveys were emailed to 27 different programs with a two week and four week follow up. Thirty-six surveys were collected, 12 of which were not usable due to missing data. In March of 2010, the survey was sent out again, inviting those who had not participated in the original sample to participate, yielding a total of 13 more responses. Two of the 13 returned surveys in the second sampling were not complete and so were eliminated from the data pool. Just as in the first sample, the main reason surveys were not complete was that certain questions were not answered. The questions that were not answered were random for most of the 35 participants; however three did not answer the same three questions. Between the two rounds of surveys sent out, there

were a total of 49 surveys collected, 14 surveys eliminated, and 35 surveys that were used for data analysis. Surveys were obtained from 11 of the 27 programs that were randomly selected for participation resulting in a 25.9% return rate. Of those 11 programs, 49 students responded, representing 49 individual evaluations of approved clinical instructors. Descriptive statistics were run on the 35 subjects that had complete surveys. Refer to Table A2 for frequencies and percentages of demographic statistics of total surveys collected (n= 49) compared to surveys that were used for data analysis (n=35).

Identification of whether the ACIs were considered servant leaders was based on Laub (2000), who developed the OLA, and identified servant leaders as those who have an average score above 4 and non-servant leaders as those who average a score of 2 or below. The scores given by the students surveyed in this research indicated that 92% of the ACI's were classified as servant leaders and 8% were classified as non-servant leaders.

Spearman Rho Correlations of Servant Leadership Qualities and Student Success. All but one of the relationships between student success and servant leadership were very weak, positive correlations that were not statistically significant $p>.05$ (see table A3). The Spearman Rho correlation coefficients were all very low as demonstrated in Table A3, indicating that as servant leadership qualities increase, there is a very small chance that grade point average will increase at the same magnitude.

The students' perception of ACI servant leadership qualities and clinical GPA was an inverse relationship, but was also very weak and not statistically significant $p>0.05$ (see figure B1). This inverse relationship indicates that as servant leadership qualities of the ACI increases, the clinical grade point average slightly decreases.

Spearman Rho Correlations of Servant Leadership Qualities and Student Satisfaction. As demonstrated in Figure B2, students' perception of their ACI's servant leadership characteristics had a strong, positive, statistically significant correlation with the student satisfaction survey (n=35, r=.877, p=.000). Since the Spearman Rho correlation coefficient was such a strong correlation, a regression analysis was run showing that 83.4% of variance in student satisfaction is accounted for by variation in servant leadership qualities of approved clinical instructors (Y=-2.53+.583x).

Satisfaction of the clinical site as a whole and the student's perception of the clinical site's servant leadership characteristics also revealed a statistically significant, positive correlation, although, not as strong (n=35, r=.601, p=.000) (see figure B3).

In summary, it is clear that servant leadership had a strong influence on satisfaction in student athletic trainers whether from the ACI or the clinical site. It also became apparent that student success, as defined in this study, was not influenced by servant leadership qualities regardless of the ACI or clinical affiliation. The following chapter will discuss possible reasons and conclusions that can be drawn from these results.

Chapter V
Discussion

The purpose of this study was to determine the effect that servant leadership had on athletic training student success and student satisfaction. Based on the literature search conducted, there was little to no research found on servant leadership in athletic training clinical education, especially from the athletic training students' perspective. This research aimed to bridge that gap. Previous research had found that servant leadership led to higher student achievement (Dunn, Griggs, Olson, Beasley, & Gorman, 1995; Farkas, 2003; Herbst, 2003; Lovelance, 2005) and greater personal job satisfaction (Greenleaf, 1977; Lowe, 1998; Spears, 1998). The current authors of this study believed it was beneficial to determine if the same held true in athletic training clinical education. Based on the results of this study, the hypothesis that ACI's perceived as being servant leaders would produce more successful student athletic trainers did not hold true. However, the hypothesis that ACI's perceived as servant leaders would lead to more satisfied students was supported by the results of this study.

Perceived Servant Leadership Qualities of ACI's and Influence on Student Success. Considering that the four relationships analyzed between student success and servant leadership characteristics were not statistically significant ($p>.05$), it is possible that grade point average is not influenced by servant leadership (refer to Table 3). In the current study it was hypothesized that clinical grade point average would be more affected than overall grade point average by ACI's who were perceived as servant leaders. The results of this study, however, were quite the opposite. Overall grade point average had a positive relationship with ACI's perceived to have greater servant

leadership qualities, whereas clinical grade point average had a negative relationship with ACI's perceived to have greater servant leadership qualities (refer to Figure 1).

Given that neither relationship was statistically significant ($p>.05$) these results might be due to chance or (refer to Table 3) due to having a small sample size ($n=35$). However, a study done by Harrelson, Gallaspy, and Leaver-Dunn (1997), found similar results where overall grade point average was a higher predictor of passing the Board of Certification Athletic Training (BOCAT) examination. These authors found that the overall grade point average was a better predictor than the clinical grade point average. The authors attributed these findings to the overall intelligence quotient of the students.

Grade point average is considered to be a good predictor for student success in athletic training education (Harrelson, Gallaspy, Knight & Leaver-Dunn, 1997; Keskula, Sammarone, & Perrin, 1995; Middlemas, Manning, Gazzillo, & Young, 2001). However, the leadership style of the ACI is not the only predictor of overall grade point average or clinical grade point average. Clinical grade point average can be affected by many different variables including life stress, hours of clinical education, learning styles, and possibly other extraneous factors (Harrelson, Leaver-Dunn, & Wright, 1998; Middlemas et al., 2001; Stilger, Etzel, & Lantz, 2001). It is important to recognize that only a fraction of the learning is with the ACI and the rest of the time is actually spent in the classroom learning from professors. Therefore, the athletic training clinical grade point average is not only based on the leadership style of the ACI but also of the professors. There is evidence showing that schools with higher degrees of servant leadership among teachers produced higher levels of student achievement (Herbst, 2003). It seems appropriate to assume the same would be true in athletic training clinical

education and that this research was not sufficient to evaluate this outcome, thus necessitating for further research. Other ways of measuring student success in athletic training education could include passing of the BOCAT examination and/or analyzing the ACI or Program Director's perception of the students' success (Harrelson et al., 1997; Middlemas, et al., 2001).

Perceived Servant Leadership Qualities of ACI's and Influence on Student Satisfaction. As shown in Figures 2 and 3, student satisfaction increased when they perceived their ACI and clinical site to have greater servant leadership qualities. Given a p value of 0.000 for both, this implies these relationships are not due to random chance. The relationship between clinical site and student satisfaction produced a Spearman Rho correlation of .601, which is moderate and indicates that there is only a 36% chance that student satisfaction will go up with increased servant leadership. The ACI-student satisfaction relationship produced a Spearman Rho correlation of .877, indicating that there is a 76% chance that student satisfaction will go up as servant leadership characteristics increase. These results make it apparent that ACI's with more servant leadership qualities can have an impact on the satisfaction of student athletic trainers.

These results are directly in line with Lowe (1998) who found that TDIndustries (a servant led institution) had almost 100% employee satisfaction from its 900 employees. Although athletic training students are not considered employees, their clinical education as second and third year students is more like an internship and intentionally mimics a working environment with the supervision of ACI's as their so called bosses (Mensch, 2006, Wong & Wong, 1987). Further research would need to be conducted to determine if the common burnout rate in athletic training students could be

improved by greater student satisfaction (Clapper & Harris, 2008; Hendrix, Acevedo & Hebert, 2000; Stilger, Etzel & Lantz, 2001).

Practical Significance

Greenleaf (1977) tells us that servant leadership is something from within that makes us want to serve, more so than a set of characteristics that can be learned. It became unintentionally apparent through the data collection of this study that athletic trainers tend to be servant leaders by nature. To make this research applicable to program directors and approved clinical instructors, it is a matter of making them understand how to use the current qualities they already possess and the benefits that would result. By having more satisfied students, retention within the program and profession could be enhanced.

The results of this study can only be applied to athletic training education programs due to the sample population. However, it may help provide some evidence to spark further research for other allied health care professions since more of them are starting to adopt servant leadership (Anderson 2003, Swearingen & Liberman 2004). The findings of this study help support Swearingen and Liberman (2004) and Anderson (2003) regarding their theory that servant leadership could help resolve the job dissatisfaction and burnout rate among health care professions.

The results of this study did not show that servant leadership influenced the grade point average, but it is still possible that it could help with learning. There is a variety of literature indicating that the effective clinical instructor qualities that improve positive learning environments for student athletic trainers are similar to those of servant leadership characteristics (Barnum, 2008; Foster & Leslie, 1992; Lauber et al., 2003;

Laurent & Weidner, 2001; Pitney & Ehlers, 2004; Mensch, March 2006; Mensch, July 2006; Weidner & Henning, 2002; Weidner & Henning, 2004; Weidner & Henning, 2005). Pitney and Ehlers (2004) found student's perceived interpersonal relationships, which are a part of servant leadership, to be the most beneficial to their learning. The literature review of this research could potentially make ACI's more aware of the effect that interpersonal relationships can have on student learning in health care professions (Pitney & Ehlers, 2004).

Limitations

There were several limitations to this study that need to be identified and recognized for future research. One was the way that student success was measured. Student success was measured through overall grade point average and clinical experience grade point average. Clinical grade point average encompasses different variables within each program. Some programs' clinical experience GPA may involve classroom learning in addition to clinical learning, whereas others may have just clinic learning. Further, as stated previously, there are a variety of ways to measure success and GPA is not necessarily the only way or best way, but was easily accessible and convenient for the researcher to collect.

A second limitation was that the return rate was lower than expected, even though it was 25.9%. The surveys were sent out in the spring when most colleges and universities were wrapping up the school year and students were approaching finals. This could have had an effect on the low return rate and may have even influenced how much attention was given to the questions. In addition to the return rate, fourteen of the surveys that were returned could not be used for data analysis due to subjects leaving questions

unanswered. There was not necessarily a theme, but three of the subjects left the same three questions unanswered. This could be due to not understanding what the questions were asking, even though this did not become apparent during the pilot study.

Future Research

There are a variety of ways this research can be used and improved. First, since response rate was lower than expected in this study, sending out surveys to an increased amount of programs would be essential to represent a larger population. Sending surveys out earlier during the academic year and avoiding main examination times could increase return rate as well. Second, this study evaluated only student perceptions. Future studies could include a comparison of ACI, PD's, and student perceptions. Third, student success in future studies should include a variety of variables discussed in the discussion (e.g. BOCAT exam passing rate). Fourth, given that satisfaction was so strongly related to servant leadership characteristics, it would be informative to understand this relationship in regard to drop out rate among students. The student's perception of the PD's servant leadership qualities should be analyzed as well in future studies.

Conclusion

Research has indicated there are incongruencies in what student athletic trainers view as beneficial for their learning and what ACI's think is important for student learning (Pitney & Ehlers, 2004). This study was designed to help bridge that gap, first, by being one of the initial studies to evaluate the effects of servant leadership in athletic training education, and second, by being one of the first studies to look at the students' perception as opposed to the ACI's perception. Given the results and information from this study, it is apparent that servant leadership could have an influence on maintaining

student satisfaction in athletic training clinical education. Since many athletic trainers are servants by nature, it would be an easy transition to incorporate it into approved clinical instructor training. Servant leadership has brought success to many companies that have adopted it, and it is possible to have the same result in health care education (Lowe, 1998; Sendjaya & Sarros, 2002; Spears, 2004). Many nursing programs have already adopted servant leadership into their clinical education; however there is a paucity of research to demonstrate its effectiveness. Therefore, there is a need for more research regarding the benefits of servant leadership in athletic training as well as other allied health care education.

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Appendix A: Tables

Table A1

Descriptive Statistics for All Variables Demonstrating Reason for Mode of Central Tendency

			95% CI	
Variables	Mdn	SD	LL	UL
Student Success				
Cumulative GPA	3.50	0.33	3.36	3.58
Clinical GPA	3.75	0.26	3.63	3.81
Student Satisfaction				
ACI	79.00	17.89	67.20	79.49
Clinical Site	52.47	8.86	46.39	53.00
Servant Leadership Qualities				
ACI	138	28.0	120.60	139.86
Clinical Site	82.0	15.0	76.45	86.75

Note. CI = confidence interval; LL = lower limit; UL = upper limit

Table A2

Frequencies and Percentages for Demographics

	Total Surveyed (n=49)		Total Analyzed (n=35)	
Variables	Frequency	Percent	Frequency	Percent
Year in Program				
1st Year	29	59.3%	21	60.0%
2nd to last year	20	40.8%	14	40.0%
NATA District				
District 1	6	12.2%	4	11.4%
District 5	12	24.5%	9	25.7%
District 10	31	63.3%	22	62.9%
Gender				
Female	35	71.4%	25	71.4%
Male	14	28.6%	10	28.6%

Table A3

Spearman Rho Correlation Results of Servant Leadership Qualities and Student Success

	Clinical GPA	Cumulative GPA
ACI Servant Leadership Qualities	r = -0.050 p = 0.774	r = 0.158 p = 0.366
Clinical Site Servant Leadership Qualities	r = 0.071 p = 0.686	r = 0.294 p = 0.087

Appendix B: Figures

Figure B1. *Inverse Relationship between Approved Clinical Instructor Servant Leadership Qualities and Clinical Experience Grade Point Average*

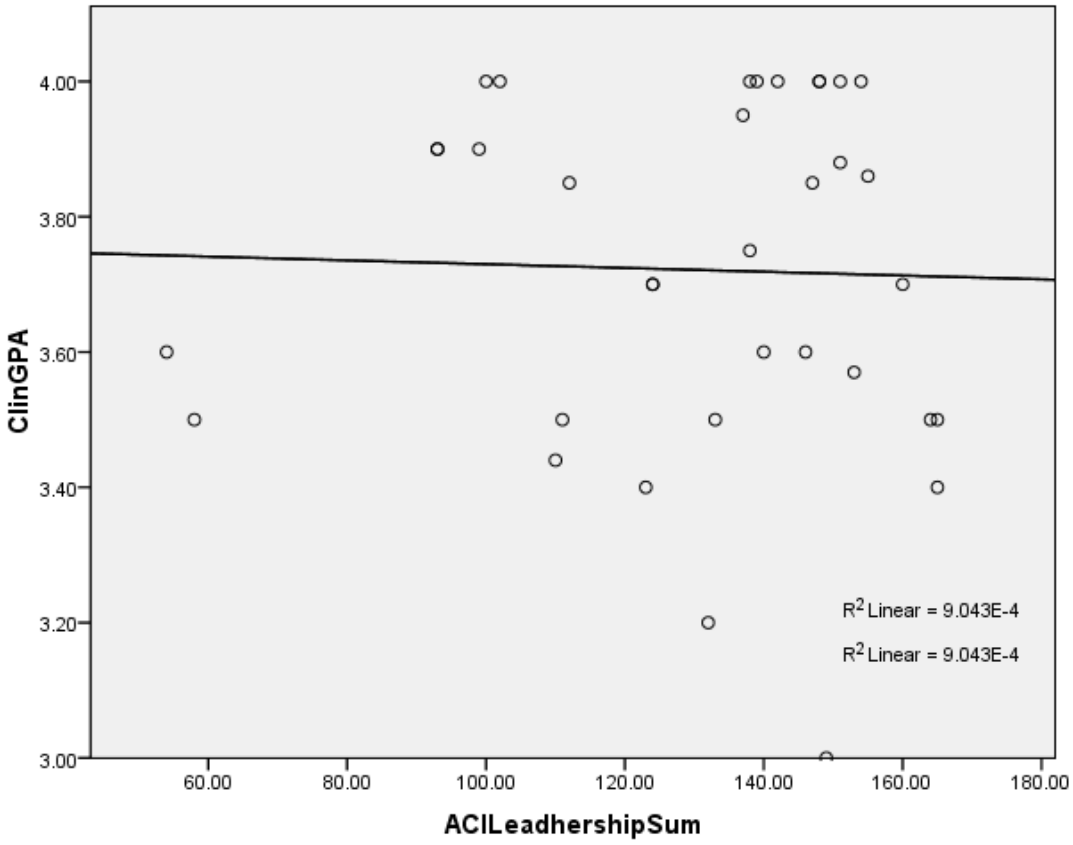


Figure B2. *Positive Relationship between Approved Clinical Instructor Servant Leadership Qualities and Student Satisfaction*

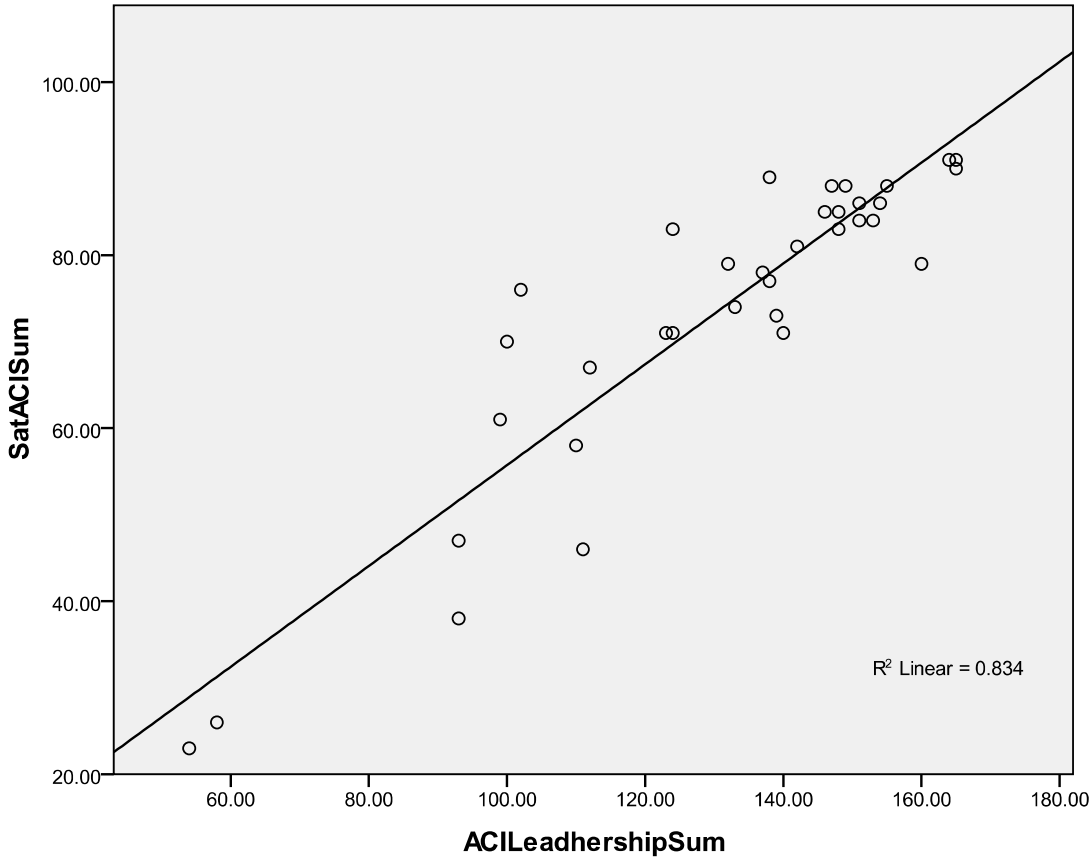
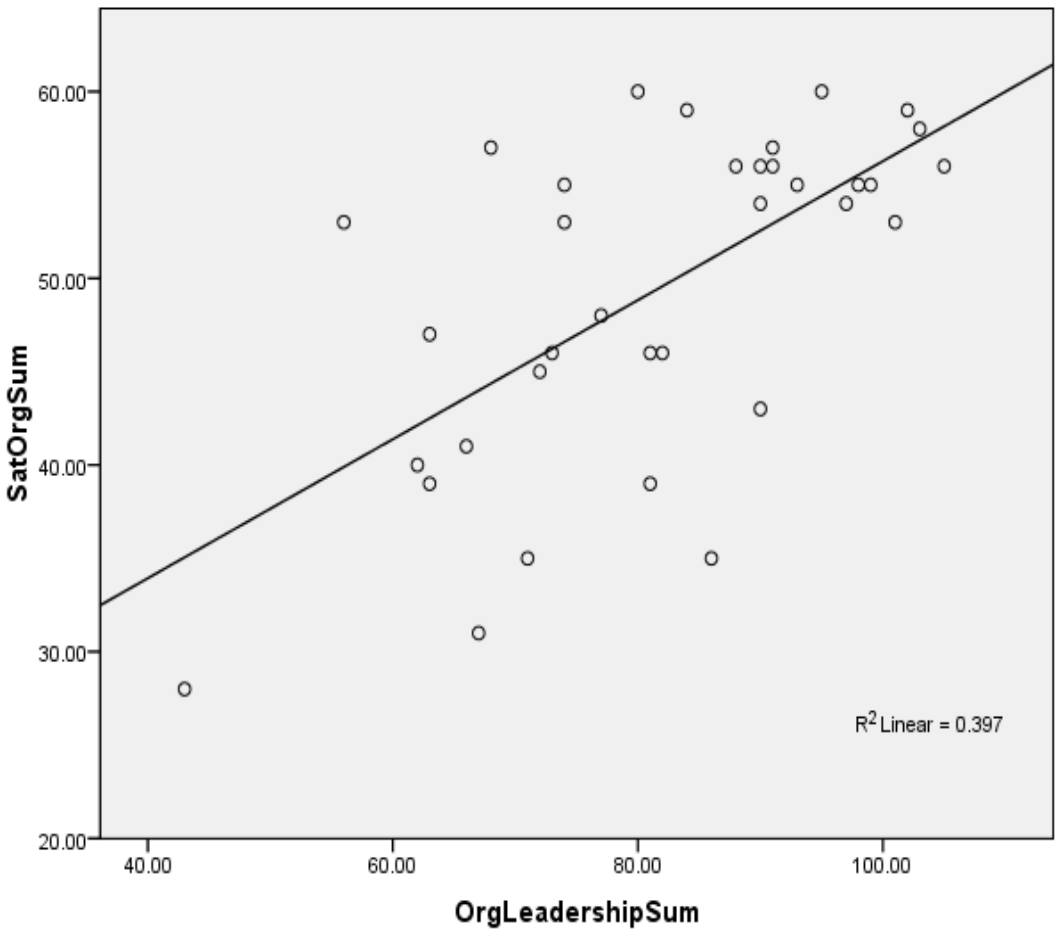


Figure B3. *Positive Relationship between Clinical Site Servant Leadership Qualities and Satisfaction*



Appendix C: Instruments

Demographics Questionnaire

SURVEY 1: DEMOGRAPHICS QUESTIONNAIRE Please check the box that applies to you or fill in the text box as indicated. DO NOT FILL IN THE TEXT BOX UNDER THIS STATEMENT!

What year are you in your program?

- ☐ 2nd to last year
- ☐ Last year

What is your gender?

- ☐ Male
- ☐ Female

What is your overall GPA?

What is your GPA for your clinical experiences? Average of all clinical experience grades

What is the name of the institution which hosts your Athletic Training Education Program? Example: Sample University

Athletic Training Student Satisfaction Questionnaire

SURVEY 2: ATHLETIC TRAINING STUDENT SATISFACTION QUESTIONNAIRE Please fill in the circle which most applies to the Approved Clinical Instructor (ACI) you have spent the most time with in the 2009-2010 school year, based on the following scale..... ..... 1=Very Dissatisfied 2= Moderately Dissatisfied 3=Slightly Dissatisfied 4=Neutral 5= Slightly Satisfied 6= Moderately Satisfied 7= Very Satisfied

The level that my ACI recognizes my value in the clinical setting

	1	2	3	4	5	6	7	
Very dissatisfied	○	○	○	○	○	○	○	Very satisfied

The level of friendliness my ACI shows towards me

	1	2	3	4	5	6	7	
Very dissatisfied	○	○	○	○	○	○	○	Very satisfied

The level to which my ACI will stand behind me

	1	2	3	4	5	6	7	
Very dissatisfied	○	○	○	○	○	○	○	Very satisfied

The level of interest my ACI has in my learning

	1	2	3	4	5	6	7	
Very disatisfied	○	○	○	○	○	○	○	Very satisfied

The level of appreciation my ACI shows me

	1	2	3	4	5	6	7	
Very dissatisfied	○	○	○	○	○	○	○	Very satisfied

My ACI's willingness to support my clinical decisions

	1	2	3	4	5	6	7	
Very dissatisfied	○	○	○	○	○	○	○	Very satisfied

Overall, how satisfied are you with your ACI as a clinical teacher?

	1	2	3	4	5	6	7	
Very dissatisfied	○	○	○	○	○	○	○	Very satisfied

The training in clinical skills I recieve from my ACI

	1	2	3	4	5	6	7	
Very dissatisfied	☐	☐	☐	☐	☐	☐	☐	Very satisfied

The style of instruction that I have recieved from my ACI

	1	2	3	4	5	6	7	
Very dissatisfied	☐	☐	☐	☐	☐	☐	☐	Very satisfied

The ACI's teaching effectiveness of the skills and techniques needed for this profession

	1	2	3	4	5	6	7	
Very dissatisfied	☐	☐	☐	☐	☐	☐	☐	Very satisfied

The level to which my ACI has helped me reach my personal clinical goals

	1	2	3	4	5	6	7	
Very dissatisfied	☐	☐	☐	☐	☐	☐	☐	Very satisfied

The level to which my ACI has contributed to the improvement in my knowledge of clinical skills

	1	2	3	4	5	6	7	
Very dissatisfied	☐	☐	☐	☐	☐	☐	☐	Very satisfied

The level to which my ACI has contributed to the improvement in my ability to perform clinical skills

	1	2	3	4	5	6	7	
Very dissatisfied	☐	☐	☐	☐	☐	☐	☐	Very satisfied

SURVEY 3: ORGANIZATIONAL LEADERSHIP ASSESSMENT There are three sections to this survey. Please read the directions for each section before answering the questions. Use the following scale for all three sections.....

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

SECTION 1: In this section, please respond to each statement as you believe it applies to the entire clinical setting in which you have spent the most time in the 2009-2010 school year including all Approved Clinical Instructors (ACI's), certified athletic training staff, and athletic training students DO NOT FILL IN THE TEXT BOX BELOW!

In general, people within this clinical setting trust each other

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

In general, people within this clinical setting are clear on the key goals of the clinical setting

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

In general, people within this clinical setting are non-judgemental-they keep an open mind

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

In general, people within this clinical setting respect each other

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

In general, people within this clinical setting know where this clinical setting is headed in the future

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

In general, people within this clinical setting maintain high ethical standards

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

In general, people within this clinical setting work well together in teams

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

In general, people within this clinical setting value differences in culture, race & ethnicity

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

In general, people within this clinical setting are caring & compassionate towards each other

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

In general, people within this clinical setting demonstrate high integrity & honesty

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

In general, people within this clinical setting are trustworthy

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

In general, people within this clinical setting relate well to each other

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

In general, people within this clinical setting attempt to work with others more than working on their own

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

In general, people within this clinical setting are held accountable for reaching work related goals

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

In general, people within this clinical setting are aware of the needs of others

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

In general, people within this clinical setting allow for individuality of style and expression

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

In general, people within this clinical setting are encouraged to share in making important decisions

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

In general, people within this clinical setting work to maintain positive working relationships

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

In general, people within this clinical setting accept people as they are

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

In general, people within this clinical setting view conflict as an opportunity to learn & grow

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

In general, people within this clinical setting know how to get along with people

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

SECTION 2: In this next section, please respond to each statement as you believe it applies to the Approved Clinical Instructor (ACI) you have spent the most time with in your assigned clinical setting in the 2009-2010 school year DO NOT FILL IN THE TEXT BOX BELOW!

My ACI communicates a clear vision of the future of the clinical setting

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

My ACI is open to learning from those who are below them in the clinical setting

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

My ACI allows athletic training students to help determine where this clinical setting is headed

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

My ACI works alongside the athletic training students instead of separate from them

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

My ACI uses persuasion to influence others instead of coercion or force

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

My ACI does not hesitate to provide the leadership that is needed

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

My ACI promotes open communication and sharing of information

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

My ACI gives athletic training students the power to make important decisions

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

My ACI provides the support and resources needed to help athletic training students meet their goals

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

My ACI creates an environment that encourages learning

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

My ACI is open to recieving criticism & challengenge from others

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

My ACI says what they mean, and means what they say

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

My ACI encourages each person to exercise leadership

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

My ACI admits personal limitations & mistakes

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

My ACI encourages people to take risks even if they may fail

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

My ACI practices the same behavior they expect from others

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

My ACI facilitates the building of community & team

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

My ACI does not demand special recognition for being a leader

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

My ACI leads by example by modeling appropriate behavior

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

My ACI seeks to influence others from a positive relationship rather than from the authority of their position

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

My ACI provides opportunities for all athletic training students to develop to their full potential

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

My ACI honestly evaluates themselves before seeking to evaluate others

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

My ACI uses their power and authority to benefit the athletic training students

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

My ACI takes appropriate action when it is needed

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

My ACI builds people up through encouragement and affirmation

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

My ACI encourages athletic training students to work together rather than competing against each other

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

My ACI is humble - they do not promote themselves

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

My ACI communicates clear plans & goals for the clinical setting

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

My ACI provides mentor relationships in order to help people grow professionally

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

My ACI is accountable & responsible to others

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

My ACI is a receptive listener *

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

My ACI does not seek after special status or the "perks" of leadership

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

My ACI puts the needs of the athletic training students ahead of their own

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

SECTION 3: In this section, please respond to each statement as you believe it is true about you personally and your role in your assigned clinical setting DO NOT FILL IN THE TEXT BOX BELOW!

In viewing my own role...I feel appreciated by my ACI for what I contribute

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

In viewing my own role...I am learning at a high level of productivity

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

In viewing my own role...I am listened to by the ACI's in this clinical setting

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

In viewing my own role...I feel good about my contribution to this clinical setting

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

In viewing my own role...I recieve encouragement and affirmation from the ACI's in this clinical setting

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

In viewing my own role...my job is important to the success of this clinical setting

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

In viewing my own role...I trust the leadership in this clinical setting

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

In viewing my own role...I enjoy being in this clinical setting

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

In viewing my own role...I am respected by the ACI's in this clinical setting

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

In viewing my own role...I am able to be creative in my clinical responsibilities

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

In this clinical setting, a person's work is valued more than their title

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

I am able to use my best gifts and abilities in this clinical setting

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

Appendix D

Emailed Consent Letter

Hi, my name is Cheree Sauer and I am a graduate student at Eastern Washington University. I am conducting a research study on servant leadership in athletic training clinical education. I would like to know if different characteristics of Approved Clinical Instructors impacts your learning experience in the clinical setting.

There are no known risks or discomforts as well as your identity will remain anonymous. Your program directors and approved clinical instructors will not see or have access to your responses, so please fill the information out honestly and accurately. The actual survey should take about twenty minutes. If you choose to participate, please read the procedures section carefully before you begin. Below is the consent form, if you have any questions, feel free to contact me. If you agree to participate, simply click on the link at the bottom of the page. By clicking on the link this means that you have read the consent form, have been given the opportunity to ask questions, and you have chosen to participate. You must be over the age of 18 when completing the survey and your participation is voluntary.

You may change your mind at any time without penalty of loss of any benefits to which you are entitled if you chose to exit this survey before completion. Thank you. Again if you have any questions please feel free to contact myself, csauer@eagles.ewu.edu or Dr. Garth Babcock, gbabcock@ewu.edu.

Eastern Washington University
Informed Consent For
Assessing the Effectiveness of Servant Leadership in Athletic Training Clinical Education

Principle Investigator: Cheree Sauer, Graduate Student, Dept of PEHR. Phone: 509-499-0698. Email: csauer@eagles.ewu.edu
Responsible Principle Investigator: Garth Babcock, Ph.D., Department of Physical Education, Health, and Recreation. Phone: 509-359-2427 (office)
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Curriculum Vita

Author: Cheree N. Sauer

Place of Birth: Spokane, Washington

Undergraduate Schools Attended: Spokane Community College,
Eastern Washington University

Degrees Awarded: Bachelor of Science, 2005, Eastern Washington University

Honors and Awards: Graduate Assistanship, Athletic Training, 2007-2009, Eastern Washington University

Graduated Magna Cum Laude, Eastern Washington University, 2005

Professional Experience: Assistant Athletic Trainer, 2009-present, Whitworth University

Graduate Assistant Athletic Trainer, 2007-2009, Eastern Washington University

Fitness Center Manager, Certified Athletic Trainer, Certified Personal Trainer, 2005-2007, Apex Physical Therapy