Determinants of Nurse Managers' Servant Leadership: A Systematic Review

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Abstract: *This systematic literature review synthesizes evidence on factors that may predispose, develop, enable, reinforce, or constrain servant leadership among nurse managers. The evidence base comprises 49 English-language publications issued within the predefined eligibility window, identified through a PRISMA-informed search of bibliographic databases, publisher platforms, Google Scholar, and supplementary citation sources. Because the corpus includes direct nursing studies as well as adjacent healthcare leadership and professional-preparation evidence, conclusions are strongest for nurse-manager samples and more tentative when transferred from related settings. Thematic narrative synthesis and frequency mapping produced four interdependent domains: personal moral-service orientation, relational leadership capability, developmental preparation, and organizational-contextual conditions. Organizational support was the most frequently represented factor, followed by service values, cultural context, empowerment practice, and relational trust; emotional intelligence, leader humility, and formal leadership training received comparatively limited attention. The synthesis indicates that servant leadership is neither a fixed trait nor a training outcome in isolation. Its enactment depends on the interaction of ethical service motives, relational competence, development opportunities, psychological safety, manageable demands, and institutional reinforcement. The review offers an integrated determinant framework while distinguishing literature coverage from causal evidence and identifying priorities for longitudinal, multilevel, comparative, and intervention research.*

Keywords: nurse managers; servant leadership; leadership determinants; nursing leadership; organizational support; systematic literature review.

1. Introduction

Nurse managers operate at the interface of organizational strategy and frontline clinical care. They translate policy into staffing, quality improvement, patient safety, professional development, resource allocation, and interdisciplinary coordination while shaping the relational climate in which nurses work. Their leadership therefore influences not only operational performance but also whether staff feel respected, supported, and able to voice concerns. Reviews of nursing leadership associate constructive approaches with stronger work environments, job satisfaction, retention-related outcomes, and organizational performance, although the conditions that generate and sustain such approaches remain less clearly specified (Cummings et al., 2018). Clarifying those conditions is

especially important in health systems facing workforce shortages, emotional strain, complex accountability, and sustained pressure to improve quality and safety.

Servant leadership is conceptually compatible with nursing because it emphasizes service, ethical stewardship, humility, empowerment, follower growth, and community. Unlike leader-centered models that treat positional authority primarily as control, servant leadership frames power as a responsibility to support legitimate staff and patient needs. The construct integrates motive, behavior, and developmental purpose: leaders are oriented toward serving others, enact that orientation through ethical and relational conduct, and seek follower growth beyond immediate task completion (Eva et al., 2019). Nursing concept analysis similarly identifies listening, empathy, stewardship, foresight, commitment to growth, and community building as recurring attributes (Neville et al., 2021). These attributes define what servant leadership looks like; they do not, however, explain why some nurse managers develop and sustain it while others cannot enact it consistently under comparable or changing conditions.

Most healthcare research has examined servant leadership as a predictor of engagement, satisfaction, commitment, psychological safety, burnout, turnover intention, performance, voice, and patient-safety behavior. Far fewer studies investigate the personal dispositions, learned capabilities, relational processes, organizational resources, and cultural conditions from which servant leadership may emerge. A healthcare-focused review similarly concludes that antecedents and boundary conditions are less developed than consequence-oriented evidence (Demeke et al., 2024). The literature is dispersed across nursing, healthcare management, professional education, organizational behavior, and cross-cultural research, and it uses determinant language inconsistently. Some publications test direct antecedents, whereas others reveal enabling or constraining conditions indirectly through mediators, moderators, contextual analyses, or outcome models. Without an integrated synthesis, frequently mentioned factors may be mistaken for empirically established causes, reciprocal relationships may be presented as unidirectional, and structural constraints may be misclassified as individual leadership deficiencies.

This review therefore identifies, classifies, compares, and synthesizes factors that may predispose, develop, enable, reinforce, condition, or inhibit servant leadership relevant to nurse-manager practice. It addresses five questions: which personal orientations are implicated; which relational capabilities translate those orientations into managerial behavior; which developmental experiences support capability formation; which organizational and cultural conditions sustain or suppress enactment; and where the evidence is consistent, mixed, indirect, or insufficient. The review deliberately separates frequency of examination from direction, consistency, and strength of influence. Because some included publications concern adjacent healthcare leadership or professional preparation rather than nurse managers directly, such evidence is used to illuminate plausible mechanisms and contexts, not to claim nurse-manager-specific effects. By organizing the evidence into a multilevel framework, the study clarifies conceptual relationships, identifies methodological and contextual gaps, and informs selection, leadership development, organizational diagnosis, and future empirical research. No hypotheses are proposed because the objective is synthesis rather than causal testing.

2. Methodology

This study used a systematic literature review design informed by the updated PRISMA reporting guideline (Page et al., 2021). The publication eligibility window matched the period specified in Figure 1. Searches were conducted across Scopus, Web of Science Core Collection, PubMed/MEDLINE, and CINAHL, together with the publisher platforms ScienceDirect, SpringerLink, and Wiley Online Library. Google Scholar, publisher reference lists, DOI records, and

backward and forward citation searching provided supplementary coverage. Search strings combined population terms such as "nurse manager," "nursing leader," healthcare, and hospital with "servant leadership" and determinant-related terms including antecedent, predictor, attribute, competency, training, support, culture, workload, barrier, enabler, and context. Syntax was adapted to each source while retaining the same conceptual blocks. Eligibility was limited to English-language journal articles and relevant review or professional publications addressing nursing, healthcare leadership, health-professions education, or comparable clinical settings.

Publications were included when they examined servant leadership and contained evidence relevant to a determinant, enabling or constraining condition, developmental mechanism, boundary factor, or contextual influence affecting its enactment or perception. Direct antecedent studies were considered alongside concept analyses, interventions, cross-cultural investigations, and outcome-focused research when they contributed determinant-relevant information; these source types were not treated as equivalent in causal strength. Publications were excluded when servant leadership was merely rhetorical, the setting was unrelated to healthcare or professional preparation, methodological information was insufficient, or the publication fell outside the eligibility period. The search identified 188 records. After removal of 41 duplicates, 147 titles and abstracts were screened; 75 were excluded, and 72 full texts were assessed. Twenty-three full texts were subsequently excluded, leaving 49 publications in the final synthesis. Figure 1 presents the reconciled identification, screening, eligibility, and inclusion pathway.

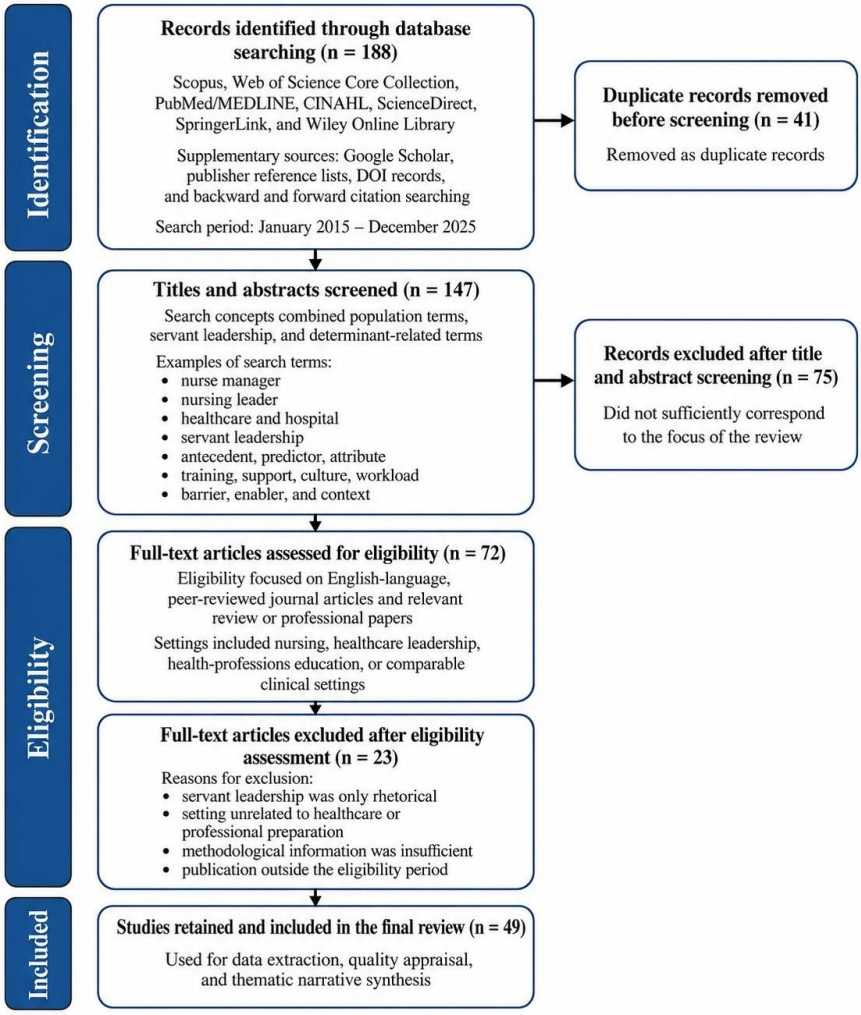

Figure 1: The Systematic Review Process

Figure 1 presents a numerically coherent screening pathway from 188 identified records to 49 included publications. Removal of 41 duplicates reduced the pool to 147 records for title-and-abstract screening; exclusion of 75 records then left 72 full texts for eligibility assessment. A further 23 full texts were excluded, producing the final corpus. The progression is internally consistent because each subtraction reconciles with the subsequent stage. Analytically, the figure shows that the broad electronic and supplementary search strategy was progressively narrowed through relevance and eligibility criteria rather than through a single restrictive source. It also indicates that approximately two thirds of the screened records were ultimately excluded, underscoring the difference between initial retrieval and determinant-relevant evidence. The figure supports transparency regarding record flow, but it does not by itself demonstrate search completeness, reviewer agreement, protocol registration, or methodological quality; those issues require separate reporting in the methods and limitations.

Data extraction captured authorship, year, country or sector, population, design, theoretical basis, servant leadership measure, determinant-relevant concepts, analytical approach, principal findings, and reported limitations. Coding proceeded iteratively: study-level concepts were first assigned to provisional categories, after which overlapping labels were consolidated into fourteen standardized factors. Methodological quality was appraised with design-appropriate Joanna Briggs Institute tools and the Mixed Methods Appraisal Tool for mixed-methods research (Hong et al., 2018). Appraisal informed the caution and weight applied during interpretation rather than serving as an automatic exclusion rule. Given substantial heterogeneity in populations, measures, designs, and causal direction, statistical pooling was not appropriate. The synthesis therefore combined thematic narrative analysis, conceptual clustering, comparative interpretation, and frequency mapping. Binary matrix counts indicate whether a publication engaged substantively with a factor; they do not represent statistical significance, effect magnitude, consistency, temporal precedence, or causal priority. This distinction is essential because much of the corpus examines servant leadership as an explanatory variable rather than as an outcome requiring antecedent analysis.

3. Conceptual and Methodological Contributions

The review's first contribution is to reorient a predominantly consequence-centered literature toward determinants. Healthcare research commonly treats servant leadership as a predictor of employee and organizational outcomes, while the processes through which it develops and persists remain comparatively underexamined (Demeke et al., 2024). Here, determinant-relevant evidence is defined broadly but cautiously as credible information that a factor may predispose, develop, enable, reinforce, constrain, or condition servant leadership practice. Direct antecedent tests are therefore synthesized alongside concept analyses, developmental studies, cross-cultural investigations, and boundary-condition research without assigning these designs equal causal weight. The resulting framework contains four interdependent domains. Personal moral-service orientation includes service values, integrity, humility, empathy, and emotional intelligence. Relational leadership capability includes empowerment, trust, open communication, and staff development. Developmental preparation concerns formal and experiential leadership learning. Organizational-contextual conditions include institutional support, workload resources, safety culture, and broader cultural context. An other-oriented service motive and ethical use of power provide the conceptual foundation, while relational practices make that orientation visible in daily management (Eva et al., 2019).

The second contribution is theoretical integration. Social-learning reasoning provides an interpretive lens for understanding how role modeling, guided practice, feedback, and leadership education may cultivate relevant capabilities (Murphy et al., 2020). Social-exchange reasoning clarifies how fairness,

trust, organizational support, and power sharing may encourage reciprocal openness and reinforce relational leadership (Saleem et al., 2022). A job demands-resources perspective helps explain why staffing adequacy, autonomy, time, and institutional support preserve the capacity required for attentive listening, individualized development, and participatory decision making (Westbrook et al., 2022). Cross-cultural evidence further indicates that humility, employee voice, and distributed authority may carry different meanings across professional hierarchies and national settings (van Dierendonck et al., 2017). These perspectives are used as complementary lenses rather than as proof of a single causal model. Together, they prevent the framework from reducing servant leadership either to stable personality or to training alone and allow for reciprocal processes in which supportive institutions facilitate servant behavior while servant-oriented managers help create trust, support, and psychological safety.

The third contribution is methodological discipline in separating three questions that are often conflated: how frequently a factor appears, whether an association is reported, and how consistently that association is supported across contexts and methods. The binary evidence map records substantive coverage rather than significance, effect size, or causal priority. A check mark indicates that a publication examined, theorized, operationalized, or otherwise contributed evidence concerning a factor; it does not mean that the factor was tested as an independent antecedent. This distinction is necessary because many included publications position servant leadership as the explanatory variable (Demeke et al., 2024). Outcome-oriented evidence on innovative behavior and performance illustrates consequences rather than antecedents (Kül & Sönmez, 2021), whereas prosocial motivation functions as a boundary condition in upward voice (Abdelmotaleb et al., 2022). Research on deep acting identifies psychological empowerment and positive affect as explanatory mechanisms (Chang et al., 2024), while qualitative evidence from resource-constrained hospitals highlights the interdependence of service culture, communication, institutional resources, and leadership support (Demeke et al., 2025). Integrating these distinct evidence types broadens the synthesis without overstating what the matrix can demonstrate.

Table 1: Determinant Coverage Matrix

No.	Author(s) and Year	Service Values	Emotional Intelligence	Moral Integrity	Leader Humility	Empathic Care	Empowerment Practice	Relational Trust	Open Communication	Staff Development	Leadership Training	Organizational Support	Workload Resource	Safety Culture	Cultural Context
1	Eva et al. (2019)	✓		✓	✓	✓	✓	✓		✓					✓
2	Anderson (2016)	✓	✓			✓				✓	✓				
3	Hanse et al. (2016)				✓		✓	✓	✓			✓			
4	Hosseini et al. (2016)	✓				✓						✓			✓
5	Allen et al. (2016)	✓		✓			✓			✓	✓				
6	Aij and Rapsaniotis (2017)	✓		✓	✓		✓		✓	✓		✓		✓	
7	Johanson (2017)	✓				✓			✓	✓					✓
8	Gorsky et al. (2018)			✓	✓			✓	✓						✓
9	van Dierendonck et al. (2017)	✓		✓	✓		✓	✓							✓
10	Cottey and McKimm (2019)	✓		✓		✓						✓		✓	
11	Nadeak (2019)	✓								✓	✓	✓			
12	Mostafa and El-Motalib (2019)						✓	✓	✓			✓			
13	Farrington and Lillah (2019)	✓				✓		✓				✓	✓		
14	Mustard (2020)	✓		✓		✓				✓		✓			✓
15	Hidayati and Zainurossalamia (2020)			✓					✓	✓					✓

No.	Author(s) and Year	Service Values	Emotional Intelligence	Moral Integrity	Leader Humility	Empathic Care	Empowerment Practice	Relational Trust	Open Communication	Staff Development	Leadership Training	Organizational Support	Workload Resource	Safety Culture	Cultural Context
16	Fahmi et al. (2020)			✓			✓		✓			✓			✓
17	Murphy et al. (2020)	✓	✓		✓					✓	✓				
18	Der Kinderen et al. (2020)					✓		✓				✓	✓	✓	
19	Neville et al. (2021)	✓	✓	✓	✓	✓	✓	✓	✓	✓					
20	Mahon (2021)					✓		✓	✓		✓	✓	✓	✓	
21	Ma et al. (2021)					✓	✓	✓	✓			✓	✓	✓	
22	Ahmad et al. (2021)	✓		✓			✓			✓		✓			✓
23	Daswati et al. (2021)	✓					✓	✓				✓		✓	✓
24	Mezu-Ndubuisi (2021)			✓	✓	✓			✓			✓			✓
25	Maglione and Neville (2021)	✓	✓	✓		✓				✓	✓				
26	Malak et al. (2022)	✓		✓			✓	✓		✓	✓	✓		✓	
27	Peng et al. (2022)	✓		✓			✓					✓		✓	✓
28	Saleem et al. (2022)						✓	✓	✓			✓	✓	✓	
29	Omanwar and Agrawal (2022)			✓				✓	✓			✓			✓
30	Westbrook et al. (2022)					✓	✓					✓	✓	✓	
31	Raoush (2022)	✓						✓		✓		✓			✓
32	Uktutias et al. (2022)	✓				✓		✓				✓			✓
33	Qin et al. (2023)	✓					✓			✓	✓	✓	✓		✓
34	Xiao et al. (2023)					✓						✓	✓		✓
35	Faraz et al. (2023)						✓	✓	✓			✓	✓		
36	Yasir and Jan (2023)			✓				✓	✓			✓		✓	✓
37	Demeke et al. (2024)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
38	Du et al. (2024)					✓	✓					✓	✓	✓	✓
39	Alolayyan et al. (2024)					✓		✓				✓	✓		✓
40	Xiao et al. (2024)						✓					✓	✓	✓	✓
41	Bayati et al. (2025)	✓				✓	✓	✓				✓	✓		✓
42	Saavedra et al. (2025)	✓		✓		✓	✓	✓	✓			✓	✓	✓	✓
43	Asfour et al. (2025)					✓	✓	✓	✓			✓	✓	✓	✓
44	Agyapong et al. (2025)	✓					✓	✓	✓			✓	✓	✓	✓
45	Malićanin et al. (2025)	✓					✓	✓		✓		✓	✓		✓
46	Kül and Sönmez (2021)	✓		✓		✓									
47	Abdelmotaleb et al. (2022)	✓							✓						✓
48	Chang et al. (2024)		✓				✓								
49	Demeke et al. (2025)	✓					✓		✓	✓	✓	✓	✓	✓	✓

Table 1 maps how the 49 included publications engage with the fourteen determinant categories; it should be read as a coverage map, not as a ranking of causal effects. Organizational support is the most frequently represented factor (36 publications), followed by service values and cultural context (29 each), empowerment practice (27), relational trust (25), empathic care (23), open communication (21), and moral integrity (20). Workload resources, safety culture, and staff development each appear in 18 publications. Leadership training (10), leader humility (9), and emotional intelligence (6) receive substantially less direct attention. The distribution supports a multilevel interpretation in which ethical orientation, relational practice, development, and organizational context interact. It also exposes an important imbalance: factors that are conceptually central are not necessarily those tested

most rigorously. Consequently, the matrix identifies priorities for focused antecedent research, but it does not establish effect size, direction, consistency, or temporal precedence.

4. Discussion

The synthesis indicates that servant leadership relevant to nurse-manager practice begins with moral-service orientation but cannot be reduced to values alone. Service commitment, integrity, humility, empathy, and emotional intelligence provide motivational and affective foundations for ethical stewardship, staff growth, and patient-centered responsibility. An other-oriented motive and ethical use of power are central to the construct (Eva et al., 2019), while nursing concept analysis emphasizes listening, empathy, stewardship, foresight, and commitment to development (Neville et al., 2021). Yet conceptual centrality is not equivalent to antecedent evidence. Service values and integrity are widely theorized, whereas emotional intelligence receives limited direct examination and is often discussed as an educational capacity rather than tested causally (Anderson, 2016). Empathy may support attentive leadership, but its expression depends on emotional regulation, time, and recovery from strain; humility may invite staff expertise, but hierarchy can discourage visible uncertainty or shared decision making. Personal orientation therefore gives servant leadership direction, whereas relational competence and context determine whether it becomes stable behavior. Selection systems should assess service motive and ethical use of power without assuming that favorable dispositions will withstand unsupportive conditions.

Relational trust, open communication, empowerment, and staff development are the principal mechanisms through which moral orientation becomes observable. Staff encounter servant leadership through repeated interactions in which managers listen, explain decisions, keep commitments, share credit, respond fairly, and create meaningful participation. Servant leadership dimensions are associated with stronger leader-member exchange among healthcare professionals (Hanse et al., 2016), and trust in the leader and psychological empowerment help explain links with performance (Saleem et al., 2022). Psychological safety is especially important in nursing because staff must report errors, challenge unsafe routines, and request assistance without fear of humiliation or retaliation. Servant leadership has been linked with psychological safety and reduced burnout (Ma et al., 2021) and with psychological safety among Jordanian nurses (Asfour et al., 2025). These variables are commonly modeled as outcomes, but they may also create reinforcing cycles: early experiences of fairness and openness can make further delegation and voice safer. Prosocial motivation also alters the relationship between servant leadership and upward voice (Abdelmotaleb et al., 2022), demonstrating that follower characteristics can operate as boundary conditions. Longitudinal designs are required to separate antecedents from reciprocal reinforcement.

Developmental preparation is highly actionable but weakly established as a direct determinant. Leadership education, reflective practice, coaching, simulation, role modeling, and multisource feedback may translate service intentions into more reliable communication, delegation, conflict management, and staff-development behavior. Training programs have been associated with servant motivation among hospital personnel (Nadeak, 2019), while health-professions students show variation in servant leadership self-efficacy (Murphy et al., 2020). These findings indicate developmental potential but do not establish which components produce durable behavior in nurse-manager roles. Formal programs may improve knowledge without changing workplace routines when participants lack authority, feedback, protected time, or senior sponsorship. Clinical experience and postgraduate preparation may strengthen systems thinking and credibility, yet prolonged exposure to command-oriented cultures may also normalize directive habits. Perceived head-nurse servant leadership varies by hospital level, employment status, and overtime (Qin et al., 2023), indicating that

ratings reflect both manager behavior and setting characteristics. Development initiatives should therefore combine individual assessment with coached workplace application and unit-level evaluation, while distinguishing skill deficits from limited opportunity or contextual suppression.

Organizational support, workload resources, and safety culture shape whether servant leadership can be sustained under clinical pressure. Organizational support is the most frequently represented factor in the matrix, but that prominence reflects coverage rather than verified causal dominance. Supportive institutions provide discretion, staffing capacity, development resources, senior-leader backing, and legitimacy for managers to invest time in coaching and participation. Without such conditions, servant leadership risks becoming an unfunded moral expectation imposed on middle managers who remain accountable for outcomes but lack control over schedules, staffing, or service redesign. Vacancies, high acuity, overtime, administrative burden, and interruption also reduce the time and emotional capacity required for listening and individualized development. Servant leadership has been associated with lower hindrance stressors and favorable nursing outcomes (Westbrook et al., 2022), while servant-oriented supervision may mitigate burnout and secondary trauma (Mahon, 2021); neither relationship substitutes for adequate resources. Safety culture provides a clinically specific purpose by connecting empowerment and voice with patient protection. Evidence linking servant leadership with standard-precaution compliance and emotional exhaustion (Du et al., 2024), together with qualitative findings on service culture, learning, communication, resources, leadership support, and policy alignment (Demeke et al., 2025), supports a systems interpretation. Training alone is unlikely to overcome punitive or chronically overloaded environments.

Cultural and contextual evidence indicates that servant leadership is recognizable across settings but not expressed or interpreted identically. Power distance, professional hierarchy, gender expectations, employment arrangements, and norms concerning voice can influence whether humility and empowerment are perceived as credibility, weakness, inclusion, or avoidance. Cross-cultural validation supports broad comparability while requiring attention to contextual meaning (van Dierendonck et al., 2017). Service-oriented leadership must also confront systemic racism and unconscious bias rather than rely on generalized benevolence (Mezu-Ndubuisi, 2021). Gender-related conclusions remain uncertain: available evidence reports favorable relationships with nursing work environments and attitudes but insufficient consistency to establish stable gender differences (Saavedra et al., 2025). Mixed findings further show that servant leadership cannot compensate for every structural deficiency. It did not consistently strengthen the relationship between work-life balance programs and psychological well-being in one study (Xiao et al., 2023), suggesting limited leverage when program design or contextual conditions are weak. The evidence therefore favors configurations rather than single determinants. Theoretical models should examine personal, relational, developmental, and contextual domains jointly, including reciprocal and cross-level processes; hospitals should align selection, development, workload design, safety systems, and senior-leader behavior rather than treating training as an isolated solution.

5. Research Gaps and Future Research Directions

The principal gaps concern causal direction, measurement, theoretical integration, scope, and reporting transparency. Most publications treat servant leadership as an independent variable, leaving its acquisition and maintenance under-specified. Cross-sectional, self-reported designs predominate, limiting causal inference and making follower ratings sensitive to unit climate, job satisfaction, employment conditions, and common-method bias. Direct evidence on emotional intelligence, leader humility, leadership training, and interactions among determinant domains is limited. Organizational support, workload, and safety culture are often modeled as controls, mediators, or consequences

rather than antecedents. Geographic and sectoral coverage is uneven, with relatively little evidence from low-resource systems, primary care, long-term care, mental health, and cross-sector comparisons. Definitions and measures vary, and gender, race, professional hierarchy, contract status, and cultural intelligence remain insufficiently examined. The review also includes adjacent healthcare and professional-education evidence, so nurse-manager-specific conclusions require caution. Reproducibility is further constrained because the report does not specify the final search date, protocol registration, reviewer numbers or agreement procedures for screening and extraction, or study-level appraisal outcomes. These omissions limit assessment of selection reliability and evidence weighting and should temper interpretation.

Future research should use longitudinal, multilevel, comparative, and intervention designs that measure personal orientation, developmental exposure, organizational conditions, and observed servant leadership behavior over time. Studies should distinguish temporally prior determinants from mediators, moderators, consequences, and reinforcing feedback. Intervention trials could compare coaching, simulation, reflective supervision, multisource feedback, and workplace projects while documenting fidelity, protected time, sponsorship, authority, and competing demands. Measurement should combine follower reports with self-assessment, observation, senior-leader ratings, and objective indicators of staffing, safety, and performance. Cross-level models should test whether organizational support, workload, safety climate, and culture strengthen or weaken the translation of service values into relational practice. Comparative studies are needed across countries, hospital types, professional groups, and resource levels, with attention to equity and differing interpretations of humility, voice, and empowerment. Future reviews should preregister protocols, report exact search dates and source-specific strategies, use independent duplicate screening and extraction where feasible, publish transparent extraction and appraisal records, and explain how quality assessments affected synthesis. These steps would strengthen causal inference, reproducibility, and the empirical basis of an integrated determinant framework.

6. Conclusion

This review synthesized 49 publications from the predefined eligibility window to clarify factors that may shape servant leadership relevant to nurse managers. The evidence supports a multilevel, conditional interpretation rather than a fixed-trait account. Service values, integrity, humility, empathy, and emotional intelligence provide motivational and affective foundations; trust, communication, empowerment, and staff development translate those foundations into recognizable managerial practice; leadership preparation may develop relevant capabilities; and organizational support, workload resources, safety culture, and cultural context influence whether the behavior can be enacted and sustained. Organizational support received the broadest coverage, followed by service values and cultural context, empowerment practice, and relational trust. Emotional intelligence and leader humility were least represented, and formal leadership training was also examined infrequently. These patterns describe the visibility of factors in the literature, not their comparative causal strength. The review's central contribution is therefore an integrated determinant map that separates conceptual importance, coverage, contextual relevance, and demonstrated influence while preserving uncertainty about direction and causality.

The synthesis has practical and theoretical implications for healthcare leadership. Hospitals should not rely on values-based recruitment or short training courses in isolation; they should align selection, experiential development, managerial authority, staffing, performance systems, psychological safety, and senior-leader behavior with the service orientation expected from nurse managers. The framework also redirects research from asking only whether servant leadership improves staff

outcomes toward examining how it develops, under which conditions it persists, and why managers with similar intentions may behave differently across units or systems. Interpretation remains cautious because the corpus is heterogeneous, predominantly cross-sectional and self-reported, often outcome-focused, and not limited exclusively to nurse-manager samples. Direct antecedent and intervention evidence remains sparse, and reporting gaps restrict reproducibility and quality weighting. Nevertheless, convergence across personal, relational, developmental, and contextual domains provides a coherent basis for future longitudinal, multilevel, comparative, and implementation research. By organizing fragmented evidence and separating examination frequency from evidential strength, the review offers a defensible foundation for theory refinement, nurse-manager development, organizational diagnosis, and empirical model construction.

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