

Training and Organizational Commitment among Nurses in New Zealand and United States Public Hospitals Experiencing Industry and Organizational Change

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This study examines the relationship between employee attitudes towards training and organizational commitment among a sample of nurses in New Zealand and the United States. Results show that perceived access to training, training frequency, motivation to learn from training, benefits of training, and supervisory support for training were positively related to the affective and normative components of commitment. Significant differences were found between training and organizational commitment variables between New Zealand and the US.

Keywords: Training, Organizational Commitment, Organizational Change

HRD is recognized as being able to foster and contribute to desired work-place attitudes and behaviors of employees during and after periods of both industry and organizational restructuring. Management of employees' commitment has also become a key management concern as intellectual and human capital become increasingly important to organizational functioning and service provision. Organizational commitment is an increasingly valued work-related attitude, especially in health care settings where retention, job performance, response to change, and organizational restructuring demand the attention of management. In recent years both New Zealand and the United States have undergone changes in their health care systems to different extents with ongoing restructuring and reorganization occurring. This provided an opportunity to explore relationships between training and organizational commitment within the entire sample as well as to examine differences between the two countries. The purpose of this research study was to explore the relationship between a number of training related variables and organizational commitment and to identify differences in a sample of New Zealand and U.S. registered nurses.

Problem Statement and Theoretical Framework

It is widely acknowledged that personnel training is the cornerstone in most organizations' HRD systems (Nordhaug, 1989). Training contributes to gains in competitive advantage (Schuler & MacMillan, 1984) with some suggesting that improvements in productivity and organizational performance have become the most dominant argument for justifying training (Scott & Meyer, 1991). During times of externally driven change many organizations alter their policies and procedures related to training. This may have implications for employee work-related attitudes and behavior.

Of the many work-related attitudes frequently examined for their relationship to the management of employee behavior, organizational commitment is increasingly valued as a predictor of work behaviors and behavioral intentions (Jaros, Jermier, Koehler, & Sincich, 1993). In general terms, organizational commitment can be thought of as a type of mind-set or psychological tie that describes the level of attachment felt by an employee towards the organization in which he or she works.

Early research considered organizational commitment to be a construct with a single dimension; however, it is now widely accepted as being multi-dimensional (Meyer & Allen, 1997). In other words, more than one form of attachment exists to describe the nature of this psychological tie or mind-set. Meyer and Allen (1991) developed a three-component model to capture the different forms of underlying mind-sets that reflect attachment to an organization. They defined the three constructs of organizational commitment as follows: 'Affective commitment refers to the psychological attachment to the organization, continuance commitment refers to the costs associated with leaving the organization, and normative commitment refers to a perceived obligation to remain with the organization' (p.1). An individual employee may have one or more of these mind-sets and report variations across all three.

Recent studies of human resource practices, including training, have been shown to influence employee commitment (Meyer & Smith, 2000; Iles, Mabey, & Robertson, 1990; Whitener, 2001). These findings support a larger body of commitment literature that explores various outcomes measures associated with organizational

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commitment. In their review of commitment research Meyer and Herscovitch (2001) noted that accepted correlations exist between all three components of commitment and turnover, turnover intention, absenteeism, job performance, and organizational citizenship behaviors. A recent meta-analysis of the antecedents, correlates, and consequences of organizational commitment highlighted that the strongest and most established consequence investigated is the negative correlation between organizational commitment and turnover intention followed by the negative correlation with actual turnover (Meyer, Stanley, Herscovitch, & Topolnytsky, 2002). Affective, normative, and continuance commitment are negatively related to both turnover intention and actual turnover, although the relationship with actual turnover is not as strong as that with turnover intention. In both cases the affective form of commitment produces the strongest negative relationship followed by normative and continuance commitment. Affective commitment also correlates negatively with self-reported stress and work-family conflict. With other outcomes measures affective commitment again provides the strongest correlations with positive relationships found between coming to work on time, job effort, job performance, and extra-role performance or organizational citizenship behaviors (Leong, Randall, & Cote, 1994; Meyer et al., 2002; Randall, 1990).

During times of industry restructuring and organizational change when performance is carefully monitored the importance of organizational commitment is perhaps most strongly emphasized. Furthermore, during these times absenteeism and turnover can be particularly disruptive for continued change efforts and can negatively affect the attitudes of other employees. A recent study of the effects of organizational change on employee commitment among bank staff in the United Kingdom and the Republic of Ireland highlighted the resulting reduced levels of affective commitment following both structural and cultural change (Bennett & Durkin, 2000). In a study of hospital restructuring Burke and Greenglass (2001) found that nurses in Canada who reported greater workloads and perceived future threats in the workplace from restructuring also reported greater work-family conflict and lower levels of job satisfaction. Low levels of organizational commitment have been found to influence burnout in hospital employees (Kalliath, O'Driscoll, & Gillespie, 1998). However, potential cross-national differences in attitudes towards training and organizational commitment resulting from organizational and industry driven change are yet to be explored. This study addresses this research need.

Research Questions

The two over arching questions for this research were; *Do relationships exist between perceived access to training, training frequency, motivation to learning from training, benefits of training, supervisory support for training, and organizational commitment?* And, *do significant differences exist between New Zealand and the United States in perceptions of access to training, training frequency, motivation to learning from training, benefits of training, supervisory support for training, and organizational commitment?* To explore these questions five research hypotheses were tested.

The relationships between perceived access to training, training frequency, and organizational commitment has only recently attracted research attention. A recently published qualitative study found that nursing staff believed that opportunities for learning were more important in explaining individual levels of organizational commitment than monetary benefits, job satisfaction, relationship with co-workers, or job security (McNeese-Smith, 2001). Furthermore, perceptions of access to training opportunities and self-report rates of training participation were both found to be positively related to all three forms of organizational commitment (Bartlett, 2001). However, the current study setting of nurses from hospitals outside of major metropolitan areas suggests that a different result could be expected, especially in relation to the continuance form of commitment. More specifically, we believe that in non-metropolitan areas nurses are likely to have fewer opportunities for employment compared to those in large cities with many hospitals. Consequently, the form of commitment based on attachment driven by the perceived high costs of lost income, time, effort, and stress of leaving the job suggests that continuance commitment may relate in a different way to the affective and normative components.

Hypothesis 1a. *There will be a positive relationship between perceived access to training, training frequency, and affective organizational commitment.*

Hypothesis 1b. *There will be a negative relationship between perceived access to training, training frequency, and continuance organizational commitment.*

Hypothesis 1c. *There will be a positive relationship between perceived access to training, training frequency, and normative organizational commitment.*

Motivation to learn is a key variable linked to actual participation in training (Tharenou, 2001). It is noted that as HRD becomes increasingly vital for organizations it is equally essential that employees who participate in development activities see their participation as rewarding (Nordhaug, 1989). It is likely that employees with a strong affective attachment to their organization will recognize the need for on-going participation in training

activities to enhance their skills, knowledge, and abilities in the achievement of organizational goals. Therefore, we would expect a positive relationship between motivation to learn from training and affective commitment. Continuance commitment describes an attachment based on recognition of the cost associated with leaving. An employee who is high in this form of commitment is perhaps a reluctant learner and a less than enthusiastic training participant and, therefore, may be characterized with lower levels of motivation to learn. An employee with high normative commitment is bound to the organization with a sense of obligation to remain. This sense of obligation may also create an awareness of the need for on going training, which may result in higher levels of motivation to learn. We therefore predict a positive relationship between motivation to learn from training and the normative form of commitment.

Hypothesis 2. There will be a positive relationship between motivation to learn from training and affective and normative commitment, and a negative relationship with continuance commitment.

Employees who believe that positive outcomes result from participation in training and development events have been found to be more motivated to seek opportunities for training (Dubin, 1990; Tharenou, 2001). Nordhaug (1989) identified three different types of reward functions or benefits that employees obtain from participation in training: job, career, and personal related benefits. Job related benefits reflect individuals' perception that training will allow a performance improvement in their current position, whereas, career related benefits will likely assist in the development of skills for a future job. Personal related benefits of training reflect psychological, political, and social outcomes that may or may not be related to the work setting. Because continuance commitment reflects attachment based on the perceived high costs of leaving we would anticipate a negative relationship with all three types of training benefits. In contrast, we would predict that all three categories of perceived training benefits would be positively related to the forms of affective and normative forms of commitment as they represent attachment based on emotional ties and personal values.

Hypothesis 3. There will be a positive relationship between perceived job, career, and personal benefits of training and both the affective and normative forms of organizational commitment and a negative relationship with continuance commitment.

Support for training from an employee's supervisor and senior staff members influences decisions to participate in training and development activities (Kozlowski & Hults, 1987; Noe & Wilk, 1993). A recent meta-analysis of training motivation places manager support for participation in training as a key situational characteristic influencing individual behavior towards training (Colquitt, LePine, & Noe, 2000). Birdi, Allan, and Warr (1997) found that managerial support was related to increased on-the-job learning, increased development, and increased career planning. Given these findings we believe that social support from senior staff and supervisors towards training participation is also likely to be related to employee perceptions of training access. Furthermore, supervisor support for training is also thought to relate to feelings of attachment to the employing organization in that employees may feel more attached to the organization if they are receiving support for training from their supervisors. In this situation employees may view training as a means to improve job performance and future career opportunities. Therefore, employees who receive support for training were thought to be more committed, hence hypothesis 4a and 4b propose:

Hypothesis 4a. There will be a positive relationship between supervisory support for training, and perceived access to training.

Hypothesis 4b. There will be a positive relationship between supervisory support for training, and all three forms of organizational commitment.

Given the magnitude of recent changes in the public healthcare system in New Zealand we anticipated that significant differences between perceived access to training, training frequency, training motivation, benefits of training, supervisory support for training, and organizational commitment would be found between the two countries. As noted above, the radical changes in New Zealand's national healthcare policy have brought many impacts to individual hospital boards forced to focus on cost reduction efforts. Kearns and Joseph (1997) noted that the affects of health-care restructuring have been more severe in New Zealand's rural communities. Despite recommendations to the contrary it appears that New Zealand healthcare administrators are viewing human resources as an area for cost reduction (Ashton, 2000). This would appear to suggest that individual hospital boards maybe viewing training and development activities as a cost rather than as an investment.

While reports of the impacts of healthcare restructuring at both the national policy level and at individual hospitals result in a temptation to predict that New Zealand would have lower scores on our training and commitment variables, there is insufficient research evidence to develop such a claim. Therefore, given the exploratory nature of this study we confine our hypothesis to a non-directional examination to determine whether significant differences in training and organizational commitment levels exist between the two countries.

Hypothesis 5. *Significant differences will be found between New Zealand and the United States in perceived access to training, training frequency, motivation to learn from training, perceived benefits of training, supervisory support for training, and all three forms of organizational commitment.*

Method

This section reports on the sample, procedures, variables, and data analysis used in this study.

Sample

The population for this study was registered nurses (RNs) employed in public hospitals in New Zealand and the United States. Three public hospitals located outside of large metropolitan areas were selected from the *State Directory of Public Hospitals* in one mid-western U.S. state. Then one similar sized public hospital was selected from the North Island of New Zealand. The four hospitals are somewhat similar in that they are located away from large metropolitan areas with each located in a small city or large town serving both the local population and surrounding rural districts. The smallest hospital was a 40-bed facility serving a population of 15,000 staffed by 70 full-time nurses and the largest a 140-bed facility serving a population of 45,000 staffed by 158 full-time nurses.

Procedures

A self-administered written questionnaire was used to collect individual-level data on the relationship between our training related variables and organizational commitment. The survey was developed and pilot tested in the same US state in which the data were collected with assistance of a group of four HRD trainers/educators with nursing backgrounds. The instrument was also examined by the head nurse and a training manager at the New Zealand hospital used for data collection. Surveys were distributed to all full-time nurses at each hospital (a total of 543 RNs) through the internal mail system with responses returned directly to the lead researcher. A single follow-up was done approximately two-weeks after initial delivery. The initial distribution and the follow-up resulted in a total of 198 completed and useable surveys representing 117 from the three US hospitals and 81 surveys from New Zealand (30% response rate from US; 51% New Zealand; 36% overall). As could be expected from a female-dominated profession, the majority (94%) of respondents were women.

Variables

The variables under investigation were divided into two broad categories related to training and organizational commitment. Training was divided into five operational variables to assess perceived access to training, training frequency, motivation to learn from training, perceived benefits resulting from training, and supervisory support for training. Perceived access to training was measured with a three-item scale used in a previous study of organizational commitment and training (Bartlett, 2001). Coefficient alpha was .77. Training frequency was measured using three items to assess the number of different types of training events employees had participated in during the past twelve months. These items, developed by Tharenou and Conroy (1994), should be thought of as three discrete questions to determine frequency of participation rather than as a scale. A sum of these questions produces a total number of training events participated in during the past year. Motivation to learn from training was measured using the 11-item motivation to learn from training scale developed by Noe and Schmitt (1986). Coefficient alpha was .85. Benefits resulting from training were measured with the 14-item perceived benefits of training scale (Noe & Wilk, 1993). Alpha coefficient was .80. This scale is an adaptation of Nordhaug's (1989) scale composed of three sub scales to measure, job, career, and personal related benefits. The reliability coefficients of these three subscales were .76 for job related benefits, .68 for career related, and .62 for personal related benefits of training. Finally, supervisory support for training was measured using the 16-item senior staff support for training sub scale from the Noe and Wilk (1993) perceived support for training instrument. Coefficient alpha was .96. The Affective, Continuance, and Normative Commitment Scales (ACNCS) of Allen and Meyer (1990) were used to measure organizational commitment ($\alpha = .86, .79, .89$ respectively).

Data Analysis

There were very few instances of missing data (less than 4% missing for any single item). Data analysis employed bivariate correlations to explore hypotheses 1-4. Possible differences between RNs in New Zealand and the United States were explored using t-tests for mean differences.

Results

Table 1 presents the mean scores, standard deviations, and correlations for the variables under investigation. Hypothesis 1 explored relationships between access to training, training frequency, and the three forms of organizational commitment. Access to training produced a positive and significant relationship with the affective and normative forms of commitment. Training participation based on frequency was also found to be positively and

significantly related to affective and normative commitment. All predictions in hypotheses 1a and 1c were supported. Hypothesis 1b predicted a negative correlation between both access to training and training frequency and continuance commitment. The result in terms of access to training was not supported ($r = .02$ n.s.) whereas the predicted negative relationship between training frequency and continuance commitment produced a negative but non-significant relationship ($r = -.09$).

Table 1. Means, Standard Deviations, and Bivariate Correlational Matrix ($n = 198$)

| | Mean | SD | α | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|--|------|------|----------|--------|-------|-------|-------|-------|--------|-------|-------|-------|-------|-------|
| 1. Access to training | 4.08 | 1.49 | .77 | | | | | | | | | | | |
| 2. Training frequency | 2.57 | 1.85 | | .39*** | | | | | | | | | | |
| 3. Motivation to learn from training | 3.98 | .41 | .85 | .21** | .11 | | | | | | | | | |
| 4. Perceived benefits of training | 3.60 | .48 | .80 | .24** | .13 | .55** | | | | | | | | |
| 5. Job related benefits of training | 2.79 | .80 | .76 | .22** | .07 | .14 | .63** | | | | | | | |
| 6. Career related benefits of training | 3.52 | .63 | .68 | .30** | .15* | .55** | .80** | .36** | | | | | | |
| 7. Personal related benefits of training | 4.14 | .52 | .62 | .25** | .13 | .60** | .78** | .21** | .651** | | | | | |
| 8. Supervisory support for training | 3.52 | .91 | .96 | .50** | .18* | .10 | .20** | .14* | .23** | .18* | | | | |
| 9. Total organizational commitment | 2.93 | .48 | | .30** | -.02 | .01 | .10 | .31** | .04 | -.02 | .32** | | | |
| 10. Affective commitment | 3.23 | 1.01 | .86 | .54** | .24** | .20** | .18* | .16* | .23** | .22** | .47** | .38** | | |
| 11. Continuance commitment | 3.06 | .89 | .79 | .02 | -.09 | -.13 | -.05 | .18* | -.11 | -.13 | .13 | .82** | .10 | |
| 12. Normative commitment | 2.84 | 1.04 | .89 | .53** | .19* | .20** | .22** | .26** | .25** | .16* | .44** | .60** | .76** | .20** |

Note: * $p < .05$, ** $p < .01$, *** $p < .001$

Hypothesis 2 examined the relationship between motivation to learn from training and organizational commitment. As predicted, we found a positive and significant relationship between motivation to learn from training and the both the affective and normative forms of commitment ($r = .20$, $p < .01$ for both relationships). The predicted negative relationship with continuance commitment was non-significant ($r = -.13$). This partially supports our hypothesis that motivation to learn from training is related to commitment; however, the ordering and magnitude of this relationship in explaining organizational commitment requires further analysis.

The relationships between job, career, and personal related benefits from training, and affective commitment were positive and significant, as predicted in hypothesis 3. In other words, those employees who believe that training participation brings rewards or benefits to their job, career, or personal life are more likely to report higher levels of the affective form of organizational commitment. Likewise, a positive and significant relationship was found between job, career, and personal related benefits of training with normative commitment. Hypothesis 3 also predicted a negative relationship between the three types of training benefits and continuance commitment. Negative but non-significant relationships between career and personal related benefits of training and continuance commitment were found. However, a positive and significant relationship ($r = .18$, $p < .05$) between job related benefits and continuance commitment was found. Additional research on training benefits and organizational commitment would help in understanding this finding.

The relationship between supervisory support for training and access to training was moderately strong and significant ($r = .50$, $p < .01$) supporting hypothesis 4a. Hypothesis 4b predicted a positive relationship between supervisory for training and all three forms of organizational commitment. This was supported but only the relationships with the affective ($r = .47$, $p < .01$) and normative ($r = .44$, $p < .01$) forms of commitment were significant. Our final hypothesis considered possible differences between RNs in New Zealand the in United States. As shown in Table 3, many significant differences were found between the New Zealand and U.S. samples in mean scores for our training and commitment variables. New Zealand nurses reported lower mean scores compared to the U.S. nurses on all variables with 10 of the 12 comparisons producing a significant difference. A high level of significance in the difference between mean score for the following variables was found; perceived access to training, training frequency, supervisory support for training, as well as the affective and normative forms of organizational commitment.

Table 2. *T-test Results for Differences between New Zealand and U.S.*

| Variable | U.S. | New Zealand | t statistic | Level of Significance |
|---------------------------------------|---------|-------------|-------------|-----------------------|
| | n = 117 | n = 81 | | |
| | Mean | Mean | | |
| Access to training | 4.7 | 3.2 | -7.33 | .000*** |
| Training frequency | 3.0 | 2.0 | -3.95 | .000*** |
| Motivation to learn from training | 4.0 | 3.9 | -2.44 | .016* |
| Perceived benefits of training | 3.7 | 3.5 | -2.19 | .030* |
| Job related benefits of training | 2.9 | 2.6 | -2.39 | .018* |
| Career related benefits of training | 3.6 | 3.4 | -2.31 | .022* |
| Personal related benefits of training | 4.2 | 4.1 | -1.70 | .090 |
| Supervisory support for training | 3.7 | 3.2 | -4.00 | .000*** |
| Total organizational commitment | 3.1 | 2.8 | -4.39 | .000*** |
| Affective commitment | 3.7 | 2.5 | -10.47 | .000*** |
| Continuance commitment | 3.1 | 3.0 | -.48 | .633 |
| Normative commitment | 3.6 | 2.1 | -10.37 | .000*** |

Note: * $p < .05$, ** $p < .01$, *** $p < .001$

Conclusions and Recommendations

This study examined relationships between employee attitudes related to training and feelings of organizational commitment, and compared these variables in a sample of nurses from New Zealand and the United States. The following conclusions can be made based on the results of this study. First, the affective and normative components of organizational commitment are related to participation in training with perceived access to training producing a stronger relationship than self-report measures of training frequency. Second, the affective and normative components organizational commitment is also related to motivation to learn from training, perceived benefits of training, and perceived supervisory support for training. This suggests a need for organizations to have supervisors and managers be active supporters of training. Third, a number of significant differences in the attitudes towards training and the level of commitment were found between the New Zealand and U.S. samples. A number of potential explanations could be offered for this cross-national difference. While differences in culture, formal educational pathways, hospital management structures, and so on no doubt play a role we also believe that the lower scores from the New Zealand nurses may highlight their frustration and concern following the reorganization of the nations public health care system. The findings potentially support statements that attribute the general low morale of New Zealand nurses compared to those in other industrialized nations as resulting from the past two decades of major health care reform efforts (Coney, 1996). While not suggesting that the industry and organizational changes in New Zealand hospitals by themselves explain the significantly lower scores related to many training and commitment variables, these findings do point toward the need for additional research to determine potential cultural, organizational, and individual level constructs that may offer further insight.

The implications of the findings from this study apply to both managers and administrators in the health-care field as well as to trainers, HRD practitioners, and researchers. Given that well-established relationships are known between organizational commitment and outcomes that influence performance, such as low absenteeism, reduced turnover, and increased levels of organizational citizenship behaviors (Meyer, Stanley, Herscovitch, & Topolnytsky, 2002), managers could adopt a view towards training that recognizes its relationship to organizational commitment. Health-care managers could perhaps acknowledge that key performance related indicators such as patient welfare, employee stress levels, and turnover are potentially connected to the relationship between attitudes towards training and organizational commitment. However, while managers should not focus solely on organizational commitment, it is important to recognize how management practices, employee responses to change, and additional stress brought on by industry-wide restructuring may impact the type and strength of commitment and consequent behaviors. This is especially true for examining retention, which has long been an issue of concern. A number of the variables investigated in this study can be influenced by supervisors and managers. For example, employee perceptions of training benefits can be enhanced by communication from supervisors and training providers. This could also

potentially contribute to positive perceptions of access to training, as shown by the positive relationships between access and benefits in this study, and encourage additional research into training results.

The findings related to the three separate constructs of organizational commitment examined in this study support a growing body of literature that indicates that employee attachment is multi-faceted. This has practical implications as different management actions related to training and development may have different impacts on affective, normative, and continuance commitment. However, as is supported in existing studies, the affective form of commitment appears to be the focus of most management interest. Recent research has suggested that public personnel administrators increasingly recognize the need to increase affective organizational commitment among public sector employees (Nyhan, 1999). Such recognition among health care administrators may also benefit the public health care field.

Researchers continue to explore which variables are related to and influence organizational commitment. This is resulting in increasingly complex models to understand the nature of organizational commitment and the variety of antecedent and consequent variables. To date, HRD researchers have not played a major role in this line of inquiry despite the potential to make major contributions. As employment practices shift to support management that fosters organizational commitment rather than management by control, additional studies are needed to determine whether changes are actually occurring in the type and strength of employees' feelings of attachment. Such studies are needed, particularly in settings experiencing significant industry and organizational change.

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