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Leadership styles and patient-centred care in tertiary hospitals

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Abstract
Underpinned by SERVQUAL, this paper extends research and theory on leadership by proposing and examining a theory-driven framework on the nexus between three relational-based leadership (transformational, emotional intelligence and individual consideration) and patient-centred care (PCC): physical comfort (PC) and emotional support (ES).The underlying philosophical paradigm for data collection was positivism and nomothetic explanation, given that the design was a cross-sectional survey. Opinions of 310 medical professionals in the two tertiary hospitals in Rivers State, Nigeria were randomly sampled from apopulation of 1675.Krejcie and Morgan's table guided the scientific determination of the sample, Bowley's model aided proportional allocation, and Structural Equation Modelling (SEM)aided by AMOS was the test statistic at 0.05 significance level.In order of significance, transformational leadership was found to boost the measures of PCC more than the two others though increase in emotional intelligence does not translate to a corresponding increase in ES, due to the objectivist tendencies of some medical professionals and the service pressures in tertiary hospitals. Implicit is that medical professionals should always improve transformational leadership; work on emotional intelligence and individual consideration by always differing in, and prioritizing, perspectives when addressing issues.

Keywords: Transformational, emotional intelligent, individual consideration, PCC, PC, ES

1. Introduction

The health care system is strategic for providing quality services in terms of wellness and extended life expectancy. Scholars posit that quality healthcare services involve patient-centered care (PCC) expressed in motivation and support received by the providers, system integrity and efficiency, availability of medical facilities, achievement of medical reforms, system performance and timely delivery, and the pattern of relationship amongst healthcare givers before, during and after routine ward rounds (Sfantou *et al.,* 2017; Zibert && Starc,2018; Mahmoud *et al.,* 2019). PCC spans meeting patient's needs in manners that respect and integrate individual differences in delivery. Arguably, PCC is responsive to patients and is guided by patient's preferences, and patient-centred reports measure the quality of PCC, including the patient's experience and satisfaction with the care.The Institute of Medicine (IOM) decomposed PCC into six proxies, which largely cross-cut those of The Picker Institute and The International Association of Patients' Organizations (IAPO). They are respect for patients' values, preferences and expressed needs; coordination and integration; provision of information, communication and education; ensuring physical comfort; providing emotional support – relieving fear and anxiety; and involvement of family and friends. These proxies recap the significance of leadership in the

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healthcare system, because scholars (Aghamolaei *et al.,* 2014, Chapman *et al.,* 2014) observe that deficiencies in medical leadership is detrimental to patient care delivery, and dynamic care system demands same level of dynamism to meet with challenges.

Hence, healthcare system is challenged by the rigor of leadership demands and expectations, occasioned by the surging pressures on healthcare professionals and non-clinical staff to deliver the best regardless of limited resources. Scholars (Shariff, 2014; Shaw, 2007) recognize the substantial changing role of healthcare professionals without a corresponding formal training or on-the-job training on leadership and management to keep up with the trend. The pressure is surging even the more amid patients' active involvement in their own treatment owing to their increasing interest in safety, cost of care and overall quality of care (Khairunnisa &Nadjib, 2019; Alloubani *et al.,* 2019; Wong & Cummings, 2009); the inadequate healthcare facilities and resources to combat health-related crises; the World Health Organization's (WHO) agenda on strengthening the health systems via the synergy between leadership and management; and the increasing global demand on repositioning healthcare leadership to strategically respond to healthcare crises. Shaw (2007) and Institute of Medicine (2004) note that the increasing shortage of healthcare providers and facilities in some economies, as well as the yearning emphasis for quality healthcare practices have attracted huge scholarship on clinical leadership. In Nigeria, the JAGBA syndrome (seeking greener pasture outside) suggests that in hospitals, the complexity of demands on leaders affirms different forms of leadership is increasingly evident to cope with shortage of health officers. Further, there is a surge on improving safety and quality, as well as creating competitive advantage with programmes instituted to move attention beyond singular patient-clinician interpretations of safety toward addressing organizational systems and issues of culture.

Arising from these, scholars (Pradani & Nurini, 2018; Woringer *et al.,* 2020) recognize the growing assumptions of common leadership models may not be suitable to deliver cognate change at the point-of-care delivery or to assure increase in clinician-patient engagement in decision-making. Others (Aghamolaei *et al.,* 2014; Sfantou *et al.,* 2017; Wong & Cummings, 2009) posit that there should be a transition to a new phase of hospital leadership, one that perceives clinical frontline and/or sees clinicians as crucial to leadership. These reposition leadership as a key strategy for well-coordinated and integrated provision of care design and/or redesign (Alloubani *et al.,* 2019; O'Neil,2008); that is, high healthcare failure may be significantly attributed to paucity of leadership skills, styles,productivity and capacity(Khairunnisa &Nadjib, 2019;WHO, 2007; Sfantou *et al.,* 2017). Scholars (Adejumo & Lekalakala-Mokgele, 2009; O'Neil, 2008; Shaw, 2007) observe that in sub-Saharan Africa, human resources for health crises research and intervention efforts addressing the healthcare workforce have focused almost exclusively on the capacity of the entry-level health officers,

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community healthcare workers, and disease-related. However, modern healthcare organizations challenge health professionals to monitor standards, develop and evaluate better ways of building working relationships, as well as advocate for patients and their families to ensure substantial quality and safety agenda, including the promotion of evidence and issue-based practice. Leadership in the healthcare industry rebuilds the health workforce, implements new models of healthcare, and brings health and wellbeing to an exhausted and stretched health workforce (Canadian Nursing Advisory Committee, 2007; Ruchlin *et al.,* 2004).

Wong and Cummings (2009) assert that healthcare managers inspire health workers' enthusiasm and commitment to get the best result through dialogues and opportunities for suggestions. These suggest that quality healthcare services ensue when the subordinate officers are involved in the entire delivery process though they often rely on their superiors' instructions on the day-to-day running of the facilities. Scholars (Zibert &Starc,2018; Cummings *et al.,* 2009; Mahmoud *et al.,* 2019; Dawson *et al.*, 2011) allude that when healthcare givers experience positive and supportive work climate and/or are satisfied with the leadership structure of their immediate supervisors, decline in patient mortality is felt and the patients feel treated with respect, care and compassion. This fosters strong transformational leadership repertoire and proactive engagement in planning, development, and management of the health workforce (WHO, 2007) in order to build changes in visibility, scrutiny, and accountability in relation to hospital care (Guastello& Jay,2019; Khairunnisa &Nadjib, 2019; Mahmoud *et al.,* 2019). To achieve leadership dreams, scholars proposed different leadership theories and styles, which are broadly grouped into task-focused and people focused (or relational). Traditionally and amongst others, scholars proposed autocratic, democratic, and laissez-faire leadership styles; and more recently transformational, individualized, transactional, resonant, and emotional intelligence styles; each of which focuses on people and relationships to achieve common goals.

Amid the myriad alternative leadership styles, Joshi (2019) posits that the healthcare industry still finds it thorny to have a style that satisfies the interests of every stakeholder given the peculiarity of the challenges they face. Further, although the leadership roles of healthcare professional are central to overcoming the ordeals confronting care delivery (Khoury, 2011; WHO, 2008), not much is known about leadership ability in the context of healthcare professionals, as well as the contextual factors that associate with leadership. The dearth of scholarship on leadership styles related to hospitals (Janssen, 2004), lack of health workers' training on leadership perspectives (Joshi, 2017), and lack of leadership models that are healthcare compliant (Joshi, 2019) leave the industry without direction and inform urgent inquiries. Scholars (Cummings *et al.,* 2009; Hibberd & Smith, 2006) affirm that in healthcare delivery, people-focused leadership predominantly guides healthcare research and practice, particularly on the grounds that relationship (which form the cornerstone of the styles) is the

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foundation for positive change. Because leadership influences people/workers and builds relationship with them to achieve a common goal of quality healthcare delivery that spans increased physical comfort and emotional support, Hibberd and Smith (2006) propose that transformational leadership and emotional intelligence leadership styles are most commonly used and discussed amongst scholars and practitioners.

Nevertheless, the critical mass of extant literature (Sheahan *et al.*, 2007; Institute of Medicine, 2004; Shaw, 2007; Ruchlin *et al*., 2004) seldom show how leadership could be enacted or chosen and/or if some forms of leadership are more desirable than the others. Other leadership studies (Sivanathan & Fekken, 2002; Cummings *et al.*, 2009; Miia *et al.,* 2006; Bass & Riggio, 2006) on healthcare delivery rarely sought to know how the different styles correlate with cost of care and patient admission. Yet most of the extant healthcare leadership studies (Cummings *et al.,* 2019; Alloubani *et al.,* 2019; Polit & Beck, 2016; Abdelhafiz *et al.,* 2016) took samples from nurses almost to the neglect of other healthcare professionals, such as physicians, physiotherapists, pharmacists, and laboratory scientists. First, the motivation behind studying healthcare environment rests on extending inquiries with a view to unveiling the most critical leadership style for healthcare practice. Second, the study rests on the fact that previous inquiries (Cho *et al.,* 2003;Sfantou *et al.,* 2017; Alloubani *et al.*, 2019; Estabrooks *et al.,* 2005; Baker *et al.*, 2004) link the characteristics and effectiveness of healthcare environment to leadership styles in terms of relationship among healthcare workers which ultimately leads to quality healthcare delivery. Third, the study is motivated to providing empirical evidence that links leadership styles with subordinates' empowerment and ability to build team spirit. The paper is structured to span a review and proposition of theoretical and conceptual framework, materials and methods, testing the framework and hypotheses, and discussion, conclusion and implications,

2. Underpinning Theory

Based on its robust cross-context theoretical and empirical validations, and its specific role on proficient manipulation of leadership styles to deliver quality PCC, Service Quality (SERVQUAL) provides the most suitable underpinning foundation for this study. Besides, SERVQUAL provides the most critical theoretical foundation for studies on service delivery, service quality measurement, and customer satisfaction (Parasuraman *et al.,* 1985), given that Buttle (1996) posits that it examines the gap between expected and actual services experienced. Although other models of service quality exist, SERVQUAL appears to be the most prominent regardless of the controversies raised by some researchers, which bother on adapting an expectation-disconfirmation model rather than simply measuring attitudes (Akinyinka *et al.,* 2019; Alloubani *et al.,* 2019; Asiri *et al.,* 2016). SERVQUAL offers technology that measures and manages service quality (SQ), because it measures how well a service is delivered, and how it consistently matches predetermined needs. Hospitals use SERVQUAL instrument as

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quantitative yardstick to measure potential service quality problems of patients and to diagnose their possible causes.

SERVQUAL follows expectancy-disconfirmation paradigm (Oliver, 1981), which suggests that patients perceive quality in terms of their perceptions of how well a given service delivery meets expectations (Aghamolaei *et al.,* 2014). When patient's expectations are greater than actual service delivery, service quality is deemed low; whereas when perceptions exceed expectations, then service quality is high. The original multiple-item scale of SERVQUAL identifies five gaps (tangibles, reliability, responsiveness, assurance and empathy), which with the choice of leadership style(s) may cause patients to experience poor or high service quality (Kleinman & Dougherty, 2013; Paquet *et al.,* 2013; Mahmoud *et al.,* 2019). Tangibles explains the hospital's perceptible touch or a visible existence (Pradani & Nurini, 2018), physical facility and amenities/equipment (Khairunnisa & Nadjib, 2019; Mahmoud *et al.,* 2019). They include ICT, tools, sites, quality of healthcare employees and other employees, and any visible facilities that reflect on quality of healthcare. However, bearing in mind the leadership styles, managers tactically manipulate these tangibles in various ways to reflect patients' differences. Where the right leadership style(s) ensues, Guastello and Jay (2019) opine that tangibles as proprietary assets are particularly important in healthcare delivery as they are crucial for developing strong, positive and inspiring patient association and experience.

Reliability involves perceived assessment of healthcare facilities in terms of assurance of and commitment to trust, faithfulness, consistency, dependability, timeliness, correctness, and overall post-consumption impression (Asiri *et al.,* 2016; Mulenga *et al.,* 2018; Aghamolaei *et al.,* 2014; Mahmoud *et al.,* 2019). Responsiveness tells medical organization's willingness and commitment to deal with the patients and to timeously resolve their problems (Santana *et al.,* 2019; Sfantou *et al.,* 2017). Further, responsiveness of healthcare delivery is perceived from patients' assessment of healthcare quality; and advances in information technology such as emails, webpage and patient-clinic interface (Mulenga *et al.,* 2018). Assurance explains the healthcare delivery representatives' proficiency to be courteous to patients, and to exhibit knowledge in professional and ethical ways to command trust and confidence (Alloubani *et al.*, 2019; Worringer *et al.*, 2020). The process of acquired knowledge being showcased by personnel in executing their term of preferences during healthcare delivery can be highly assuring to patients. However, not all patients have the expertise to understand the quality of healthcare and values they receive; as such, they may require empathy, effective communication or personal explanations to understand their problems and the value they receive.

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2.1 **Leadership in healthcare**

To be competitive amidst limited resources, management and leadership of healthcare principally initiate and/or sustain programmes and reforms that proficiently strengthen quality and integrate care system. Leadership is critical for creating and sustaining quality relationships, outcomes and mutual co-existence amongst key stakeholders - care workers and their bosses, and care givers and their patients. It fascinates people and society, attracts cross-context inquiries, creates and sustains quality relationships and outcomes, and emphasizes leader-induced followership aimed at mutually beneficial changes (Northhouse, 2004; Sarros & Santora, 2001). Horng and Loeb (2010) posit that followership willingness signifies real leadership since followership strives only when the influenced relationship provides the means to achieving followers' goals, desires, wants and needs. Thus, leadership defines the relationship between the individuals who lead and those who follow; it is the behaviour of directing and coordinating the activities of a team towards a common goal (Al-Sawai, 2013). Leadership is multi-disciplinary, from psychology, military, education, management to healthcare, and more recently to nursing and other healthcare providers (Cummings *et al.,* 2009). Within these fields, leadership is most commonly conceptualized in the contexts of four elements that centrally define it. Scholars (Shaw, 2007; Shortell & Kaluzny, 2006; Schreuder *et al.,* 2011) posit that it is a process - it is transactional, interactive and appears between healthcare managers and other workers and becomes available for everyone, not only the formally assigned leader in the group; it entails influence - actions of superiors, peers or subordinates to induce followership and the achievement of set objectives in given situations; it occurs within group context, where it exists formally and/or informally; and it involves achieving goals and common vision - relational, one-accord, mutual co-operation, group achievement and impact on one another.

The academic assumption that *no leadership no discipline,* tellsthat leadership influences and gets followership in mutually beneficial activities; it instills obedience, respect, loyalty, discipline and co-operation on followership (Kort, 2008; Sarros & Santora, 2001) through the rules and regulations that encapsulate carrot and stick theory of Frederick W. Taylor. Hallinger and Hack (2010) proposed three areas integrated into the lenses of leadership; first is vision, how the leaders organize the enterprise (that is, establishing interrelationships amongst tasks and people) and facilitate some actions to achieve shared goals - improved outcomes and nurtured commitments. Leadership improves outcomes and thus, it involves discipline; indeed, it is an essential ingredient that prepares and guarantees firm's future success (Hariri *et al.,* 2012; Leithwood *et al.,* 2006). To achieve these, Leithwood *et al.* (2006) posit that the manager needs to exploit his emotional and cognitive skills to appropriately motivate the involvement and commitment of all stakeholders. Fullan (2001) proposed that leaders should (1) be accommodative (work with all stakeholders to stimulate actions), (2) focus on workers' learning (observe areas of strengths and weaknesses and work further on them), (3) be productive (achieving investors' goals without compromising standards) and (4) put pressure and support (in all circumstances, show support, politeness, and empathy). Similarly, Hariri *et al.* (2012) advised leadership to recognize that effective decision-making significantly correlates to assist workers to meet their job achievements and job satisfaction. Wong and Cummings (2009) note that

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healthcare managers inspire workers' commitment and pride in a manner that ignites their willingness and morale to engage in new practices, voice-out patient issues, and make suggestions for positive workplace changes. Specifically, healthcare leadership creates opportunities for meaningful dialogue amongst workers, aids resolution of care issues that risk patients' safety, and then follows through staff suggestions for improved role-model to commitment to patient care.

In healthcare facilities, leadership creatively drives the smooth and turbulent waters, and aids subordinates to achieve goal congruence. Given the standards set by the various regulatory health agencies, a through-put to desirable work-life without compromising corporate goals involves the manipulation of leadership styles to permit productive and satisfying work environment, civility, morality, and peaceful co-existence within the facility. These suggest that managers are statutorily obliged to take proactive (scanning the environment and discounting the effect of future changes today to minimize future surprises) and/or reactive (unforeseen exigencies) actions in attempt to direct workers and other stakeholders to reach collective goals. Second is governance, how the leaders manage and control their staff and encourage their participation. Different assumptions may be made by the manager about every individual involved in the delivery of set tasks based on the theoretical conceptualization of acceptable leadership styles: autocratic, democratic and laissez-faire leadership styles. The use of each is situation and context-specific. Third is resource allocation, how the leaders place resources to support workers. The high-level competitive-context of most industries requires the application of psychologist's believe in the theory of *tabularizer or clean slate.* And, so everybody is born with no knowledge though development takes place overtime within the environment; thus, the managers/leaders are the agents of positive transformation.

2.2 **Study variables and conceptual framework**

A conceptual framework is a theory-driven or rudimentary proposition of a network of interlinked concepts that comprehensively describes the presumed understanding and relationships between the concepts in the phenomena under investigation (Jabareen, 2009; Van der Walt, 2003). The role and effectiveness of leaders in achieving this has been highlighted by researchers (Cummings *et al.,* 2009; Sfantou *et al.,* 2017; Sarros & Santora, 2001). Thus, the study's proposed conceptual framework tells the relationship between the concepts and how the concepts situate in the phenomenon under study. Figure 1 explains it all; based on extensive review (Denison Consulting, 2013; Kouzes & Posner, 2013; Smith & Peterson, 1998; O'Neil, 2008; Cummings *et al.*, 2009;Sfantou *et al.,* 2017), three (transformational, emotional intelligent, and individual consideration leaderships) endogenous factors were identified and hypothesized to correlate with two exogenous factors (physical comfort and emotional support) out of the six dimensions of PCC proposed by IOM, IAPO and Picker Institute. PCC is a recognized measure of quality of care, and refers to holistic healthcare which is perceived as a shift from the traditional biomedical disease orientation to a simply patient involvement and individualization of care (Robinson *et al*., 2008). Mead and Bower (2000) proposed the bio-psycho-social model

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which conceptualized PCC as being composed of the dimensions of the patient as a person, sharing power and responsibility, the therapeutic alliance and the doctor as a person.

Similarly, the Institute of Medicine (IOM) defines PCC as providing care that respects, and responds to, individual patient preferences, needs and values, and ensures that patient values inform all clinical decisions. PCC develops and empowers caregivers, and offers opportunity for developing initiatives and creativity (Yancer, 2012) in a manner that impacts greatly on the residents' quality of life. As such, when a residential care facility targets PCC, authoritarian leadership is supplanted by leadership styles that support PCC principles, and promote nurturing care culture at an organizational level. Physical comfort and emotional support were factored in here to decompose PCC because of their huge scholarship and their peculiarity to the Nigerian health setting. Physical comfort explains how the adopted leadership styles promptly provide appropriate pain relief to patients and attend to physical symptoms and needs. The level of physical comfort patients report has a significant impact on their experience. Three areas were reported as particularly important to patients: pain management, assistance with activities and daily living needs, and hospital surroundings and environment. Emotional support explains how the adopted leadership styles address that patients' concerns and anxiety due to uncertainty, fear, finance, or effect on family.

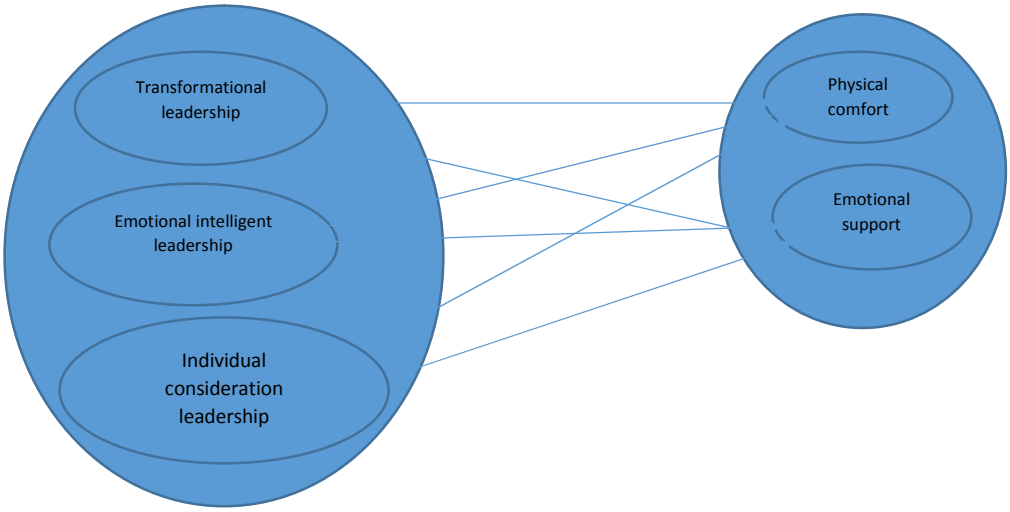

Figure 1: The proposed conceptual framework.

On the other hand, fear and anxiety associated with illness can be as debilitating as the physical effects. As such, caregivers should pay particular attention to: anxiety over physical status,

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treatment and prognosis; anxiety over the impact of the illness on themselves and family; and anxiety over the financial impact of the illness. However, a priori is that the conceptual framework suggests that effective management of physical comfort and emotional support is a function of the use of such leadership styles as transformational, emotional intelligent, and individual consideration. The strength of these styles lies on not compromising the pacesetting and commanding style of autocratic style or dissonant leadership that neglects the emotional attributes required to support and promote employee progression (Goleman *et al.,* 2002). They believe that relational or people-centred approach to leadership contributes to healthy work environments through support, open and honest communication and trust. Health leaders who are concerned about the well-being of their followers, listen to and acknowledge their inputs, respond openly and truthfully to their concerns, and act on values that support exemplary patient care will have the healthcare workers' support and patients' trust. Thus, the assumptions and the unique selling points of these three leadership styles are quite modest in the healthcare delivery. Transformational leadership is a psychological perspective to study and understand how to influence and impact on subordinates.

It creates relationship and motivation amongstworkers; typically, the team leader inspires confidence, respect and loyalty through a shared vision, resulting to increased morale, productivity and job satisfaction (Sfantou *et al.,* 2017). Scholars (Akinyinka *et al.*, 2019; Alloubani *et al.,* 2019) posit that transformational leaders are committed to greatness, urgency, long-range and broad perspective by raising subordinates' awareness, and helping them to seekfor self-fulfillment and to understand the need for change. The leaders integrate the followers' needs and aspirations with the desired corporate goals by fostering the followers' commitments towards the organization and encouraging them to surpass their expected performance (Sivanathan & Fekken, 2002; Miia *et al.,* 2006; Bass & Riggio, 2006). Cummings *et al.* (2009) posit that it motivates the workforce to do more than they originally intended or often more than they thought possible. Individualized considerations involve the leader understanding the followers' needs and continuously working in close contact to get them develop their full potential (Avolio *et al.,* 1999); and resonant leadership is based on emotional intelligence, and inspires, coaches, develops, and includes others even in the face of diversity (Boyatzis & McKee, 2005).

2.3 **Empirical Review and Hypotheses**

The link between the latent variables as shown in figure 1 is reported though fromdifferent contextual bases. There are relationships between leadership styles and PCC in terms of shared values and similar concepts, but there seems a dearth of works linking the constructs to tertiary hospitals. In medical practice, research and interventions in leadership styles predominantly

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adopt task- versus people-oriented qua relationship approach (e.g., transformational, emotional intelligent and individual consideration leaderships) for positive change nay successful care deliveryas oppose to rigid systems, policies and procedures (Cummings *et al.*, 2009; Sfantou *et al.,* 2017; Žibert & Starc, 2018; Mahmoud *et al.,* 2019; Hibbard & Smith, 2006). Duncan *et al.* (2010) argue that proficient leaders foster environment where medical practitioners are encouraged to exercise their clinical judgment and agency, which allow greater degree of freedom to provide PCC that meets flexible objectives in responsiveness, personalized attention, and support for patients' autonomy. Often such leadership uses wider range of appropriate mix of leadership styles to deal with different situation specifics (Sarros & Santora, 2001; Goleman, 2000; Cummings *et al.*, 2009).

Studies (Ayeleke *et al.,* 2018; Wong & Cummings, 2007; Chapman *et al.,* 2014) found that a mix of transformational and resonant leadership styles lowers patient mortality because the residents are co-opted in the entire care decisions. In his study of nurse executives on organizational culture and power relations, Dunham-Taylor (2000) reported that well-organized and competent executives, as well as higher educational degrees and more participative organization resulted in higher frequency of transformation though teamwork efficiency and staff satisfaction were more transactional. Similarly Medley and Larochelle (1995) affirmed that job satisfaction is more transformational than transactional, and for staff in acute care hospitals, transactional and transformational leadership behaviours drive PCC. Transformational, emotional intelligent and individual consideration leaderships attract patient satisfaction, reduction of adverse effects and indirectly reduce mortality rates by inspiring, motivating, retaining and supporting medical and non-medical staff with experiential knowledge (Worringer *et al.,* 2020; Health Facilities Scotland, 2011; Wong & Cummings, 2007; Havig, Skogstad, Kjekshus & Romoren, 2011). Reflecting on PCC, Taiwanese nurses (Medley & Larochelle, 1995; Dunham-Taylor, 2000); hospital CEOs in Iowa (Janssen, 2004); and nurses in Belgium (Vandenberghe, Stordeur & D'hoore, 2002) unveiled the criticality of relational leadership on additional effort, perceived efficiency, job satisfaction, staff maintenance and satisfaction. Al-Mailam (2004) compared public and private hospitals in Kuwait on leadership styles and PCC, and found relational leadership styles critical for high degree of effectiveness in private hospitals than in public hospitals.

Thomas *et al.* (2014) and Wong (2015) opined that changes in working conditions that span access to resources, guiding individual and team attitudes, behavior and performance, communicating clear care standards and performance expectations, or enabling teamwork and staff participation in patient care decisions are some potential mechanisms that connect transformational, emotional intelligent and individual consideration leaderships to patient

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satisfaction. Previous (Page, 2004; Houser, 2003; McCue *et al.,* 1986; Baker *et al.,* 2004; Dunham-Taylor, 2000; Cummings *et al.,* 2009) and slightly recent (Ayeleke *et al.,* 2018; Oyekale, 2017; Mahmoud *et al.,* 2019) studies found that relational and agile focused managers critically implement clinical management culture of patient safety and reduced medication errors or mortality by creating safe working environment that promotes satisfied and high performing staff and establishing adequate staffing and resources to avoid unnecessary deaths, disability or extended stay in the hospital. Similar studies (Baker *et al.,* 2004; Kleinman & Dougherty, 2013; West *et al.,* 2014) show that relational-driven leaderships were positively related to staff expertise and reduced medication errors, and negatively related to staff turnover all of which contributed to reduced patient mortality and other adverse patient outcomes leading proficient leaders to retain greater number of skilled workers through increased staff stability and reduced turnout.

McCue *et al.* (1986) study of leadership and effectiveness of junior doctors through both self-assessment and assessment by nurse colleagues, found people-orientated styles (encouraging and coaching styles) to predominate over what they termed 'low-relationship' styles such as delegating and structuring. Trust in leadership and manager's support relate to patient's length of stay (Paquet *et al.*, 2013); their influence on patient outcomes is indirectly working through others and occurring overtime (Wong, 2015). Health Facilities Scotland commissioned PCC research (Health Facilities Scotland, 2011) to explore how leadership impacts on the quality of PCC received by patients. The team outlined the key principles as a welcoming environment, respect for patients' values and needs, patient empowerment, account taken of patients' backgrounds, the coordination and integration of care, comfort and support, shorter waiting times, convenient hours, and community outreach initiatives. Given the conceptual framework and the foregoing, we formulate six working hypotheses.

Ho_1: There is no statistically significant relationship between transformational leadership and physical comfort.
Ho_2: There is no statistically significant relationship between transformational leadership and emotional support.
Ho_3: Emotional intelligent leadership does not significantly interact with physical comfort.
Ho_4: There is no significant relationship between emotional intelligent leadership style and emotional support.
Ho_5: There is no significant relationship between individual consideration leadership and physical comfort.
Ho_6: The interaction between individual consideration leadership and emotional support is not statistically significant.

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3. Methods and Materials

The paper keys into the social science tradition of positivism and nomothetic explanation. Positivist ontology is a philosophical realism linked to objectivity and deductivism, and which unravels definable and quantifiable social facts through systematic observations and interactions in a natural setting. Positivism is adopted because the epistemology underlying descriptive and quantitative paradigm is to generate reality by natural mechanism. Specifically, explanatory and cross-sectional survey through the use of self-reported questionnaire was the design adopted essentially because it is difficult to control or manipulate the variables. Opinions were sampled from two tertiary hospitalsin Rivers state: University of Port Harcourt Teaching Hospital (UPTH) and Rivers State University Teaching Hospital (RSUTH). All things being equal, these hospitals host greater number of qualified medical professionals, and have more budgets and facilities than other classes of healthcare givers in the state. Besides, Rivers state was chosen because she is one of the most populous states in Nigeria; she has a vast distribution of primary, secondary and tertiary healthcare facilities that will assist this study; she is famous in oil and gas exploration; and she plays host to seaport and international airport, expatriates, different Nigerian tribes, commercial activities, federal and state ministries, as well as parastatals.

Table 1 shows the population of the medical professionals that conform to the study's laid-down standards. Those on NYSC and internship, as well as house doctors were excluded because they may lack the cognate experience required of the study, given their supposed short stay. The unit heads were the target and to qualify, the unit heads must be in charge of at least three subordinates and must have a minimum of one-year experience in the current position. Further, the unit head should be in a position to share their experiences about conscious and well-oriented patients, who received the care and got discharged. With a population of one thousand, six hundred and seventy-five (1675), the sample size was scientifically determined to be three hundred and ten (310) using the Krejcie and Morgan (1970) table as a guide. However, because we are interested in different groups of audience, Bowley's (1926) proportional allocation was applied to aid the administration of instrument based on simple random sampling. We involved five research assistants and one desk-top officer from each hospital aided that administration of the instrument and follow-up visits. On the whole 231 usable cases aided the analysis.

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$$n1 = \frac{n(Nh)}{N}$$

Where n1 = proportion; n = sample size; Nh = population for each location; and N = overall population.

	UPTH	Sample size	RSUTH	Sample size	Total Sample Size
Medical doctors	504	93	175	32	125
Nurses	703	130	209	39	169
Pharmacists	40	7	8	3	10
Laboratory technicians	24	4	12	2	6
	1271	**234**	**404**	**76**	**310**

Table 1: **Population distribution and sample size**

3.1 **Measurements**

The constructs in the conceptual framework are well-developed; hence, the multi-item scales came from validated sources. PCC was measured using relevant scale items of evaluating hospital care quality as developed by Rubin, Ware Jr., Nelson and Meterko (1990) in their Patient Judgments of Hospital Quality (PJHQ) tool. Rubin *et al.* (1990) developed 106 items for PJHQ, out of which 46 dealt with hospital care evaluation. The 46 items were critically assessed and from there, five scale items were generated and rephrased for physical comfort and emotional support. A self-assessment Leadership Practice Inventory (LPI) adapted from Kouzes and Posner (2013) was used to measure the three leadership styles. Kouzes and Posner (2013) proposed leadership style that models the way, inspires shared vision, challenges process, enables others to act, and encourages the heart. From the numerous items from each of Kouzes and Posner's (2013) constructs, 7 items were generated for transformational leadership, 5 for emotional intelligent leadership and 8 for individual consideration leadership. Although responses for LPI was scaled on a ten-point Likert-type continuum, the paper reverted to a four-point continuum to have a uniform scale for both PCC and LPI.

4.0 **Analysis and Results**

4.1 Clean ups and purification

In keeping with the study's two-dimensional conceptualization, exploratory factor analysis (EFA) of leadership variables was the starting point of data analysis. The results of principal components factor analysis, with varimax rotation were satisfactory because all the variables met the threshold of factor loading of 0.60 and none of the variables loaded on more than a factor. Confirmatory factor analysis (CFA) followed to check if the psychometric properties of the

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constructs meet their individual thresholds. The conceptual framework and the hypothesized relationships were estimated using Structural Equation Modeling (SEM); hence the two-step analysis (Hair Jr. *et al.,* 2016; Anderson & Gerbing, 1988; Schumacker & Lomax, 2010). And with a sample size of 310 (see table 1) surpassing a sample benchmark 100 or 150 to 200 and above, SEM suffices (Anderson & Gerbing, 1988; Bagozzi & Yi, 1988; Awa *et al.*, 2021). SEM works when the proposed framework has latent variables with interrelated dependence or a series of causal relationships amongst themselves. The first stage subjected the constructs to measurement model and then fixed the measurement model into the second stage where the structural model was estimated. The first measurement model involved evaluating the test items of leadership styles and then, estimated the second measurement model to include PCC and specified as indicators of leadership styles the ones resulting from the first model. Table 2 reports on measurement model and shows the validity and reliability of the multi-item indicators, where it was found that the indicators represent reliable and valid measures of the constructs.

	Loading	Mean	Skewness	Kurtosis
Transformational leadership(α = 0.863; AVE = 0.588)				
I counsel and motivate others on what needs to be accomplished.	0.94	3.02	-0.877	0.614
I work with others satisfactorily and heighten their desire to succeed and to try harder.	0.87	3.06	-0.894	1.180
I specify the importance of having a strong relationship and sense of purpose.	0.66	2.81	-0.820	0.694
I spend time teaching and coaching.	0.73	2.99	-0.058	-0.492
I display a sense of power and confidence.	0.80	2.95	-0.646	0.228
I avoid making decisions personal.	0.79	2.84	-0.624	0.204
I emphasize the importance of having a collective sense of mission.	0.72	3.10	-0.589	0.308
Emotional Intelligent Leadership (α = 0.832; AVE = 0.672)				
I seek differing perspectives when solving problems.	0.84	3.21	-1.073	1.119
I make clear what one can expects to receive when performance goals are achieved.	0.89	3.23	-0.996	1.106
I concentrate my attention on dealing with mistakes, complaints, failures and aligning with everyone.	0.80	2.77	-0.911	0.560
I delay responding to urgent questions to make consultations.	0.84	3.00	-1.035	0.766
I get others to do more than they expected to do.	0.62	2.61	-0.304	-0.558
Individual Consideration Leadership (α = 0.902; AVE = 0.609)				
I provide others with assistance in exchange for their efforts.	0.68	2.78	-0.616	-0.261

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I talk about my most important values and beliefs.	0.61	2.94	-0.021	-0.890
I discuss in specific terms who is responsible for achieving performance targets.	0.72	2.59	-0.122	-0.934
I go beyond self-interest for the good of the group.	0.87	2.66	-0.464	-0.057
I treat others as individuals rather than just as members of a group.	0.80	3.25	-1.271	1.113
I consider individuals as having needs, abilities, and aspirations different from others.	0.85	3.16	-0.858	0.535
I get others to look at problems from many different angles.	0.87	3.23	-1.122	0.701
I help others to develop their strengths.	0.86	3.20	-0.933	0.610
Physical Comfort (α = 0.796; AVE = 0.550)				
The interpersonal attributes within the facilities contribute to physical wellness.	0.81	2.97	-0.550	-0.291
The leadership designs drive effective delivery and satisfaction.	0.80	2.87	-0.405	-0.913
The institutional and systems design of healthcare facilities contribute to patients' well-being.	0.77	2.95	-0.652	-0.636
The services are easily accessible.	0.74	2.64	0.008	-0.825
Pain management and hospital design aid my satisfaction.	0.71	2.59	-0.038	0.319
Emotional Support (α = 0.712; AVE = 0.833)				
The healthcare officers treat patients with empathy, respect and honor.	0.69	2.72	-0.290	-0.279
They offer streams of assistance, counselling and guidance properly.	0.64	2.85	-0.592	0.221
Our team goes extra miles trying to see how patients are coping with treatments.	0.62	2.77	-0514	-0.352
We encourage health-officers to always be around as at when their services are needed.	0.63	3.05	-0.734	-0.059
Patient wellness is the core business.	0.64	3.17	-1.046	0.714

Table 2: Scale items, psychometric properties and normality

Convergent validity checks if the constructs were reflected by their own indicators to ensure unidimensionality and to eliminate unreliable indicators (Gefen *et al.,* 2000; Bollen, 1989; Awa *et al.,* 2017; Awa *et al.,* 2016). Adequate internal consistency and convergent validity were supported, given that the Average Variance Extracted (AVE) for each of the latent variables surpassed the scientific threshold of 0.5 as proposed by Fornell and Larcker (1981). The discriminant validity assesses the extent of statistical difference between different constructs; it explains the magnitude with which a construct shares more variance with its measures than other latent variables in the model (Tarhini *et al.,* 2016; Fornell & Larcker, 1981; Hair Jr. *et al.,* 2016). Discriminant validity was supported because the Maximum Shared Squared Variance (MSSV) for all constructs was less than AVE and the square roots of constructs' AVEs in the diagonal surpassed the inter-construct correlations (see table 3). To establish internal reliability of

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instrument, Hair Jr. *et al.* (2016) suggest that Cronbach Alpha must not be less than 0.7; a criterion supported in table 2. Another condition for the use of SEM is a second-order measurement model, which predominantly involves tests of goodness of fit of the data set. Both measurement models fit well into the data set since the fit statistics or the parameter information met the critical values, affirming that the test items were reliable to explain and predict the constructs.

	TRF	EML	ICL	PC	ES	Sq. Root of AVEs
TRF	1					0.828
EML	0.763	1				0.820
ICL	0.702	0.763	1			0.780
PC	0.604	0.592	0.625	1		0.742
ES	0.778	0.679	0.791	0.740	1	0.844

**. Correlation is significant at the 0.01 level (2-tailed).

Table 3: Correlation of latent constructs

Guided by scholars (Hu & Bentler, 1999; Hair Jr. *et al.,* 2013; Baumgartner & Homburg, 1996), we have Chi-square (1143df) = 559.49, AGFI = 0.942, RMSEA = 0.119, CFI = 0.951, NFI = 0.963 and TLI = 935 for leadership; and Chi-square (155df) = 659.49, AGFI = 0.901, RMSEA = 0.224, CFI = 0.981, NFI = 0.974 and TLI = 957 for PCC. Finally, we did normality test in table 2 by checking the symmetric nature of the data distribution (skewness) and the peakedness or the height of the distribution (kurtosis). Going by Balmer's (1998) guide, there were no major issues with normality, because the data set followed his thresholds – for highly skewed distribution, the value is <1.0 or >1.0; for moderate, the value is within $\pm$0.5 and $\pm$1.0 (i.e between -1.0 & -0.5, and 0.5 and 1.0); and for fair, the values are between -0.5 and 0.5.

4.2*Structural model*

Having assessed the bivariate relationships and affirmed the adequacy of psychometric properties of the instrument, including the goodness of fit of the data set in the measurement model, we head to estimate the structural model (see figure 2) in the bid to test the hypothesized relationships. AMOS 24.0 was used. AMOS is a covariance-based software for SEM that favours such critical conditions of parametric statistic as normality, linearity, equality of variance and randomization of the data set. Scholars (Hair *et al.,* 2016; Fornell & Larcker, 1981) posit that PLS-SMART is a variance-based software that is amenable to non-parametric statistic and represents an alternative to AMOS when the data set fails to accomplish any of the aforementioned conditions. To use structural models to test hypotheses, Byrne (2006) posits that

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the standard decision rule(s) for not supporting H0 are that (1) the Standardized Regression Weight (β) should be greater than 0.5 and preferably above 0.7; (2) CR value should be greater than or equals 1.96 (where CR is the critical ratio); and (3) p-value must be less than or equals 0.05.

Generally, structural model shows that TRL, EIL, ICL differ in their relative influence on, or explanation of, PC and ES. Table 4 shows that the test of hypotheses results were in line with Byrne's (2006) thresholds and that except for H04, none of the hypotheses was statistically supported. Specifically, TRL (β = 0.838, p <0.001), EIL (β = 0.817, p <0.01) and ICL (β = 0.703, p <0.05) were found to critically interact with PC. This means that H01, H03 and H05 were not supported; implying that TRL, EIL and ICL statistically shape PC. TRL, EIL and ICL respectively explained 84, 82 and 70 percent variances of PC, with TRL having the strongest significance within the proposed model.Further, TRL (β = 0.817, p <0.001) and ICL (β = 0.770, p <0.01) significantly interact with ES; thus, rejecting H02 and H06.TRL and ICL respectively explained 82 percent and 77 percent variances of ES. Surprisingly, the path coefficient from EIL to ES (β = 0.095, p <0.01) was not significant, suggesting statistical support for H4.

Hypothesis	Basic Model effect	Path Coefficient (β)	CR	Decision
Ho1	TRL → PC	0.838***	5.225	Not support
H02	TRL → ES	0.817***	2.118	Not support
H03	EIL → PC	0.797**	4.652	Not support
H04	EIL → ES	0.095**	0.094	Support
H05	ICL → PC	0.703*	4.451	Not support
H06	ICL → ES	0.770**	2.150	Not support

Table 4: Path coefficient and their significance

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

5.0 **Discussion and implication**

Research issues

The main purpose of this paper was to provide further insight into the relationship between leadership styles and PCC by proposing a conceptual framework based on SERVQUAL theory in order to explore and integrate critical leadership dimensions and measures of PCC in the context of tertiary hospitals in Nigeria. Previous studies (Ayeleke *et al.,* 2018; Wong &

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Cummings, 2007; Chapman *et al.,* 2014; Cummings *et al.*, 2009; Sfantou *et al.,* 2017; Žibert & Starc, 2018; Mahmoud *et al.,* 2019) alluded to relational-leadership, especially mixing more of transformational leadership style with resonant and/or transactional styles to promote healthcare efficiency and staff satisfaction. Although still in the relational domain, the current paper moves beyond prior studies by specifically providing evidence that TRL, EIL and ICL offer clinical judgment that directly and indirectly affects PC and ES. The results indicate that in healthcare delivery, leadership styles elicit PC and ES and ultimately satisfaction from patients and health workers. That H01, H03 and H05 were not statistically supported means that the path coefficients of TRL, EIL and ICL to PC were critical; implying that transformational, emotional intelligent and individual consideration leaderships were stronger predictors of patients' physical comfort. The path coefficient of TRL to PC was supported by previous scholars who found that TRL establishes a culture of patient safety (Page, 2004), promotes greater expertise via staff stability and reduced turnout (Houser, 2003), and attracts additional effort, perceived efficiency and satisfaction (Janssen *et al*., 2004).

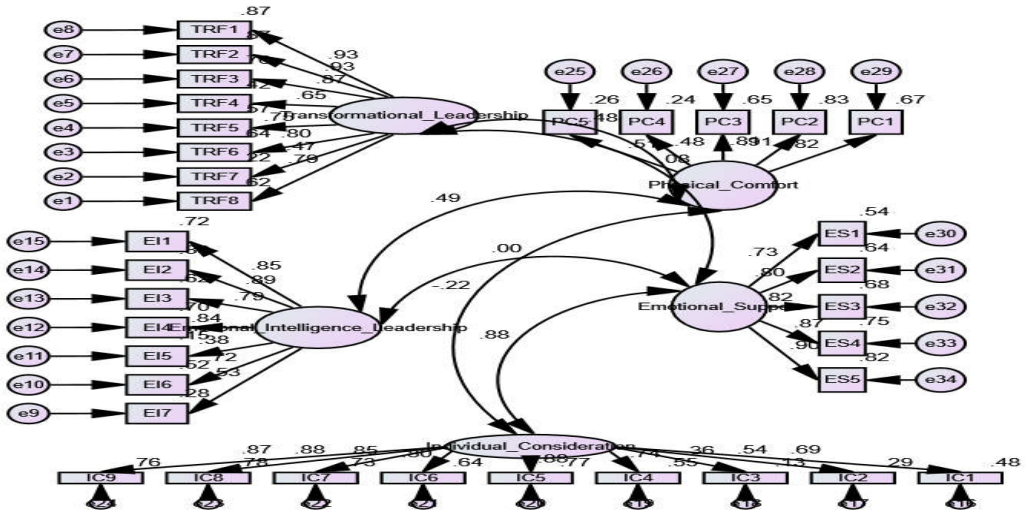

Figure 2: Algorithm and Structural model

Further, the finding lays credence to theoretical position of SERVQUAL (Buttle, 1996), because it suggests that medical organization's ability to show courtesy to patients, to display knowledge

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in their professionalism, and to behest confidence and trust, give patients assurance of professional and ethical healthcare delivery. Thus, responsiveness is perceived from patients' assessment of healthcare quality; and advances in information technology such as emails, webpage and patient healthcare interface improve the responsiveness of healthcare delivery. The path coefficient of EIL to PC reports that emotional intelligence interaction with physical comfort was supported by other scholars (Paquet *et al.,* 2013; Worringer *et al.,* 2020; McCue *et al.,* 1986) who affirmed that relational and people-oriented leadership (encouraging and coaching styles) surge patient satisfaction in acute care and home healthcare settings much more than delegating and structuring. The finding that individual consideration leadership associates with physical comfort aligns with previous findings (Goleman, 2000; Pennington, 2003; Worringer *et al.,* 2020; Thomas *et al.,* 2014). They found that facilitating changes in working conditions, creating access to resources, guiding individual and team attitudes, behavior and performance, or enabling staff participation in unit and patient care decision making are some potential mechanisms that connect leadership and patient outcomes.

Similarly, TRL and ICL to ES or H02and H06were supported; inversely indicating that transformational and individual consideration leaderships were strong determinants of patients' emotional support. The interaction between transformational leadership and emotional support as well as between individual consideration leadership and emotional support corroborate with extant studies (Al-Mailam, 2004; Mahmoud *et al.,* 2019; Hibbard & Smith, 2006;Duncan *et al.,* 2010) that reported transformational leadership to associate with flexibility, participatory prowess and staff maintenance, autonomy and leeway to exercise of professional ingenuity in medical practice over fixation of rigid and due process. Further, the path coefficient of ELS to ES was statistically supported, which means a rejection of H4 and the assertion that emotional intelligent leadership has no interaction with emotional support. Although previous studies record that emotional intelligent leadership works effectively in medical practice because of its relational virtue (Cummings *et al.*, 2009; Sfantou *et al.,* 2017; Žibert & Starc, 2018), in more severe cases, patients prefer medical team of stable skills and flexible expertise that offer direct solution to their health problems or minimize medical error and patient mortality to one that manipulates emotional intelligent prowess (Baker *et al.,* 2004; Kleinman & Dougherty, 2013; West *et al.,* 2014; Oyekale, 2017).

One of the main conclusions of the paper is that in the tertiary hospitals, leadership styles adopted has strong dominance in explaining health officers' willingness to deliver PCC. Specifically, transformational leadership most critically predicts patients' physical comfort, followed by emotional intelligent and individual consideration leaderships. The same transformational leadership predicts emotional support more critically than individual consideration leadership. A much more striking conclusion is that emotional intelligent leadership does not attract emotional support, which to a reasonable extent suggests that patients prefer direct solution to their problems to any other thing. These conclusions have theoretical and managerial implications.

Theoretical strengths

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First, this study further extends the theoretical postulation of SERVQUAL to healthcare delivery by alluding that healthcare givers use SERVQUAL to measure potential service quality issues and to diagnose their possible causes. In relations to the latent variables in tertiary hospitals, SERVQUALoffers technologies that measure and manage service quality, given that it measures how well services are delivered and how they consistently match the pre-determined expectations. Specifically, the study affirmed that SERVQUAL improves PCC because service organizations gun for high quality and customer retention when they consistently meet or surpass expectations and conceptions. Second, this paper contributes to, and/or extend, the theoretical and methodological discourse in leadership by developing a conceptual framework from extant literature and testing it empirically in the healthcare domain on account that reports from previous studies (Cummings *et al.*, 2009; Abbasi, 2014; Abdelhafiz *et al.,* 2016) sometimes seem contradictory and difficult to elicit cross-context generalization.

The strength of our kind of framework is that to the best our knowledge, no previous inquiries developed and empirically tested it on the healthcare in developing economies and so, decisions based on the results are supposedly devoid of the errors associated with cross-context application of results. However, the framework was tested using SEM to provide strong evidence for the goodness of fit, and affirming the validity and structural fitness of the latent variables.Third, unlike extant leadership studies (Ayeleke *et al.,* 2018; Oyekale, 2017; Chapman *et al.,* 2014; Cummings *et al.*, 2009; Sfantou *et al.,* 2017; Žibert & Starc, 2018; Mahmoud *et al.,* 2019) that looked at its styles and job satisfaction nay performance in different contexts, this paper provides specific relevance by unveiling the connection between leadership styles, job satisfaction and patient satisfaction. And finally, surprise ensued regardless of the peculiarity of the healthcare on account that the path coefficient showed no statistically significant interaction between emotional intelligent leadership and emotional support. This explains that regardless of the caregivers' proficiency in emotional intelligent, the patients seek more of direct solution to their health challenges.

Managerial strengths

The operationalization of the specific leadership styles and PCC enables the study to examine the differential impacts of each dimension on the two measures of PCC. This suggests that health managers and/or caregivers must carefully and proficiently look at the different leadership dimensions and their respective impact on PCC; in other words, they should strategically manipulate transformational, emotional intelligent and individual consideration leaderships to create patients' physical comfort and emotional support. In order of significance, they should imbibe transformational, emotional intelligent and individual consideration leaderships to create or enhance patient's physical comfort and emotional support. That is to bring about PCC, healthcare officers should recognize that TRL, EIL and ICL suggest mechanism for counselling and motivating others on what to accomplish and helping them (others) to develop their strengths and realize their differential needs, abilities and aspirations; and instigating interpersonal relationship and sense of purpose within the facilities.

Further, facilities should step up emotional intelligence by differing perspectives when solving problems, making clear path on the back when goals are achieved, dealing with mistakes and

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complaints, considering the moral and ethical consequences of decisions, and avoiding delayed responses to urgent queries. Individual consideration should equally be enhanced by providing others with assistance in exchange for their efforts, talking about the most important values and beliefs, discussing in specific terms who is responsible achieving certain targets, going beyond self-interest for the good of the group, treating others as individuals rather than just as group members, considering individuals as different in all ramifications, getting others to perceive a problem from different perspectives, and helping others to grow and develop their potentials.Finally, caregivers should understand that in critical challenges, the patients prefers direct solution to other things including the use of emotional intelligence to create emotional support.

Limitations and further studies

This study is a fruitful attempt to knowledge and theory but like every other empirical inquiry, its results need be interpreted with cautions; thus, providing opportunities for further studies to extend the capabilities of the instrument(s). First, the subject of analysis was sector or context specific and the use of cross-sectional data seldom unveils how changes occur amongst variables overtime. This impedes generalization given the identified context-specific causal relationship (Mattila, 2001), which often lose relevance overtime. Causal inferences are made with reference to theories and so, the direction of the causality and long-term application of findings is often strengthened when measures are extended or longitudinal studies involving quantitative and/or qualitative overtures ensued. Thus, replication of studies in other contexts and sectors is fruitful to strengthen causality and scale items in the instrument. Second, the measures of constructs were subjective perceptions and were prone to common error biases though such errors were avoided or minimized by the use of scientific approaches in the various stages of the inquiry.

Third, the paper takes deductive approach, which means further studies may adopt inductive approach with critical incident technique in order to have more in-depth knowledge about the study phenomena. Fourth, the demographic characteristics of the study limits the applicability of its findings and calls for further studies with different demographic features in terms of age, gender, educational attainment, and experiences. Finally, there are too many dimensions and measures of the key variables existing in literature, which were not captured in the proposed framework; therefore further inquiries should capture them and possibly integrate moderators, antecedents and consequences in order to improve knowledge promoted by the conceptual framework. However despite these limitations, we are optimistic that generalization or implications of the results have no restrictions, especially in the healthcare and allied areas because of minimized biases occasioned by the painstaking use of sciences.

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