

EXAMINING THE INFLUENCE OF TRANSFORMATIONAL LEADERSHIP ON
ORGANIZATIONAL CITIZENSHIP BEHAVIOR IN THE HEALTHCARE SECTOR
OF BRITISH COLUMBIA

by

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MBA (USJ), B.Mgt HRM(Hons), University of Kelaniya

DISSERTATION

Presented to the Swiss School of Business and Management, Geneva

In Partial Fulfilment

Of the Requirements

For the Degree

DOCTOR OF BUSINESS ADMINISTRATION

SWISS SCHOOL OF BUSINESS AND MANAGEMENT GENEVA

May 2026

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Dedication

I would like to dedicate this thesis to my mother Kanthi Weerakoon whose support, encouragement, and sacrifices have continuously been a source of strength during my life journey. Her love, strength, support and faith in the importance of my education have been a cornerstone in becoming who I am today. I would also like to dedicate this work to my teachers whose inspiration, knowledge, mentorship and commitment to nurturing have had a significant impact on my spiritual, intellectual and professional growth. Their kind advice, inspiration and commitment to academic excellence have played a big role in ensuring that this research was completed successfully with high standards. This is the work that is viewed as the symbol of their long-term influence and assistance.

Acknowledgements

I would like to express my heartfelt gratitude to my thesis supervisor, Dr Ivica Katavic, PhD, for his invaluable support, guidance, coaching, inspiration and mentorship throughout the research. His critical feedback, quick responses, scholarly knowledge, and constant motivation have played a pivotal role in the development of this study and in bolstering my research skills.

I am very grateful to my beloved wife, Nisansala, and my two children, Risandu and Camelia, whose unwavering support, patience and understanding throughout this rigorous learning journey I owe much. The support and the faith they have in me have been an eternal source of encouragement and energy. I also wish to take this opportunity to appreciate my present employer, University of Canada West (UCW), which provided me with a supportive academic environment that has allowed me to follow and complete this research study successfully. Besides that, I am also grateful to have worked back home under the AIA Insurance Lanka, where I had the honour of working for nearly a decade. This wonderful organisation has offered me the priceless opportunities to learn global best practices and have professional exposure, which has played a noteworthy role in my personal development in People Management and my perspectives on this particular research. Last but not least, I would like to mention Mr. C. Hewapattini, who was my first leader in my career, who inspired and guided me to become passionate about People Management. His initial impact has contributed and influenced greatly towards my career path. I am so much indebted to all who have assisted me in many ways in the successful completion of this thesis.

ABSTRACT

EXAMINING THE INFLUENCE OF TRANSFORMATIONAL LEADERSHIP ON ORGANIZATIONAL CITIZENSHIP BEHAVIOR IN THE HEALTHCARE SECTOR OF BRITISH COLUMBIA

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2025

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Co-Chair: <If applicable. Co-Chair's Name>

This paper discusses how Transformational Leadership (TL) affects Organisational Citizenship Behaviour (OCB) in the healthcare industry of British Columbia, with special reference to Employee Engagement, Job Satisfaction, and discretionary behaviours of people. The study aims to determine the most important organisational and leadership-related variables that influence the performance of employees, and to examine how workplace conditions (workload, staffing levels, and work-life balance, relationships) impact discretionary effort among professionals who work in the healthcare industry in British Columbia. To present a profound analysis, a mixed-method research design was adopted by the researcher. Previously tested and well-trusted questionnaires were given to 159 frontline healthcare workers to gather quantitative data, and semi-structured interviews with 14 respondents in leadership positions were conducted to obtain qualitative insights. Statistical data analyses were done, including descriptive statistics, correlation, regression and moderation analysis to test relationships among key variables involved in the study. Thematic analysis was used to examine the qualitative data in order to derive deeper contextual evidence on the employee experiences and organisational people management

practices. Results show that Perceived Organisational Support (POS) and TL leadership are positively related to OCB, employee engagement and job satisfaction. However, Perceived Organisational Politics (POP) shows a negative correlation with these outcomes. The findings of the study also emphasise that workload and related pressures, staffing pressures and deteriorated work-life balance challenges greatly affect the ability of employees to perform discretionary behaviours. Qualitative results of this study support the implication of leadership practices, employee recognition and rewards, and well-being programs, and recognise integrated engagement strategies, including leadership development interventions, employee recognition and well-being programs as important elements for better employee outcomes. The research also indicated that effective leadership, enabling organisational climate, and working conditions that could be managed are essential in promoting employee engagement and discretionary behaviours in the health care systems across the province. These findings are worthwhile in the context of healthcare organisations in dynamic service environments to appraise the overall understanding of people in organisations. This study recommends developing the transformational leadership skills of employees in the healthcare sector by conducting leadership development trainings specifically, using sharing and communication forums to improve required competencies, implementing employee rewards and recognition schemes, building positive workplace cultures, and promoting employee engagement and day-to-day discretionary behaviours in the healthcare industry. It further emphasises the need to minimise organisational politics and enhance POP to boost job satisfaction and organizational commitment. Future studies are recommended to study these relationships across Canada with longitudinal and mixed methods to figure out a better picture of the changing nature of health care workforce challenges, employee well-being and sustainable organisational performance.

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CHAPTER I:

INTRODUCTION

1.1 Introduction

The healthcare sector of British Columbia serves nearly 5.5 million residents in the province, as per statistics of 2023 (Government of British Columbia, 2024). The performance of the healthcare sector is critical for the industry as well as for the well-being of any community. Jun & Lee (2023) concluded that “a key mechanism via which transformational leadership encourages employees to innovative behaviors in the transformational efforts of an organisation or community” (p.320). Meanwhile, the urgent need for transforming healthcare services is more than a need, and it has become a critical matter in the province of British Columbia. Organ (1988) defined Organisational Citizenship Behaviour (OCB) as “discretionary individual behavior, not directly or explicitly recognised by the formal rewards system, and that in the aggregate promotes the effective functioning of the organization” (p.04). Whilst leadership challenges such as developing employees, inspiring them for change, retaining, and preventing them from mental exhaustion are some of the priorities of the leaders in the healthcare sector in the province.

The discretionary behaviors found in healthcare workers in the industry will be a definite requirement for transformation efforts in the industry. Therefore, the researcher is envisioned to find the true nature of the behavior found between Transformational Leadership (TL) and OCB and then create useful insights that support the transformation journey of the healthcare sector of British Columbia.

1.2 Research Problem

A significant problem within the healthcare industry in British Columbia concerns the lack of employee engagement, job satisfaction, and the exercise of discretionary behaviours (Business Intelligence for BC, 2024). Consequently, there is a considerable gap between service delivery standards and actual performance. Despite the prevailing need for transformation in the healthcare sector, the gap remains in understanding how transformational leadership influences OCB of employees in the sector. Hence, this research is aiming to investigate how the elements of TL relate to OCB, in exploring strategies to harness a culture of discretionary behaviors among the employees in the British Columbia healthcare sector. This gap outlines the current status, explores the knowledge gap and creates a good base for the proposed research study.

1.3 Purpose of Research

The prime purpose of this study is to examine the factors contributing to low employee engagement, job satisfaction, and limited discretionary behaviors among healthcare workers in British Columbia. Identifying strategies and organisational practices that can enhance workplace morale, improve job satisfaction, and foster a culture of voluntary, positive employee contributions. This present study will aim at identifying and describing potential solutions for what and how to develop relevant leadership competencies among the employees in the region of British Columbia.

The research will also make use of existing theoretical insights combined with some previous studies to provide ways in which leadership development programs can be enhanced, continuous learning fostered, and leaders' adaptive capability regarding the changing healthcare environment developed. The outcome of this study will create meaningful insights for the healthcare sector of British Columbia to lead its employees effectively and contribute toward improving organizational efficiency and patient care outcomes.

1.4 Research Questions

The following research questions presented by the researcher guided this study.

RQ1. What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia?

RQ2. How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector?

RQ3. What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers?

RQ4. What strategies and organisational practices have been effective in other regions or sectors in enhancing employee engagement and satisfaction?

1.5 Significance of the Study

The level of Employee Engagement and Job Satisfaction in the health sector of British Columbia is comparatively at a lower level. Service gaps are presently evident in a situation where the general quality of care of patients and efficiency within the healthcare sector demand the right time for researchers to undertake studies to understand the impact which the transformational leadership approach potentially has on OCB. This study planned to provide evidence on how TL inspires followers to accomplish discretionary work efforts, that are leading to higher levels of employee engagement and positive organisational results across the sector.

The findings of this research could benefit healthcare service providers in British Columbia about the type of leadership in designing leadership development strategies that would help narrow current gaps through inspired and engaged employees, ensuring a high level of service standards. This research will also create new knowledge on Transformational Leadership, OCB, Perceived Organisational Politics and Perceived Organisational Support specific to the healthcare sector of British Columbia.

1.6 Summary

The service gaps present in the healthcare sector, like disengagement and low levels of job satisfaction, have seemingly declined in discretionary behaviours. Transformation of the healthcare sector is a timely requirement in serving the increasing population of the province. Therefore, this research will endeavour to harness the relationship that exists between transformational leadership and OCB to enrich employee discretionary behaviours and positive work outcomes in the sector. This research is intended to present its contribution to the current knowledge on the concepts of TL and OCB, creating new insights.

CHAPTER II: REVIEW OF LITERATURE

2.1 Introduction to the Literature Review

The researcher intended to comprehend and describe existing knowledge and insights on how transformational leadership influences OCB. Hence, the overview of relevant leadership theories, theoretical content relating to transformational leadership philosophy, and OCB. The researcher has also discussed the relevant theoretical contents about Perceived Organisational Politics (POP) and Perceived Organisational Support (POS), and the contextual factors in the British Columbia Healthcare sector in this chapter of the literature review. Further, the outcome of this literature review will organise specific knowledge and applications relating to the Healthcare sector of British Columbia.

2.2. Documentation / Inclusion criteria

The tools used by the researcher to extract the conceptual content consisted of Google Scholar, Emerald Insight, JSTOR and SAGE Journals for journal articles, peer-reviewed papers, and empirical studies on OCB, TL, POS, POP and dynamics of the healthcare.

sector in British Columbia. Some institutional library resources were used in accessing books, research papers, peer-reviewed papers, and journals at the University of Canada West Library. These provided many contributions to determining the research gap, integrating existing research findings, and developing this study as a part of a thought-provoking intellectual dialogue.

Table 2.1.

The Nature and Sources of References

Author(s)	Nature of reference	Sources
Barling, Weber, and Kelloway, (1996)	Transformational leadership	<i>Journal of Applied Psychology</i>
Bass, B.M., (1990)	Transformational leadership	<i>Organizational Dynamics</i>
Jun, K. and Lee, J., (2023)	Transformational leadership	<i>Behavioral Sciences</i>
McCann, E.J., (2011)	Transformational leadership	<i>SSRN Electronic Journal</i>
Organ, D.W., (1997)	Organizational Citizenship Behavior	<i>Human Performance</i>
Organ, D.W., (2018)	Organizational Citizenship Behavior	<i>Annual Review of Organizational Psychology</i>
Putra, B.S., (2020)	Organizational Citizenship Behavior	<i>Counselling, and Humanities</i>
Zhou, H., (2010)	Organizational Citizenship Behavior	<i>International Conference on E- Product E-Service and E- Entertainment</i>
Kacmar, K. M., & Ferris, G.R., (1993)	Perceived Organizational Politics	<i>Impression Management in the Organization.</i>
Eisenberger, R. et al., (1986)	Perceived Organizational Support	<i>Journal of Applied Psychology</i>
Government of Canada, E. and S.D., (2023)	Healthcare Sector of BC	<i>Job Bank, Government of Canada</i>

2.3 Theoretical Framework

The theoretical framework for this study is intended to study the relationship between TL and OCB with the influence of two moderate variables: POP and POS. This framework is derived by the researcher after extensively studying the leadership behaviour-related theories on how leadership approaches influence discretionary behaviours that result in organisational success. Further, the researcher has taken POP and POS as possible moderating variables that would impact the potential relationship between independent variables and dependent variable. The diagram below illustrates the theoretical framework of this study.

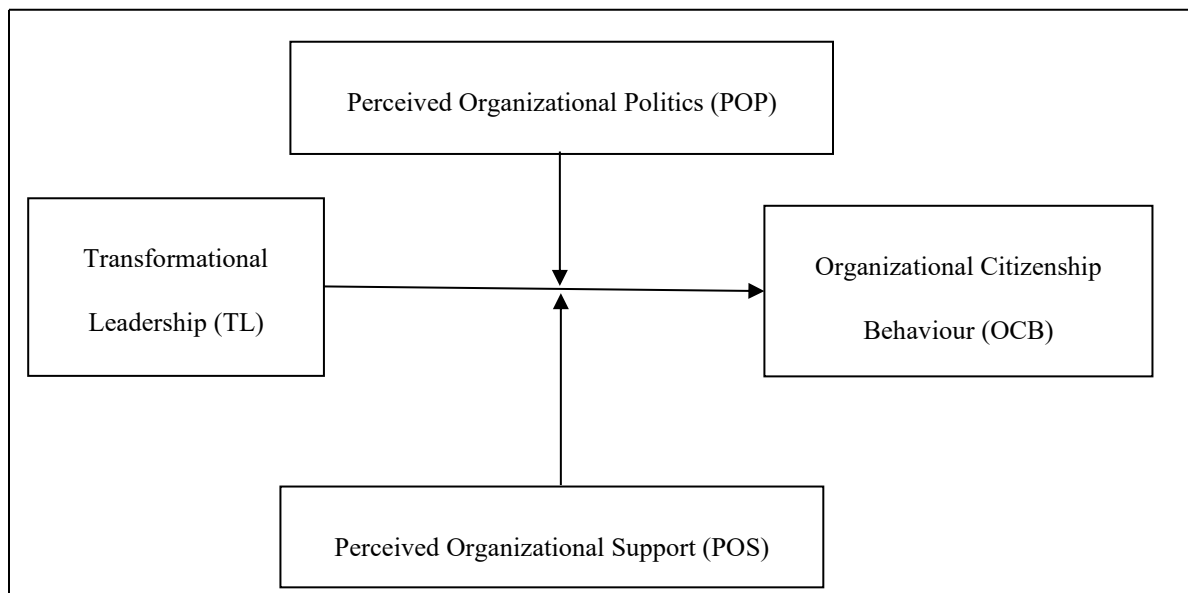


Figure: 2.1

The Theoretical Framework of This Study

2.4 Leadership Theories Overview

The concept of leadership is one of the most impactful and widely discussed topics in management and social phenomena globally. Over the last few decades, it has been deliberated upon by most scholars; however, it continues to be more captivating and debatable than ever before. Bennis and Nanus (1985) mention that “leadership is the most studied and least understood topic of any in the social sciences” (P.20).

In this study, the researcher compiles and presents the evolution of leadership theories and follows the development that has been made over the decades. It discovers four main schools of thought in leadership theory and practice: the trait theory, the behavioral approach, situational theory and contemporary leadership.

2.4.1 The Trait Theory of Leadership (1900-1940)

One of the main beliefs of this early leadership theory is that leaders are born with leadership characteristics, which they call leadership traits. In this era, leadership is more or less viewed as a built-in quality that a person brings with their birth. The core assumption of this theory is that leaders are born with leadership characteristics and that leadership skills cannot be developed over time. On the other hand, leadership and the leaders are rare people born with a unique gift. The examples of such leaders are often described as unique leaders who were considered unique personalities at that time. It was believed that leaders were born with innate leadership characteristics, which distinguish them to lead others in societies, communities, politics, sports and business.

The trait theory initially has several assumptions, comprising the evidence that traits of leadership are innate and do not accumulate over time with experience or training; some individuals are born leaders because of their unique personal traits. The association and quantification of these traits are most of the time predictive of the effectiveness of the leadership. The leadership characteristics are applied to dissimilar situations, meaning that effective leaders will be successful in various circumstances and situations. These expectations are very often like the research of psychology, which was based on the categorization of personalities and intelligence assessments.

Key characteristics that were established in the initial studies included several empirical and conceptual research efforts that tried to isolate the traits that are most often recognized with leadership. Though the results did not come consistent, some character variables were highlighted consistently: Intelligence, superior cognitive ability and problem-solving skills, confidence, their belief in making judgment and their capabilities, dominance, assertiveness and influence over others colleagues, integrity levels and moral character, their trustworthiness and ethical behavior, physique, vitality and stature, physical stamina, and leadership presence, and sociability, ability to interact with other people effectively.

In one of the early and comprehensive traits research, Bird (1940) identified more than 70 leadership characteristics but concluded that no single combination could be expected to predict leadership success in all situations under the study. This trait theory contributed to the field of leadership studies in some ways.

It began as methodical research on leadership, which lowered the approach of philosophy in the study of leadership and moved it to empirical research. It recognized the foundation of leadership based on the personality traits, which learned the subsequent study models like charismatic leadership and transformational leadership. It endorsed the psychometric procedures of the leadership prospect. Notwithstanding these deficiencies, the trait approach of leadership puts leadership as a valid, steady and scientific study area.

This trait theory became increasingly condemned and started declining during the period of 1930 to 1940: it became unreliable, and it was not found that the existence of a customary set of leadership traits (Stogdill, 1948). The trait theory did not consider situational variables such as the context, status of followers and organizational internal/external dynamics. The extreme focus on the character of heredity, critics argued, that leadership was something to be developed as a skill and acquired over time. The groundbreaking review by Stogdill (1948) concluded that “leadership is not a product of individual characteristics, but instead, it is a combination of people and demands of the situation” (P.35-71).

This established criticism was the main cause of the emergence of behavioural and situational leadership theories in later decades. Although much of the initial work of earlier explained trait theory has become outdated, later studies of leadership re-adapted perspectives of leadership theories in more forward-looking forms.

Contemporary research associated personality characteristics like the Big Five Model with the development and effectiveness of leadership and recognizes that traits and personality-based factors do not have an impartial effect on leadership, but instead have an association with the context (Judge et al., 2002).

In this context, the concept of the trait leadership theory can be called a conceptual predecessor of the modern and contemporary leadership frameworks, including the transformational leadership in which the central role is played by such characteristics as charisma, follower orientation, confidence, and level of integrity.

2.4.2 Behavioral Theories of Leadership (1940-1960)

Behavioral theory progressed from trait theories and emphasized that leaders are predominantly made, rather than born, and the behaviors can be studied, learnt or modified over time to become effective leaders (Johns and Moser, 1989). This leadership style focuses on the behaviors and the skills of the leaders that differentiate them from the followers, and it largely disregards the situation and circumstances in which the leaders are. They are often chosen to lead followers by the system, by authorities or the followers themselves. In today's context, this leadership theory is the mainspring behind the leadership development programs.

The Behavioral Leadership theories have been developed during the time of the 1940s and 1960s, as a direct neutralization to the limitations associated with trait approaches.

Although primaeval studies of leadership were overly concerned with innate personal qualities, there was a change of perspectives by the behavioral school of thought, which focused on the leadership behaviors, debating that good leadership is not born or character-based but acquired and developed through organizational studies, specifically in the time antecedent and after the World War II, was highly contributory in this paradigm shift since at that time the prominence of leadership effectiveness as a key factor of organisational effectiveness and military manifestation was highly desired (Stogdill, 1950).

One of the salient arguments about behavioural leadership theories is that leadership effectiveness is based on the actions and reactions of leaders and not the images or the characteristics of leaders. This supposition brought on several key concepts, such as: leadership behaviours are identifiable, categorizable and scalable, that effective leadership behaviours are trainable and learnable, and that diverse behavioural patterns and styles lead to various performance and positive organisational outcomes. This made leadership much more egalitarian in that it did not accept the mere fact, which was established earlier, that there can be only a few persons with certain leadership traits who can lead.

This style of leadership, which was based on behaviours of leaders, was one of the primary research projects on behavioural leadership theories as investigated by Lewin, Lippitt and White (1939), who defined three main leadership styles namely; Autocratic leadership which is characterized with centralized authority, directive decision making, Democratic leadership, which appreciated participative decision making and group involvement, Laissez-faire leadership, which made minimal leader intervention and guidance with high level of empowerment.

Their trial study exposed that democratic leadership style resulted in greater levels of satisfaction and creativity among the followers, and autocratic leadership resulted in greater short-term productivity but also hostile relationships among the leaders and followers and dependency.

Ohio State University studies are one of the breakthrough studies to the theory of behavioural leadership school of thought. Researchers involved in this study determined two self-governing dimensions of leadership behaviour, which are Initiating Structure, where the degree to which leaders define roles of the followers, set goals, and organise tasks and Consideration, where the degree to which leaders are concerned with the well-being, trust and respect of followers, which was more follower-centred. These study dimensions showed that leaders may score high and low on both behaviours at the same time, and the previous hypotheses that the style of the leaders was on a single growth continuum were also not evident in this study (Fleishman, 1953). These studies carried out at the University of Michigan established two main types of leadership orientations: Employee-orientation that placed the emphasis on interpersonal, relational aspects and employee needs and Production orientation leadership where the core emphasis was on the end task performance and productivity.

Research findings made a recommendation that an employee-centered leader was related to greater job satisfaction, reduced turnover, and better organizational outcomes (Likert, 1961).

The behavioral leadership theories made some key contributions to leadership scholarship: moved leadership research and studies toward empirical and observational methods; founded the basis for the development of leadership skills and related training programs; influenced posterior leadership frameworks and perspectives, including situational, contingency, and transformational leadership theories; and reinforced the importance of relationships between leaders and followers. These influences marked a remarkable advancement beyond the static assumptions of leadership trait theory. Despite its strengths, behavioral leadership theory had its own limitations: inconsistency of findings across contexts and in different organizations; neglecting situational variables, such as organizational, politics, culture, task variety or task complexity; and inability to identify a universally optimal or standard leadership style.

These restraints persuaded the development of the theory of situational leadership and contingency leadership theories, which evolved in the 1960s and hypothesized that leadership effectiveness relies on the relationship between contextual factors and the behaviors of leaders (Fiedler, 1967). The behavioral leadership theories are still very relevant in modern research on organizations. They focus on leadership behaviors, their interactions with followers, and the quality of the relationships, which is why the contemporary leadership models are directly related to transformational leadership theory, which unites the task-oriented behaviors with the individual approach of a leader and their inspirational motivation.

The behavioral leadership concept still remains relevant in implementing leadership development programs in healthcare and complex organizational settings, aiming at enhancing effective communication, trust building and participative decision making.

2.4.3 Contingent and Situational Leadership Theories (1960-1980).

Safonov (2018) recognised that ‘the environment plays a significant role in the leader-follower dynamic, and this belief dominated the situational era’. As indicated by its name, the situational leadership theory is focused on leadership behaviors demonstrated in different situations, other than on the characteristics or skills of leaders. This indicates that those who are in leadership roles should be able to read the situation in which they operate and then pick what style suits the situation best. The best style is dependent on the circumstances; this school of thought is recognised as the contingency leadership theory.

The emergence of the contingency leadership theory and situational leadership theories during the period of 1960-1980s was a significant development in the study of leadership. Intensifying on the shortcomings of the two leadership approaches, these theories did not credit having a universally effective leadership style but focused on the role of interactions between behaviors of leaders and variables relating to the situation.

The main argument of the research professionals of this time was that leadership effectiveness depends on situational factors, the nature of the task, attributes of followers, organisational factors, and the leader-member relationships (Fiedler, 1967). This ideology was a departure from the fixed leadership perspectives to dynamic and agile models.

Theories of contingency and situational leadership share several core assumptions: there is no single leadership style that is universally effective; leadership effectiveness depends on the fit between the leader's behavioral aspects and situational factors; situational factors moderate the relationship between the behaviors of the leaders and outcomes; and effective leaders often demonstrate adaptability and flexibility.

These assumptions have given a more realistic insights on leadership aspect in a complicated organisational setting. The leadership theory of contingency developed by Fiedler was among the pioneers of effective contingency theories. This theory, suggested by Frieder (1967), was that leadership performance is provisional upon the congruency between the disposed leadership style of the leader and the extent of situational favorability. This leadership style was assessed using the Least Preferred Co-Worker (LPC) scale, classifying leaders as either Task-orientation (low LPC) or Relationship-orientation (high LPC).

Fiedler argued that the leaders of task orientation work fairly well in high favorable or high unfavorable contexts, whereas the leaders with relationship orientation would work well in moderately favorable contexts. This leadership theory, conversely, was empirically based and was condemned on the assumption that this leadership style is fairly fixed and quite difficult to change.

The theory of Situational Leadership was developed by Hersey and Blanchard (1969; 1977) and contained a flexible approach used by a leader, depending on the readiness or maturity level of followers.

The four styles of leadership suggested in the model: telling (S1) – high task and low relationship; selling (S2) – high task and high relationship; participating (S3) – low task and high relationship; and delegating (S4) – low task and low relationship.

The theorization of followers' level of readiness was in terms of competency level and commitment, implying that the leaders of this nature should adapt their behavior as the followers grow in their maturity continuum. This model of leadership has become popular in leadership training and development field, due to its intuitive nature and practical orientation, even though there are mixed empirical research outcomes. Path-Goal Theory, which was developed by House, R.J. (1971), said: "it was a mix of both the expectancy theory and the behavioral leadership theory, whereby leaders boost the impulse of their followers by explaining the set goals and removing the roadblocks" (p.324-327). Four leadership behaviors were identified as per this approach: leadership styles of directive leadership, participative leadership, supportive leadership and achievement-oriented leadership.

The normative decision-making model which was developed by Vroom and Yetton (1973) and particularised by Vroom and Jago (1988), was used to determine the extent to which the followers are to be involved in the decision-making processes of organisations. Quality of leadership was also correlated with the quality of decisions made by the leaders, acceptance and time constraints, which gave an organised approach to leadership decisions. These theories made several continuing contributions: Introduced context as a pivotal variable in leadership research, bridged leadership theory and industry practice, influenced

posterior models such as adaptive leadership style and the transformational leadership model and provided pragmatic foundations for leadership development models.

Notwithstanding their advances, contingency and situational theories also faced some considerable criticism: challenges of measurement of outcomes, particularly with the LPC scale; unpredictable empirical validation across contexts; overemphasis on rational decision-making processes; limited concern with emotional, symbolic, cultural and ethical dimensions of leadership. These restraints opened room for the growth of charismatic and kind of transformational leadership styles during the period of the 1970s and 1980s.

The contingency and situational leadership theories are still valid in today's context and apply especially in multi-layered, high-stakes, and complex settings (healthcare, emergency services, and public administration). They focus on the adaptability of the leader depending on the situation, followers' needs and contextual fitment, which are very often related to the current problems of leadership in business. On top of this, these theories offer a theoretical basis for how transformational leaders could modify their behaviours in line with organisational culture and followers' preparedness.

2.4.4 Contemporary Leadership Theories (1970-1980)

Modern leadership theories characterise a significant departure from traditional leadership models, enlisting a larger prominence on the nature of interactions between leaders and members, demonstrated ethics, and circumstantial adaptability of leaders. Instead of focusing entirely on traits of leaders or their authority, modern leadership

theories conceptualise leadership as a lively and socially constructed process designed by interactions between leaders and followers, in an organisational setting (Northouse, 2022).

Among the contemporary leadership approaches is TL, which highlights the ability of leaders to successfully inspire, motivate and influence followers through creating a compelling vision, stimulating followers intellectually, through individualised consideration, and idealised influence. Another empirical study has linked TL to positive organisational outcomes like improved employee engagement levels, organisational commitment, and high performance (Bass and Riggio, 2006). Closely associated with this school of thought is authentic leadership, which emphasises self-awareness of leaders, their transparency, ethical conduct, and right alignment between values and their actions. Authentic leadership is predominantly relevant in inculcating trust and credibility in uncertain organisational contexts (Avolio and Gardner, 2005).

Another significant leadership perspective is servant leadership, which appreciates continuous growth, well-being, and the right empowerment of its followers. This leadership school of thought recognises leadership as a follower and service-oriented act, which emphasises moral content, their empathetic behaviour, and stewardship (Greenleaf, 1977). Separately, the ethical leadership perspective has also gained distinction due to increasing community, societal and organisational expectations for a high level of integrity, credibility, fairness, and accountability in leadership interactions (Brown and Treviño, 2006). In modern perspectives, shared and distributed leadership encounter the notion of leadership as a person-centric sensation. In its place, it is highlighted that leadership is a

holistic process rooted within teams of followers and their networks, predominantly in knowledge-based and co-operative work environments (Bolden, 2011).

Generally, modern leadership perspectives reflect the increasing importance of ethical conduct, relational influence, and agility in handling the complex problems of modern organisations.

During the period from 1970 to the 1980s most significant shifts in leadership studies occurred, where the concept of modern leadership theories began to evolve. Contemporary theories, as opposed to those that were developed in the past, concentrate on relational aspects, influencing processes, making sense and impact, motivation, inspiration and social exchange. This movement was a broader change that took place in organizational settings, such as the rise in the complexity of the environment, the emergence of computer technology, diversification of the workforce, and the growth of commitment, innovation, and organizational change (Yukl, 1989). The leadership perspectives were conceptualized more as a social contract that was dynamic, agile and not a role or specific set of behaviors.

Theories of contemporary leadership presented several introductory ideas that distinguished them from earlier schools of thought: Leadership has been viewed as a relational and shared process; Emphasis on perceptions of followers, values, inspirations and motivation; focus on leaders' non-directive influence, vision, and meaning, rather than directive control; recognition of situational and organizational substitutes for leadership; these characteristics laid most of the groundwork for modern leadership models and perspectives, particularly transformational and ethical leadership behaviors.

One of the most influential improvements of this period was presented by Burns (1978), who remarkably distinguished between the leadership styles of transactional leadership and transformational leadership. As per their study, transactional leadership style is grounded on various types of exchanges between leaders and followers, where compliance is achieved through continuous rewards and corrective actions. The transformational leadership style involves enriching the values of the followers, inspirations and their motivations, and moral aspirations, leading to higher levels of organizational commitment and performance.

Burns (1978) claimed that “leaders and followers raise one another to higher levels of motivation and morality” (p.20). This theoretical modification was later to help as the foundation of the empirical study models suggested by Bass (1985), though the original involvement of Burns is central to this theory of leadership.

Charismatic leadership theory was established as behavioral scientists tried to explain noteworthy aspects of leadership that could not be explained using logical or structural theories. House (1977) proposed the idea that charismatic leaders have discretionary traits that make their followers devote themselves and be highly emotionally attached to them. Key characteristics of this charismatic leadership include vision articulation (Envisioning); personal risk-taking, sensitivity to follower needs; and unconventional behaviour. Charismatic leadership theory highlighted followers’ level of attribution, suggesting that the effectiveness of leaders is partly constructed through perceptions of followers.

The theory of Leader-Member Exchange (LMX) was created by Graen and his peers in the 1970s. LMX theory arguably disproves the general belief that leaders have to treat all of their followers equally, but it presents the differentiated relationship between leaders and individual followers (Graen and Cashman, 1975). LMX theory significantly advances leadership research by changing the perspectives from the leader alone to wider leader-member relationships.

Kerr and Jermier (1978) developed the terminology substitutes of leadership in which they enunciate that, “in some cases, circumstantial and organizational variables may lower or nullify the effectiveness of leadership behaviours” (p.375-403). As per their model, the leadership substitutes are: Highly structured tasks; Professional norms and expertise, Strong organizational culture, Self-managing teams. This model confronted traditional assumptions about leadership supremacy and emphasised the role of organizational systems in influencing outcomes.

The contemporary leadership perspectives made several enduring contributions: stretched leadership research beyond traits and behaviors; presented moral, emotional, and relational dimensions of leadership; recognized the foundation for transformational, ethical, and servant leadership theories; and influenced leadership competency development, organizational change, and culture building. These leadership approaches strengthened the significance of leadership studies to complex organizational environments such as healthcare, aviation, science and technology, education, and public administration.

Notwithstanding their influence, contemporary leadership theories have been subject to critique: theoretical overlap between charismatic and transformational leadership; Assessment-related challenges and validity of instruments concerns; risk of leader idealization and romanticization; Limited attention to power- related behaviors and negative leadership outcomes. Nevertheless, these critiques have contributed to theory improvement rather than desertion.

The modern leadership theories still have a noteworthy influence on the currently practised leadership studies and practice. They are fixated on values, trust, motivation, influence, and involvement of followers, which bring into line well with the current organizational priorities, including the well-being of the employees, diversity management, inclusion, and ethical governance. Considerably, TL theory is now considered as one of the most empirically established leadership theories, especially in health care and the work of the state apparatus.

2.4.5 Transactional and Transformational Leadership Theories (1990-present)

Theories of transactional and transformational leadership characterise foundational but conflicting approaches to leadership, offering separate ways through which leaders could potentially influence the behaviours of their followers and the organisational results. Transactional leadership is based on interactions between leaders and followers, where amenableness is achieved through dependent rewards and expected behaviours. Leaders refine the roles of their followers, set expectations, and reward or impose sanctions based on the achievements of their followers and adherence to set standards (Bass, 1985).

This leadership approach has been somewhat effective in situations where the environments are stable, efficiency, structure, and routine performance are kept in order. Nevertheless, the transactional leadership approach has been critically commented on for its low capacity to harness innovation, inner motivation, and sustainable commitment among followers (Northouse, 2022).

On the contrary, the transformational leadership approach spreads beyond transactional interactions by focusing on elevating followers' level of motivation, personal values, and collective purpose. Transformational leaders tend to inspire their followers through creating a compelling and shared vision, providing intellectual stimulation to them, demonstrating idealised influence, and offering individualised consideration (Bass and Riggio, 2006). Before relying solely on inner rewards, this leadership approach inspires their followers to surpass their own interests for the success of their organisations. To support this perspective, empirical evidence constantly links the transformational leadership approach to positive organisational outcomes such as improved job satisfaction, high organisational commitment, high employee engagement, and discretionary behaviours, including organisational OCB (Podsakoff et al., 1990).

In the meantime, frequently presented as oppositional, the modern leadership school of thought recognises that transactional and transformational leadership are not interchangeably replicable. Successful leaders frequently incorporate transactional behaviours to establish clarity of goals and organisational structure, while instantaneously employing a transformational approach to drive constant change and inspire high performance of organisations (Bass, 1999).

Collectively, this leadership perspective provides a holistic framework for comprehending how business leaders can strike a good balance between the achievement of short-term goals and long-term organisational goals and sustainability.

2.5 Transformational Leadership

Transformational leadership style is very much relevant to today's turbulent world as it has the potential to harness mutual trust, members' inspiration, change agility, and innovations and technology appreciation of employees. Transformational leadership is a developmental leadership construct that emphasises followers' development through charismatic and inspirational leadership (Organ, 2018). Transformational leadership has been defined by Khan et al. (2020) as "Transformational leadership defined as leadership approach in which a leader transforms his followers, inspires them, builds trust, encourages them, admires their innovative ideas, and develops them" (p.02). This has been identified as one of the most cited definitions of transformational leadership in contemporary leadership literature.

Followers are being inspired by transformational leaders to understand, appreciate and achieve shared vision and performance expectations defined by the organizations (Anderson et al., 2017). Thomas and Velthouse (1990) concluded that transformational leadership can be successfully implemented in the business context. McCann (2011) argues that transformational Leadership is the leader's distinctive capability of driving his or her followers to achieve a discretionary level of performance objectives by intrinsically

motivating them. In this approach, the efforts of leaders have attracted a great deal of attention in the field of organizational management.

This leadership approach is supposed to be characterized by the leaders' competency to internally motivate his/her followers to achieve discretionary work outcomes that lead to organisational change initiatives.

2.5.1 Transformational Leaders and Followers

Leading researchers worldwide have explored the transformational leadership concept extensively enriching the literature with key components of the transformational leadership philosophy highlighted. Transformational leaders very often inspire followers to achieve more by engaging with the followers' personal values system and helping the followers align their values with the values that of the organisations they work in. Furthermore, it was evident in most of the research that transformational leadership style is a relationship in which the leader and the follower motivate each other to higher levels needs which results in value system congruence between the leader and their followers (Krishnan, 2002).

Ala'i (2019) recognized that transformational leadership is a process where leaders work with their followers to enrich morale, which eventually creates change initiatives resulting in positive work outcomes. Transformational leadership characteristics were elaborated by Boehnke, K. et al., (2003) describing them as “specific leaders who can make his/her followers well aware of issues of consequence, envision the big purpose of what

they are engaged in and improve self-confidence, inner strength to distinctly identify what is right or wrong, rather than pleasing everyone with popular choices” (p.5-15).

2.5.2 Elements of Transformational Leadership

According to Bass (1999), transformational leadership contains namely four elements, which are: Emphasised Influence, Inspirational Motivation, Intellectual Stimulation, and Individualised Consideration. Idealised influence can be observed when a leader is making his/her followers clear on purpose through appropriate visualisation. The leader’s ability to create inspiration and inner motivation is defined as inspirational motivation. These types of leaders are characterised by the right attitude, which enables them to deal with a variety of emotional traits of employees by giving the right feedback at the right time and building self-confidence. The support extended by the leader to his/her followers is referred to as individual consideration. The efforts put by a leader to encourage his/her followers to be agile to learn new ways to adjust to various situations is considered intellectual stimulation, another characteristic of a transformational leader. This will prepare followers for the ability to adjust according to diverse situations and face adversity successfully.

It has been established that TL is a critical success factor for followers to achieve meaningful work outcomes successfully. TL supports maximising the professional performance levels of followers in the organisational context (Barling, Weber, & Kelloway, 1996).

2.5.3 Distinction between Transformational and Transactional Leadership

Perspectives of transformational and transactional leadership characterise two separate yet mostly corresponding leadership approaches that vary essentially in their core assumptions, mechanisms of inspiration, and impact on their followers. Although both models seek to realise organisational goals, they do so through significantly dissimilar processes and alignments (Bass, 1985).

Transactional leadership is predominantly grounded in an exchange-type relationship between leaders and their followers. Leaders make clear roles, establish performance goals and outcomes, and reward or take corrective actions dependent upon the achievement of assigned objectives. The prominence is placed on obedience, efficiency, and managing existing structures and processes (Northouse, 2022). Transactional type of leaders very often rely on external motivational factors, such as remuneration, recognition, or penal measures, to change and govern the behaviour of followers. This leadership philosophy is exceptionally effective in constant and highly stable environments where role expectations are constant, and performance expectations are clearly defined. Nevertheless, the transactional leadership approach has been critically commented on for its limited ability to endorse innovation, creativity, novelty and sustainable follower development, as it focuses fundamentally on short-term performance expectations (Bass and Riggio, 2006).

In comparison, the TL approach is focused on inspiring and motivating the followers to surpass self-interest in pursuit of the common goals of the organisation.

Transformational leaders enunciate an enthralling vision, stimulate followers' intellectual capacity, demonstrate idealised influence by example, and deliver individualised consideration (Bass, 1999).

Rather than relying mainly on extrinsic rewards, TL nurtures intrinsic motivation by positioning personal values with the purpose of the organisation. This approach has been consistently associated with optimistic outcomes such as a high level of employee engagement, organisational commitment, followers' trust in leadership, and discretionary behaviours of followers, including OCB (Podsakoff et al., 1990).

A key differentiation between the two leadership perspectives lies in their emphasis on the change element. Transactional leadership pursues to maintain stability and leverage existing systems, whereas TL dynamically challenges the current situation and endorses organisational change and agility. Besides, transactional leadership centres on task and project completion, performance, and process compliance, while TL spotlights the development of the followers, their empowerment, and organisational sustainability and scalability in the long run.

Notwithstanding these distinctions, modern-day leadership research proposes that the two leadership perspectives are not mutually exclusive. Successful leaders very often syndicate transactional behaviours to establish the system and transformational behaviours to consistently inspire and engage with followers (Bass, 1999). Understanding the difference between these leadership perspectives has always been critical for any leader operating in the modern, turbulent business environment.

2.5.4 Theoretical Models Supporting Transformational Leadership

Transformational leadership is supported by a few other well-established theoretical models that cooperatively clarify how leaders should influence the motivation of the followers, behaviours and performance expectations beyond exchange relationships. One of the pivotal such leadership models is the TL Theory of Bass (1985), which is recognised as “transformational leadership under four components: idealised influence, inspirational motivation, intellectual stimulation, and individualised consideration” (p.5-7). This model suggests that leaders harness followers’ values, their aspirations, and commitment by affiliating individual roles and their goals with shared organisational goals.

Closely associated with this framework of Bass is Burns’ theory of transformational leadership, which highlights leadership as a moral, ethical and relational process. Burns (1978) differentiated the TL approach from the transactional leadership approach by emphasising its capability to engage their followers with a higher level of motivation, needs and ethics. This standpoint accentuates the role of personal and corporate values of organisations, common interests of members and the growth of followers in leadership success.

From this point of view, transformational leaders appreciate leader–cohesive member relationships, characterised by a high level of trust, mutual respect, and reciprocity towards followers, which inspire followers to respond through a higher level of contribution and discretionary efforts for organisational success (Blau, 1964; Cropanzano

and Mitchell, 2005). This theoretical framework supports explicating the strong empirical relationships between TL and OCB.

Moreover, the theory of self-determination also emphasises TL perspectives by revealing how leaders should improve the intrinsic motivation of the followers. Making satisfying followers and their psychological needs for their autonomy, skill, and relatedness, transformational leaders encourage intrinsic motivation and sustained engagement in the long run (Deci and Ryan, 2000). Intellectual stimulation and individualised consideration are predominantly accompanying with this point of view.

Conclusively, social learning theory, which contributes to understanding transformational leadership style by highlighting behavioural modelling. Followers always observe and suppress exemplary behaviours of leaders, their values, and ethical standards, underlining transformational influence through simulation and bonding (Bandura, 1977). These theoretical approaches jointly provide a significant supporting framework for transformational leadership, establishing how it could operate through moral obligations, intrinsic motivation of followers, interactions with followers, and social learning patterns to produce sustainable personal and organisational results.

2.5.5 TL in Healthcare Organisations:

Healthcare organisations function in extremely complex, vibrant, and emotionally straining environments depicted by workforce shortages, regulatory pressures, patient safety concerns, growing demand and swift technological change. In this context,

transformational leadership has appeared as a timely and important leadership approach for addressing both clinical and people challenges in organisations.

Transformational leaders in healthcare strive to inspire and motivate healthcare workers by enunciating a shared vision pinpointed on patient care standards, quality standards, and continuous improvement (Bass and Riggio, 2006). One of the crucial intensities of TL in the healthcare sector is its prominence on individualised consideration, which is closely related to the people-centricity of healthcare work. After much consideration and appreciating individual needs and wants, supporting personal and professional development of employees and nurturing physical and psychological safety, transformational leaders will improve employee physical and mental wellness and the level of resilience among frontline healthcare workers and allied health professionals (Wong and Cummings, 2007). This is a pivotal consideration in the healthcare sector, where constant burnout and mental exhaustion are prevalent. The TL approach promotes intellectual stimulation, encouraging staff to question existing practices, escalate when things are not going well, engage in decision-making, and provide innovative and novel solutions to day-to-day clinical and operational problems.

These kinds of leadership styles have been linked to enhanced safety of patients, higher levels of care quality, and rich cultures of learning within the healthcare industry (Weberg, 2010). Additionally, transformational leaders try to exercise and have ethical conduct and professional integrity, strengthening trust and commitment levels across diverse teams in the healthcare sector.

Empirical research has reliably established positive relations between TL and key organisational outcomes in healthcare, including high job satisfaction levels, employee engagement, collaboration, and OCB (Boamah et al., 2018). These critical outcomes are vitally important in the healthcare sector, where effective teamwork and collaboration, cohesion, and discretionary efforts directly impact patient outcomes and service quality.

Generally, transformational leadership delivers an impactful framework for circumnavigating the complications of healthcare organisations by developing a high level of engagement, agility, and shared purpose amongst the employees in the sector. This considers values-driven leadership school of thought, and interpersonal influence underpins it, especially suitable for supporting superlative performance and patient care in modern healthcare systems.

2.6 Organisational Citizenship Behaviour (OCB)

Organ (1997) defined OCB as “discretionary actions that are helpful to the smooth running of an organisation that go beyond existing obligations or role requirements but are not always rewarded” (p.85-97). Organ further defined (1997) OCB: as a force that encompasses several components: Altruism, which proposes helping others with work-related tasks; Conscientiousness-that is, being diligent and reliable work performances; Sportsmanship-that is, maintaining an Optimistic attitude even in difficult situations; Courtesy-that is, helping avoid interpersonal conflicts by treating others with mutual

respect; and Civic Virtue-described as a sense of responsibility and making initiative in t in functioning of the organization (p.88-89).

Organ (1997) further defined OCB as “discretionary individual behaviour, not directly or explicitly recognised by the formal rewards system, and that in the aggregate promotes the effective functioning of the organisation” (p.85). Organ et al. (2006) further emphasised the discretionary nature of OCB by defining it as “discretionary contributions that go beyond the strict description and that do not lay claim to contractual recompense from the formal reward system” (p.03). OCB are discretionary behaviours or extra efforts that employees put into their day-to-day routine, which go beyond the call of duty and are known to be factors that contribute to above-average performance (Organ, 1997). Organ (1997) further described OCB as “a direct contribution that exceeds expected role demands in an organisation and has the potential of earning awards based on achievements” (p.85).

2.6.1 OCB and Organisational Success

The concept of OCB has evolved as something similar to currency that is reflected as payment for the discretionary contribution of individuals in an organisation. OCB embraces informal cooperation and contribution where followers perceive fulfilling a higher level of internal satisfaction with equity and fairness. It further demonstrates spontaneous gestures from the followers with strong interpersonal relationships, fostering positive outcomes such as problem-solving and a greater level of creativity (McCrae and Costa, 1987).

Voluntary and discretionary behavior demonstrated by employees going beyond their call of duty to effectively contribute to the organisational goals is referred to as OCB (Putra, 2020). Neither rewarded nor mandated formally but the discretionary behaviors are crucial for the success of any organisation (Bolino and Turnle, 2003).

According to Putra (2020) TL is a management approach that inspires and motivates followers to translate their inner motives to create better organisational outcomes. As per the study concluded by Wisnawa and Dewi (2020), TL style is shown to have a positive impact on OCB. Transformational leaders have been able to increase OCB by inspiring the followers to realise the organisation's long-term objectives and overall purpose, whereas transformational leaders have also shown their ability to cultivate a sense of ownership and psychological connectivity between employees and organisations through discretionary behaviors (Podsakoff et al., 1990).

Further to that, Putra (2020) has suggested that employee engagement and organisational commitment can also positively impact OCB. Organisations that have been able to build a culture of employee engagement and organisational commitment are much more likely to have staff who demonstrate discretionary behaviours, which eventually will result in effective organisational performance (Podsakoff et al., 1990).

To conclude, the previous study outcomes have concluded that TL is likely to increase OCB among employees of the organisations that were subject to the discussed scholarly studies.

2.6.2 Linking TL and OCB

TL has been broadly known as a pivotal aspect of OCB, defined as discretionary behaviours that contribute to organisational success and are not formally rewarded phenomenon (Organ, 1988). The association between TL and OCB is supported by many conceptual paths, associated with robust theoretical incorporation and wide-ranging empirical evidence across industries, including the healthcare sector.

Conceptually, motivation signifies a considerable path through which TL leads to OCB. Transformational leaders improve inner motivation by enunciating a compelling vision, intellectually inspiring followers, and providing individualised consideration, thus inspiring employees to exceed role expectations (Bass and Riggio, 2006).

Separately, alignment of individual values plays a critical role, as transformational leaders stimulate shared institutional values that inspire employees to internalise organisational purpose and engage in discretionary behaviours (Burns, 1978). This incorporation nurtures discretionary behaviours such as camaraderie and advocating for the institution. The level of trust establishes another crucial mechanism connecting TL and OCB. Ethical conduct and consistency between words and actions, transformational leaders cultivate trust by demonstrating integrity, which has been shown to envisage discretionary efforts and OCB (Podsakoff et al., 1990).

Moreover, emotional septicity categorically explains how the positive impact of leaders, their optimism, and enthusiasm is transmitted to their followers, creating mutual emotional connectivity that reinforces camaraderie and OCB (Bono and Ilies, 2006).

Empirical research has recognised a few mediating and moderating relationships within the transformational leadership and OCB.

Multiple studies have disclosed that variables such as employee engagement, organisational commitment, POS, and leader–member exchange relationship regularly mediate the relationship between TL and OCB (Podsakoff et al., 2000; Wang et al., 2011). Mediating associations, including POP, leadership culture, and diversity, have also been recognised to influence the potency of this relationship, emphasising the sensitivity of TL.

This conceptual content further reinforces this link. Social learning theory proposes that followers demonstrate the behaviours, personal values, perceptions and attitudes exhibited by transformational leaders, imparting OCB through behavioural modelling (Bandura, 1977). The well-known leader–member exchange theory supplements this point of view by highlighting the quality of leader-member relationships; high-quality networks categorised by trust and accountability increase employees' voluntary engagement in OCB as a form of mutuality (Graen and Uhl-Bien, 1995).

Empirical evidence unfailingly supports the affirming relationship between TL and OCB in multiple sectors, including manufacturing, education, service and public administration (Podsakoff et al., 1996; Wang et al., 2011). Inside the healthcare sector, TL has been associated with higher levels of OCB among frontline healthcare professionals, consistently delivering improved collaboration, patient care, safety and quality of service (Boamah et al., 2018; Wong et al., 2013).

In the middle of the relational and emotionally challenging nature of healthcare and clinical work, the emphasis of transformational leadership on mutual trust, individual and shared values, and self-motivation is particularly prominent in furthering discretionary behaviours that are required for effective patient care.

2.7 Perceived Organisational Politics (POP)

Rosen et al. (2014) refer to POP “an individual's perception of the extent to which behaviors in the workplace are self-serving and aimed at gaining a personal advantage, often at the expense of others or the organisation” (p.1032). POP could obstruct positive work outcomes for employees in any organisational setting. This phenomenon has been ignored in history, but recently, a considerable amount of literature has shed light on the significance of POP and related factors in organisational settings (Bukhari, & Kamal, 2015). The detonation of politics is divergent according to different circumstances. From an organisational perspective, politics can be described as the strategies people deploy to achieve their objectives based on various personal agendas. This line of thought gives the idea that politics is a set of tasks manifested in organisations in day-to-day activities and could either produce positive or negative results. Politics in Organisations is defined as the "actions by organisational members who are directed toward the goal of achieving one's self-interests without regard for the well-being of other stakeholders or that of their organisation"(p.04) (Kacmar, & Baron, 1999). In general, organisational politics spreads self-serving behaviours, harming the organisation's common achievements.

According to studies relating to organisational politics, it is often observed that this behaviour consists of manipulative and self-gaining achievements, often viewed negatively by scholars who got involved in such studies (Ferris & Kacmar, 1992). This narrower definition was observed in most of the research that explores politics as unsolicited attempts to influence others, to fulfil one's interest at the cost of organisational objectives (Kacmar, & Ferris, 1993). Ferris, et al., (1989) were the researchers who first mentioned that “workplace politics could influence employees in different ways: the ones that make an impact on the emotional state of others in the organisation or mental status, which could create stress or anxiety, which could eventually impact his/her performance”(p.150-155).

Organisational politics is an unavoidable and central reality. Organisational politics in a company manifests itself over the fight for resources, interpersonal conflicts, the contest for power, authority and leadership and the ability to influence exercised by employees and power-seeking groups to build their image, domineering access to information, not revealing objectives, building alliances, etc.

Furthermore, empirical research has shown noteworthy relationships between perceptions of organisational politics and negative organisational outcomes, including high or unauthorised absenteeism, intention to quit, prolonged stress levels and dissatisfaction, commitment levels, role performance and OCB (Kacmar & Naron, 1999). Further, the studies found correlations between political intentions and negative organisational outcomes such as high stress levels, role ambiguity, low clarity regarding wider organisational purpose, intent to quit and self-withdrawal.

By and large, employees characteristically respond to POP in one of the following ways: self-withdrawal or planning to leave, by reduced work involvement, or by reacting with the same or more offensive political behaviours (Kacmar & Ferris, 1991).

Organisational Politics and Interpersonal Relationships

A more focused study of the organisational politics-related literature gives some insights as to the possible exposure of an aggressive type of behaviour in organisations with high degrees of politics. Kacmar & Ferris (1991) proposed that organisational politics has some dismissive consequences and interpersonal conflicts, which emerge when members are indented against each other or the organisation. Kacmar & Ferris (1991) further explained this dilemma by using the term 'hostile environment' for the exosphere that organisational politics can create. However, if organisational politics may enhance interpersonal conflicts, creating a hostile workplace, where employees' behaviour would potentially be affected in some way, perhaps reaching hostile and unhealthy behaviors such as aggression towards co-workers or backstabbing other members.

2.8 Perceived Organisational Support (POS)

Eisenberger et al. (1986) defined POS as “employees' belief that their organisation values their contributions and cares about their well-being” (p.501). Aube, Rousseau, & Morin (2007) mentioned that “POS encloses the degree of an employee's state of mind that the workplace is considered as fairly treating and rewarding for what they contribute and

also includes their overall perception of the workplace to the extent that it helps and supports them” (p.429-430). Proactive organisations understand the fact that the best way of rewarding and recognising the contributions of employees is a blend of financial incentives and various types of benefits, along with non-financial rewards such as recognition, professional development, and an empowered work environment.

Aube, Rousseau, & Morin, (2007) further emphasised that Investment in human capital includes the investments in creating a conducive environment that would go a long way in empowering employees to be happier, engaged, involved, motivated, and inspired with their work. Higher efficiency gains, improved retention, steady business growth and overall development of the organisation would be warranted through the consequential influence on work-related employee behaviours and attitudes.

Rhoades and Eisenberger (2002) mentioned that “the Organisational Support Theory (OST), employees create a general perception considering to what extent the organisation values their work outcomes and cares about their physical and emotional well-being”(p.698). Rhoades and Eisenberger (2002) further mentioned that “the three keyways that employees perceive that they are being well treated by their organisations are: (1) through supervisory support; (2) through pay and work environment; and (3) through fair practices”(p.699). If employees identify that the workplace values their real contribution, then they will also show discretionary behaviour towards their organisation, but in general, employees might have different perceptions regarding sustenance lent by their organisation, so it becomes important to understand these differences in their perceptions.

OST has become an attractive topic because of the way it looks at the employee and organisation's relationship from employees' point of view. The clear content of the POS construct, and the significant associations of POS with employee engagement, commitment, and employees' discretionary outcomes. OST suggests that POS should be developed to such an extent that workers get fair and affirming treatment conferred by the organisation in a positive regard. Consistent with this rationale, rewards and benefits (financial and non-financial) that employees value, and therefore are specific to the needs of employees, should increase POS.

POP and Social Exchange.

Cropanzano & Mitchell (2005) explained that "OST weights on social exchange theory, where a job is viewed as the exchange of contributions on the part of the employee for tangible and intangible benefits and resources from the organisation" (p.875). POS should provoke the idea of exchange, leading to a felt compulsion to help the organisation when it needs it, as well as the expectation that amplified performance will eventually be rewarded. As a result, a higher level of POS among employees would create positive work outcomes. This upturns their job performance as well as their discretionary performance, placing the organisation on top of the curve.

An emotional form of organisational commitment is apprehended where the employees strike a good balance between their relationship with the organisation from side to side, forming positive attitudes and behaviours that correlate with POS. Therefore, in workplaces where the POS is evident is engaged and committed. (Eisenberger et al., 2001).

Perhaps, OST is sometimes erroneously explained as only a social exchange relationship. However, OST sometimes deals with self-initiated processes. POS is also believed to satisfy socioemotional needs, social esteem, affiliation, and emotional support, which will eventually lead to recognition with the organisation. OST advances that self-enhancement and social exchange might affective organisational commitment and employee engagement. Particularly, regarding self-enhancement, the organisational identification restricting from POS might facilitate affective organisational commitment by nurturing shared values (Meyer, Becker and van Dick, 2006).

2.9 Healthcare Sector in British Columbia

According to Dickson (2020), Canadian healthcare leaders are experiencing unprecedented change. According to the Government of Canada (2024), due to the growing tendency of the population, specifically the elderly group, the influx of immigrants will raise the demand for healthcare services, and consequently, the industry will grow quantitatively and qualitatively.

While there is a historical shortage of healthcare professionals in the province, the COVID-19 pandemic also increased the workload of existing employees in the health care sector, especially in hospitals and clinics. This increased workload created additional pressure that increased the level of tardiness and stress levels among the employees in the healthcare sector.

The dire need to redeploy the existing resources to handle COVID-19-related workload delayed other priorities in the sector, and it resulted in a backlog and waiting list

for patients. To date, the sector has been struggling to meet the demands of those who were on the waiting list, with added day-to-day volume, the sector seems to be falling short in meeting patient care standards promised by the sector.

The healthcare system of British Columbia is organised into seven regional health authorities. Fraser Health, Northern Health, Interior Health, Island Health, Vancouver Coastal Health, Provincial Health Services Authority (PHSA) and First Nations Health Authority (FNHA) are the authorities servicing a population of approximately five million in the region. Each authority delivers customised healthcare services to fulfil the current healthcare needs of its region. Together, these authorities have employed around 200,000 direct healthcare professionals and indirect staff, meeting a wider variety of healthcare needs in the region.

Even though it looks like these authorities have wide coverage, challenges such as workforce deficiencies, especially in interior and rural areas, and increasing demands for elderly care, mental health remanning are under-addressed. However, the industry authorities have implemented various types of people, process-related and strategic initiatives to address these challenges. Still, the effectiveness of those initiatives is yet to be proven. (BC Ministry of Health, 2023; CIHI, 2024).

The Canadian healthcare sector, specifically in British Columbia, currently faces some challenges that necessitate transformational leadership to make positive changes and build OCB among the healthcare sector staff (Moe, Pappas, and Murray, 2007).

Like other regions in Canada, the healthcare industry in British Columbia is struggling with some issues, including scarcity of resources, increased demand, service standard

expectations, low supply of skilled staff, and swift need for adaptation. Transformational leadership, with a high emphasis on inspiring and empowering followers to embrace change, can play a pivotal role in making a positive shift to the next level of the industry. In this way, transformational leaders in the healthcare sector can potentially mobilise, inspire and motivate staff to address the said challenges. Govender, Proches, and Kader, (2018) mentioned the importance of having a personal commitment and the ability to take decisive actions for this leadership style.

Warriner (2009), through his extensive study in the healthcare sector, further elaborated that transformational leaders can drive his/her followers to achieve a shared purpose among the employees in the healthcare sector, which will potentially lead to better business outcomes characterised by discretionary behaviours. To be effective, a TL approach should not be limited to the upper echelons of the organisation; it has to emerge from all levels, assuming leadership accountability for organisational results. As per Warriner's study, the provincial government of British Columbia is expecting the Emergency Medicine Network (EMN) to improve its standards of clinical care and patient outcomes by effectively providing point-of-care clinical resources and collaborating with research bodies, improving the continuous professional development initiatives of the professionals in the sector, and building real-time support with the support of emerging technology.

To transform the industry, people in leadership roles should necessarily incorporate the new set of leadership competencies that are vital to creating value. If the leaders' efforts are unsuccessful, it will undervalue the role of leaders in the industry. Leaders are being

pressurised to redouble the efforts they put into transforming their leadership capacity and reinvent the leadership impact they make on the sector, by engaging multiple stakeholders like healthcare professionals, entrepreneurs, government institutions, local and global universities and the community at large. To reimagine and create leadership supportive of the patient care model, healthcare leaders will have to act collectively to grow their competencies to fill the prevailing competency gap in the healthcare sector of British Columbia.

2.9.1 Organisational Structure and Leadership Dynamics in BC Health Authorities

The public healthcare system of British Columbia is structured on a regionalised operating model, containing six regional health authorities, namely Interior Health, Fraser Health, Northern Health, Island Health, Vancouver Coastal Health, and a single province-wide regulatory body, the Provincial Health Services Authority (PHSA). This model is developed to balance the supervision of the provincial with responsiveness. Regional authorities, allowing health authorities to create focused service delivery to population and community needs while keeping aligned with the key priorities of the Health Ministry (Marchildon and Sherar, 2018).

Health authorities of BC are symbolised by highly vertical and complex organisational structures, mirroring the accountability demands through regulatory control inherent in public healthcare. Leadership involvement within this type of system is moulded by a few governance layers, technical and professional hierarchies, unionised labour, and regulatory control. Consequently, leaders working in this kind of confined

decision-making environment often face decision-making that is controlled by union agreements, professional code of ethics, and governing policies (Tourangeau et al., 2020). In this environment, organisational leaders are dispersed across executive management teams, clinical and operational leaders, and professional practitioners. Whereas decision-making authority is centralised, leadership autonomy or abilities increasingly rely on collaborative influence before role authority, particularly in multidisciplinary-based care environments.

This phenomenon has amplified the relevance of leadership approaches that highlight collaboration, building trust, and employee engagement (Wong et al., 2013). Transformational leadership practice is particularly noticeable within the BC health sector due to various reasons: prevailing high demand for the service, system pressures, labour shortages, service integration initiatives, and post-pandemic recovery trends. Leaders should motivate and create engaging work cultures given the resource limitations and emotionally vulnerable labour, making leadership crescendos highly reliant on collaborations, personal interactions and emotional well-being (Boamah et al., 2018).

Generally, the organisational hierarchies of the BC healthcare sector create a leadership landscape marked by a sense of accountability, complexity and limited or controlled autonomy. Comprehending these hierarchical and relationship dynamics is pivotal for studying how leadership conduct influences the performance of employees, including OCB, within the health sector of BC.

2.9.2 Cultural and Policy Context Affecting Leadership and Employee Behaviour

Leadership success and behavioural outcomes of employees are meaningfully moulded by the wider cultural and policy environment in which organisations operate in the modern context. The culture of organisations, demarcated as the common values, prevailing norms, and core assumptions that shape behaviour, plays a key role in prompting how leadership contributions are perceived and implemented (Schein, 2010). In cultures that appreciate teamwork, mutual trust, and psychological well-being, leadership practices that endorse employee participation and empowerment are more apt to nurture positive employee contributions, including employee engagement and employees' discretionary behaviours.

National, provincial and sectoral cultural environments further outline expected leadership interactions and possible employee reactions. In the healthcare sector, ethical standards, professional expectations and service-focused values powerfully influence employee behavioural outcomes, often underpinning collective responsibilities, accountabilities and professional conduct. Leaders functioning within this type of environment must find deeply embedded professional uniqueness while positioning behaviours of employees with organisational outcomes (Hofstede et al., 2010).

Leadership styles that are overly totalitarian or dictatorial may conflict with these community expectations, hypothetically reducing trust and commitment from employees in leaders. Policy agendas have a significant amount of influence on leadership practices and behaviours of employees. In highly regulated industries, policies soliciting accountability, managing performance, labour relations management, and professional

exercises can impact the expected scope of work from leadership. Whereas policies offer structure and consistency, excessive protocols may limit leaders' autonomy to respond to employees' unique needs, thus impacting the level of morale and motivation (Moynihan and Pandey, 2007). Employees whose conduct is more prejudiced by perceptions about procedural fairness and transparency of processes and policies embedded within policy administration. When policies and procedures are employed, a low level of consistency or the perception that the policies are politically motivated, employees might not engage or may limit their discretionary efforts.

Contrariwise, supportive, fair and equitable policy environments always reinforce employee engagement, and well-being can invariably strengthen trust placed in leaders and improve OCB. Largely, leadership practices and employee responsive behaviour cannot be fully comprehended without considering the culture and the policy environment of the organisation. Employees in leadership roles who are culturally competent and skilled at circumnavigating limitations in the policy and procedures are better positioned to nurture mutual trust, a high level of engagement, and employees' discretionary behaviours within any organisational setting.

2.9.3 Previous Research Conducted in Canadian or BC Healthcare Contexts

Multiple research studies done in the area of leadership in the healthcare sector in British Columbia examined leadership behaviour, employee conduct, and organisational performance, with particular weight on clinical leadership, frontline employees' engagement, and healthy patient outcomes. Overall, Canadian healthcare organisations are

publicly funded, heavily regulated and characterised by strong regulatory governance and a unionised labour force, making them a unique circumstance for leadership research (Marchildon, 2013).

In the context of Canada, researchers have consistently emphasised the affirming influence of transformational leadership on employee outcomes such as employee engagement, strong organisational commitment, and OCB. Research conducted by Wong and Cummings (2007) established that “collaborative and transformational leadership styles among clinical managers were associated with higher levels of patient outcomes and higher job satisfaction across several healthcare organisations in Canada” (p.508-521). Likewise, Laschinger et al. (2012) discovered that transformational leadership was positively correlated with structural empowerment, trust in management, and employee engagement among nursing staff in the Canadian context.

In British Columbia province, empirical studies have observed leadership practices within a complex, hierarchical healthcare sector organisational structure. Boamah et al. (2018) described that “transformational leadership is one of the leadership styles that is among clinical leaders in healthcare settings in Canada, including British Columbia, was associated with improved safety-concerned environments and reduced adverse patient-related incidents” (p.235-236). Other social research conducted within British Columbian health authorities has emphasised the role of leadership in extenuating burnout, nurturing psychological safety, and endorsing cohesive practices in highly demanding and challenging clinical environments (Wong et al., 2013). A Canadian study has also discovered environmental variables prompting leadership effectiveness and their success,

such as a high level of perceived organisational support, organisational commitment, and policy compliance.

Studies have also suggested that leadership conduct with these situational factors to outline perceptions of employees and discretionary behaviours, particularly in environments with labour unions and environments with limited resources (Spence, Laschinger and Read, 2016).

Overall, multiple studies conducted in Canadian and BC healthcare environments emphasise the pivotal role of leadership in changing employee behaviour and organisational performance. Nevertheless, researchers have mentioned the timely need for further environment-specific studies that incorporate leadership practices with moderating variables, such as perceived organisational politics and perceived organisational support, to better comprehend behavioural outcomes within the healthcare system of British Columbia.

2.10 Summary

The literature review presents some of the extracted content of existing knowledge relating to the study topic of 'Influence of TL on OCB ' within the healthcare sector of British Columbia. Furthermore, this literature review explores the concepts of TL, OCB, POP, POS and the status of the healthcare sector of British Columbia. Overall, TL is a leadership philosophy where leaders focus on envisioning a big purpose for his/her followers and inspire them to create an inner drive to achieve impactful organisational results.

Whereas OCB is characterised by followers' inner motivation to go beyond their job scope, demonstrating discretionary efforts. Meanwhile, in the healthcare industry of British Columbia, increased demand for services, declining employee engagement, and job satisfaction are evident in the presented literature. Further, there are no records of structured studies done on the impact of TL on OCB in the healthcare industry of British Columbia Province. Hence the proposed study by the researchers will contribute to the industry as well as academic fraternity in terms of new knowledge.

CHAPTER III:

METHODOLOGY

3.1 Overview of the Research Problem

A significant problem within the healthcare sector of British Columbia concerns the lack of employee engagement, job satisfaction, and exercising of discretionary behaviors (British Columbia Stats, 2024). Consequently, there is a considerable gap between service delivery standards and actual performance. Despite the prevailing need for transformation in the healthcare sector, the gap remains in understanding how TL influences the OCB of employees in the sector. Hence, this research aims to investigate how the elements of TL relate to OCB, in exploring strategies to harness a culture of discretionary behaviours among the employees in the British Columbia healthcare sector. This gap outlines the current status, explores the knowledge gap and creates a good base for the proposed research study.

3.2 Research Purpose and Questions

In the turmoil of current leadership challenges and the analysis carried out on the service outcomes within British Columbia's health sector, the researcher points out various gaps in effective leadership competencies and drives innovation in the industry, with some immediate needs to be addressed. This present study aims to identify and describe potential solutions for what and how to develop relevant leadership competencies among the employees in the region of British Columbia.

The research also makes use of existing theoretical insights combined with some previous studies to provide ways in which leadership development programs can be enhanced, continuous learning fostered, and leaders' adaptive capability regarding the changing healthcare environment developed. The outcome of this study will create meaningful insights for the healthcare sector of British Columbia to lead its employees effectively and contribute toward improving organisational efficiency and patient care outcomes. The following research questions present a framework for this research:

RQ1. What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia?

RQ2. How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector?

RQ3. What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers?

RQ4. What strategies and organisational practices have been effective in other regions or sectors in enhancing employee engagement and satisfaction?

3.3 Operationalisation of Theoretical Constructs

TL and OCB are the variables coming under this study, considering POP and POS as the moderating variables. In the quest to achieve construct validity and measurement reliability, all the variables in this study have been operationalised with the help of well-established, previously validated scales that are commonly used in organisational

behaviour and leadership studies. The dependent variable of OCB was measured through the scale created by Podsakoff et al. (1990) that covers five dimensions, namely altruism, courtesy, civic virtue, sportsmanship, and conscientiousness. These dimensions capture the discretionary behaviors of employees that add up to the overall effectiveness of the organisation.

TL is an independent variable which was measured through the Multifactor Leadership Questionnaire (MLQ) developed by Avolio and Bass (2004). This tool consists of five sub-dimensions: intellectual stimulation, idealised influence, inspirational motivation and individual consideration, which describe together the degree to which leaders influence, develop and inspire their followers to demonstrate discretionary performance.

POP is the moderator variable, which was measured by the POP Scale created by Kacmar and Carlson (1997), as a form of measurement of the level of perception of employees towards favouritism, dominance of the powerful groups, manipulative behaviour, and openness to the expression of dissenting ideas of employees. POS is the second moderator measurement scale, assessed through the scale invented by Eisenberger et al. (1986), which is based on how the employees perceive the organisation to be recognised and care about their welfare, responsive to their needs, and equitable in their decisions. These items were rated on a five-point Likert scale in order to reflect how strong the perception and experiences of the respondents are. These validated instruments were used so that the constructs in the study can be measured similarly, and the measures correspond to the theoretical and empirical constructs.

Table 3.1.

Operationalisation of Variables

Concept	Variable	Indicator / Measurement	Questions
OCB	Altruism	The scope of how an employee assists other workers with their work-related problems, assists new workers, and goes on assisting their fellow workers even after their tenure.	OCB 1,2,3
	Courtesy	The degree of care a particular worker expresses, whether or not they respect the rights of other employees, whether or not he/she causes trouble and whether or not they use a language that is respectful to others.	OCB 4, 5, 6
	Civic Virtue	How much an employee is informed, interacts with the policies, and engages in activities that help the organization to operate and serve its interests in a voluntary manner.	OCB 7, 8, 9
	Sportsmanship	The frequency at which an employee is able to wait and accept inconveniences without any complaint and how the employee would respond with a positive attitude when faced with minor problems.	OCB 10, 11, 12
	Conscientiousness	How willingly an employee behaves in a disciplined, dependable and law-	OCB 12, 14, 15

		abiding manner in excess of the demands of employment.	
TL	Intellectual Simulation	How much leaders influence employees to think differently, adopt innovation, challenge status quo and engage in independent, critical thinking.	TL 1, 2, 3
	Idealised Influence – behaviour	To what extent do leaders demonstrate integrity, communicate a clear vision, maintain high standards, match words with deeds, and gain the trust and respect.	TL 4, 5, 6, 7
	Idealized Influence – Attributed	To what extent do leaders make people respect, trust and be loyal to them with the help of their confidence, determination, vision and personal qualities.	TL 8, 9, 10, 11
	Inspirational Motivation	The level, at which leaders can inspire commitment through conveying an inspiring vision, expressing confidence and inspiring by encouraging employees.	TL 12, 13, 14, 15
	Individual Consideration	The extent to which the leaders extend support to the employees in terms of meeting the personal needs, mentoring, listening, providing feedback and supporting the growth.	TL 16, 17, 18

POS	Recognition & Value of Employee Contribution	Extent to which leaders recognize, appreciate, and value employees' input and accomplishments	POS 1, 4, 9, 5
	Care for Employee Well-Being & Fair Treatment	Extent to which leaders show genuine care, fairness, and do not exploit employees	POS 2, 6, 10
	Support & Responsiveness to Employee Needs	Extent to which leaders provide help and respond to special requests or complaints	POS 7, 11, 8
	Fairness in Decision-Making	Extent to which leaders make decisions in employees' best interests and avoid disregard	POS 3
POP	Favoritism & Unfair Advancement	Perceptions that personal connections and favoritism, rather than merit, drive career progress and rewards.	POP 1, 2
	Dominance of Powerful Groups	Perception that certain groups control outcomes and discourage opposition.	POP 3
	Manipulative & Self-Serving Behaviors	Perceptions of people advancing by undermining others and changing policies for personal benefit.	POP 4, 5
	Openness to Dissenting Ideas	Perception that disagreement and diverse ideas are welcomed rather than punished.	POP 6

3.4 Research Design

Deductive, inductive or abductive reasoning can be used to develop theories using mixed methods of research design. As an example, they may start by conducting one or more theoretical propositions through a quantitative approach and then proceed to do further studies through the qualitative approach to obtain a deeper insight into the theory. The theoretical frameworks can also be used as a guide on how to give shape on the study and define its scope (Tashakkori & Teddlie, 2003). In the mixed methods studies, there are many techniques of integrating the quantitative and qualitative methods, some being simple direct applications, and there are some complex ones, such as sequential designs.

In many previous studies, the number and level of integration between these approaches have led to the presence of the various identified forms of mixed designs (Creswell & Plano Clark, 2007). Tashakkori & Teddlie (2003) have mentioned that “mixed methods research has special significance in the social and health sciences, in which the examination and clarification of phenomena usually involve the use of numerous types of information and analysis”(p.3-10). The mixed methodology utilises the previous discussion of research issues, philosophical premises, data gathering, and analysis plans to develop well-coordinated and organized personal research (Creswell, 2017).

The mix method of quantitative and qualitative combination in a study that has the aim of giving a more complete picture of complex research problems is what is referred to as mixed methods research (Johnson, Onwuegbuzie & Turner, 2007). Combining methodologies: researchers use this method as a way of taking advantage of the capabilities of each of the methodologies, e.g. qualitative findings may be used to examine or interpret

quantitative findings, or the other way round. This approach has had different terminologies over the years, which include multimethod, integrative design, and mixed methodology. The term mixed methods has, however, come out as the most preferred term used in modern literature (Bryman, 2006; Tashakkori & Teddlie, 2003).

This researcher used a mixed methods approach because it reinforces both research objectives. Discovering whether certain leadership styles are linked to OCB in a general way (quantitative) involves analysing reasons and real-life experiences (qualitative) that describe those relationships. This form of research is similar to the pragmatic paradigm because it directs attention to the key problem and employs various methods to tackle it completely (Creswell, 2017). Since leadership in healthcare can be quite complex and Organizational dynamics affect it, this design allows the findings to be trusted and applicable in both leadership training, policymaking and practice in the BC healthcare system.

3.5 Population and Sample

Population

This study dwells upon three major groups on the territory of British Columbia within the field of public health care, including front-line workers, front-line management and senior leadership team members. The population was made up of all healthcare workers and leaders who are based in the seven healthcare regional authorities in British Columbia, Canada:

1. Fraser Health,

2. Vancouver Coastal Health,
3. Island Health, Interior Health,
4. Northern Health,
5. The Provincial Health Services Authority (PHSA)
6. First Nations Health Authority (FNHA)
7. Providence Healthcare (PHC)

The total number of employees working in these authorities was estimated to be about 148,000 employees (BC Ministry of Health, 2023), more than 135,000 people employed in frontline work (nursing, allied health, and paramedicine, in different care settings). The population of this employee group offers a wide and varied group to investigate the influence of the leadership practices in the OCB within clinical and non-clinical settings. Besides, the leadership population has a total of about 120 senior leaders who either work as a CEO, a Vice President or an Executive Director. This group consists of people who meet the following criteria: a senior leadership position which has been held no fewer than six months; directly dealing with strategic decisions made and with the workforce managed. Together these populations demonstrate a holistic cross-section of the healthcare system, thus providing an ample background on looking at the impact of transformational leadership in complex healthcare organizations.

The population is suited to the study because: In healthcare, leaders with a particular style can greatly affect team members' attitudes, performance and results. Highly complex organizations create varying experiences for employees and leaders, so they are best to study how transformational leadership changes OCB. Each health authority is a

public agency, allowing the outcomes from their research to be useful for improving services and training for the healthcare sector. The study conducted its research on various individuals within the five health authorities, and this will give them a chance to generalize the research findings on the entire healthcare system of British Columbia.

Sample

The study population was clearly defined within the British Columbia healthcare system. The first sample comprised all seven publicly funded regional health authorities in the province ($N = 7$): Vancouver Coastal Health, Fraser Health, Island Health, Northern Health, Provincial Health Services Authority, Interior Health and First Nations Health Authority. Including all health authorities ensured comprehensive representation across diverse geographic regions, organizational structures, and healthcare delivery contexts within the province.

The second sample comprised 159 frontline employees, including paramedic professionals, nurses, and allied health professionals, across the seven health authorities. A minimum of 14 participants were purposively targeted from each authority to ensure variation in professional role, work location, and care setting. This approach enhanced the diversity of perspectives and strengthened the generalizability of findings related to organizational citizenship behaviour (OCB).

The third sample comprised 14 individuals in leadership positions (two from each health authority). These participants were members of executive or senior management teams and met the inclusion criterion of having held a formal leadership role for at least six months with direct responsibility for organizational strategy, workforce engagement, or

clinical operations. The selected sample sizes enabled multi-level analysis while maintaining feasibility for in-depth quantitative and qualitative examination.

Sampling strategy

A mixed-methods design was used by the researcher, involving both types of sampling, to examine how transformational leadership explains the occurrence of OCB in the healthcare sector.

Quantitative Phase: The quota sampling method was used. In quota sampling, researchers divide the total population into several groups and choose a certain number of people (a quota) from every group. In place of choosing randomly with probability-based methods, participants are picked because they are easy to get hold of (Etikan and Bala, 2017). In the quantitative component, to make sure each health authority in British Columbia is equally represented, 159 employees were chosen for this phase of the investigation. Recruitment of survey participants was carried out by sending out internal emails, using leadership and HR contacts at every health authority and obtaining informed consent electronically.

Qualitative Phase: The qualitative phase includes semi-structured interviews with 14 individuals who represent two members from each of the seven healthcare authorities who were picked to participate in qualitative research. Employees who are in leadership roles, ideally department managers, were identified on a convenient basis. Convenience sampling involved selecting people who are at hand or who readily agree to join the study, even though the sample is not chosen at random (Etikan and Bala, 2017). The research was designed to understand how various ways of leading employees are connected to OCB,

based on both organization and country differences. Interviews helped the researcher confirm and detail the results received in the first phase.

Professional networks in healthcare sector, HR, department heads and other channels were used to recruit both phases. Employees of each organization could be accessed when administrators and data access approvals are given from both organizations. Before their involvement, everyone got the study information and a consent form. Both statistical generalizability from numbers and rich contextual knowledge from stories are obtained, making the findings trustworthy and useful in the B.C. healthcare system.

3.6 Participant Selection

To ensure a wider range of geographic and organisational-level participants, the study focused on selecting participants from the seven publicly funded health authorities in British Columbia (Vancouver Coastal Health, Fraser Health, Island Health, Northern Health, Interior Health, PHSA, and FNHA). The quantitative sample consisted of 159 frontline workers (nurses, paramedics, and allied health professionals), who represented each authority chosen using quota sampling so as to represent different roles and different settings.

This qualitative sample included 14 leaders, representing two members from each authority, purposely selected according to their leadership experience (minimum six months) in workforce engagement, clinical operations, or organisational management. All participants were informed of consent as the recruitment would be supported by professional networks, HR departments, and internal communications. This qualitative and quantitative approach proposed by the researcher will enable statistical extrapolation and contextual exposition, improving the applicability of the results to the B.C. healthcare industry with reliability.

3.7 Instrumentation

TL and OCB were measured using validated and standardised measures embedded in a structured survey that would include constructs of transformational leadership based on the well-established model developed by Avolio and Bass (2004) and the OCB developed by Organ (1988) and later operationalised by Podsakoff et al. (1990).

POP was considered a moderator variable through POP Scale that was presented by Kacmar and Carlson (1997), and this Scale measures the perceptions of employees on favoritism, power relationships, manipulative practices, and the willingness to dissent. POS was the second moderator, which was measured according to the scale created by Eisenberger et al. (1986) that reflects the beliefs of the employees concerning the organizational care, responsiveness to the needs of employees, recognition and equitable decision-making. Such instruments used five-point Likert Scale items, for which 1 to 5 were utilized such that reverse-coded items would be handled accordingly.

Besides survey statistics, unstructured interviews were done with the purposefully chosen leaders from seven health authorities in British Columbia. The interview procedure was developed following the accepted qualitative research principles and will target the responses connected with the areas of influence of leadership behavior and organizational factors. The researcher used the method of open-ended theory-informed interviewing questions to correspond to the thematic focus of the study. In order to analyze the data, a

thematic analysis was conducted using NVivo software. The interviews conducted were manually recorded by the researcher with permission and transcribed verbatim.

The researcher referred to some secondary sources of data, resulting in a combination of valid information. Provincial employee engagement and work environment surveys done by BC Public Surveys, Health Authority-specific engagement surveys done by Doctors of BC, collective agreements and related data published by Health Employers Association of British Columbia (HEABC), and other health quality reports published by the Ministry of Health are some of the secondary data sources that were used by the researchers.

3.8 Data Collection Procedures

The data collection method used in this study was a sequential mixed method that involved a sequence of both qualitative and quantitative methods. At the quantitative stage, 159 frontline healthcare workers in the seven regional health authorities within British Columbia will be provided a structured questionnaire. The questionnaire was done through electronic and paper formats to facilitate organizational email limitations and to have generalized coverage.

The involved participants are the nurses, nurse practitioners, paramedics, and allied health professionals who voluntarily consented to participate in the study. The questionnaire was adopted from the Multifactor Leadership Questionnaire (MLQ) invented by Avolio and Bass (2004) to measure the TL. The researcher also adopted a 5-point Likert scale questionnaire to measure OCB (Podsakoff et al., 1990), POP was measured by the

questionnaire developed by Kacmar and Carlson (1997), and POS was measured by the instrument developed by Eisenberger et al. (1986). After the data collection was completed, the data were input into a spreadsheet and cleaned of missing values and outliers, then analysed using SPSS. The demographic was summarised, descriptive statistics were computed, and internal consistency reliability and correlation (r) tests were analysed through IBM Statistical Package for Social Sciences (SPSS), (Version 29; IBM Corp., Armonk, NY).

To understand and establish the predictive impact of TL on OCB and the moderating impact of POP and POS, Multiple Regression and Moderated Multiple Regression analyses were conducted using SPSS. The semi-structured interviews with 14 leaders representing all healthcare authorities (taking two representatives from each health authority) were conducted after the quantitative stage to obtain qualitative data. Such interviews comprehended leadership views about the quantitative results and prevailing contextual issues that affect employee behaviour. The interviews were manually recorded with their consent, transcribed verbatim and analyzed manually by the researcher. The results of the two phases would then be triangulated in order to confirm the results and present a holistic picture of how TL influences OCB in the healthcare sector in British Columbia.

3.9 Data Analysis

The researcher entered the data into the spreadsheet and cleaned for missing values, outliers and normality check before analysis. Descriptive Statistics variables are used to

describe the samples. Cronbach's Alpha Reliability Analysis helped determine how consistent the items in the scale are. Pearson's Correlation method is used by the researcher to study how closely two variables are related. Multiple Regression Analysis is conducted to check if the independent variable is able to predict the various aspects of the dependent variable, OCB. Further, the impact of moderator variables of POP and POS on OCB is analysed through Moderated Multiple Regression analysis through SPSS. This way of analyzing data agrees with past research on leadership and behavior and fits the requirements for analyzing interval-scale data from self-report questionnaires (Field, 2024).

Purposively picked healthcare leaders from the seven healthcare authorities are interviewed by the researcher, and the interviews are manually recorded. The recorded data was manually analysed by the researcher to understand the emerging themes. After collecting the data, inductive coding was used:

- Assigning codes to the important components of the data
- Looking for patterns by deploying Axial Coding. Carrying out axial coding is essential in Grounded Theory because it plays a crucial role in data analysis.

To do this, researchers group pieces of information by category and subcategory, helping them to reveal new patterns among the data (Strauss and Corbin, 1998).

- Applying themes to make sense of the statistics and what they mean.

Triangulation Interview findings were checked against what people said in their surveys to make sure the results are reliable (methodological triangulation). During this

stage, the researcher will take steps to control their biases, such as writing reflections of their thoughts. The researcher focused on looking at both what the participants said and the statistical patterns that appear. Integration Strategy Results from every phase would be combined and discussed during interpretation. The researcher used the secondary sources of data to carry out the content analysis and compare the results with the primary data analysis. This comparison would be insightful and contextualised using the interview with leaders used in the study and would aid in not only validating but also putting the realities of transformational leadership, OCB, Perceived POP, and POS into perspective.

3.10 Research Design Limitations

The paper focused on reporting the description of TL and OCB in the British Columbia healthcare sector, but it had some limitations that would have to be taken into account. There was a possibility that out of 159 employees, the survey results could be affected by social bias, peer pressure, or a lack of understanding. To counter this, the researchers used a validated instrument, the Likert scale, which was adopted to increase clarity and validity.

Only one interview per health authority was conducted as qualitative source data, and thus, it wouldn't represent the diversity in the sector. Through triangulation and purposive sampling of survey results, credibility was enhanced. Since the study design was cross-sectional, the results couldn't be drawn as time varying, and it would not be possible to define causality; hence, the results were treated as correlational. Access limitations, generalizability of response and instrument cultural relevance were also seen as possible

consequences of generalizability. The validity of the instruments was confirmed through a set of existing instruments, an expert view, and a well-established conceptual framework. Quality of data collection and manually taken comments were used for data collection methods and the reliability of the qualitative analysis. In combination with other measures, the researcher added depth to the rigour of the study, its reliability and situational relevance.

3.11 Conclusion

This chapter presents the research design employed in the study to determine how TL affects OCB in the British Columbia healthcare industry. It described the study design, sample, the selection of participants, tools, and methods of data collection and analysis. The employment of the selected quantitative methodology that is backed by validated scales of TL, OCB, POS and POP provided the methodological rigour and suitability for the study purposes. This study examines participants in all seven regional health authorities, and hence it gets various views in the provincial healthcare setting. The approaches taken are reliable, valid and ethically sound. The next chapter contains the data analysis and findings, with the important findings pointing to the hypotheses of the study.

CHAPTER IV:

RESULTS

4.1 Introduction

This chapter presents the findings of the research studying the impact of TL on OCB within the healthcare sector in British Columbia. A mixed-method research design was followed by the researcher, integrating quantitative survey data with qualitative insights gathered from industry leaders by interviewing them to present a complete understanding of the prevailing research gap and the research problem.

The quantitative phase of this study involved 159 healthcare employees representing various teams in the healthcare authorities of British Columbia. TL was tested as the independent variable, whereas OCB was hypothesised as the dependent variable, and POP and POS were examined as moderating variables. Statistical analyses were conducted by the researcher to assess relationships, predictive strength, reliability, and moderation effects within the conceptual framework proposed by the researcher.

This chapter presents demographic characteristics of respondents, followed by descriptive statistical analysis for the key variables. Reliability analysis was done as per Cronbach's Alpha method to ensure internal consistency of the measurement instruments. Pearson's correlation analysis is performed by the researcher to identify the strength and direction of relationships among TL, OCB, POS, and POP. Multiple regression analysis measures the predictive effect of TL on OCB, and moderation analysis estimates the influence of POP and POS on this relationship between independent and dependent variables in the research model.

Besides quantitative results, thematic findings gathered from semi-structured interviews with healthcare leaders are presented by the researcher to complement and contextualize the statistical outcomes. Overall, this chapter methodically presents the empirical evidence, concentrating on the research objectives and testing the research variables.

4.2 Demographic Analysis of Respondents

able 4.1.

Demographic Analysis of Respondents

Demographic Factors		Number of Respondents	Percentage
Gender	Male	41	25.8%
	Female	95	59.7%
	Undefined	23	14.5%
Age	18-24	35	22%
	25-34	29	18.2%
	35-44	45	28.3%
	45-54	22	13.8%
	55+	28	17.6%
Experience Level	01-03	28	17.6%
	04-07	26	16.4%
	08-12	26	16.4%
	13-19	43	27%
	20+	36	22.6%
Job Function	Admin	29	18.2%
	Front Line	130	81.8%
Job Level	Management	24	15.1%

	Non-Management	135	84.9%
Employee	Unionized	116	73%
Group	Excluded	43	27%

The researcher provides demographic analysis for the 159 respondents in line with gender, age, level of experience, job function, job level and employee group of the respondents. On the gender distribution, the majority of the respondents, 95 (59.7%), were female, 41 (25.8%) were male, and 23 (14.5%) were undefined in the survey process. As far as the age groups are concerned, the highest age group reported was 45 respondents (28.3%) belonging to the age group of 35 to 44. It was comprised of 35 respondents (22%) between the ages of 18 and 24, 29 respondents (18.2%) between the ages of 25 and 34, 28 respondents (17.6%) between the ages of 35 and 44 and 22 respondents (13.8%) between the age group of 45-54.

In terms of the experience level of respondents, 43 (27%) said that they had experience of 13 to 19 years, and 36 (22.6%) had over 20 years of experience. Also, 28 respondents (17.6%) had served less than 01 to 03 years, and 26 respondents (16.4%) had less than 04 to 08 years and 08 to 12 years of experience, respectively. One hundred and thirty (130) responses (81.8%) were from front-line employees who responded in the survey, and 29 employees (18.2%) were in administrative roles. Hundred and thirty-five respondents (84.9%) were in non-management jobs, and 24 respondents (15.1%) were in management-level jobs. Meanwhile, 116 respondents (73%) were unionised employees, and 43 respondents (27%) were excluded.

Table 4.2.

Descriptive Statistics of Key Constructs

	N	Min	Max	Mean	Std Dev	Skewness	Kurtosis
						Statistic	Std Error
OCB	159	1.83	3.67	2.8022	0.4225	0.383	0.192
TL	159	2.13	3.93	2.7921	0.4294	0.551	0.192
POP	159	1.83	4.50	2.7914	0.4901	0.856	0.192
POS	159	2.17	3.83	3.0908	0.2600	-0.286	0.192

The responses of 159 participants were calculated into descriptive statistics of OCB, TL, POP, and POS. In the case of OCB, the range between the scores was 1.83 and 3.67 with mean and standard deviation as 2.8022 and 0.4225, respectively. The sk value was 0.383 (SE = 0.192), and kurtosis was -1.142. The range of scores of TL was 2.13 to 3.93 and the mean score was 2.7921 and standard deviation of 0.4294. TL skewness value was 0.551 (SE = 0.192), and kurtosis = -0.929. In the case of POP, the lowest score was 1.83 and the highest was 4.50 and this gave a mean of 2.7914 and a standard deviation of 0.4901. Skewness = 0.856 (SE = 0.192) kurtosis = 0.597. Lastly, POS inter-rater reliability scores were between 2.17 and 3.83, the mean was 3.0908 and the standard deviation was 0.2600. The skewness of POS had the value = -0.286 (SE=0.192), the kurtosis = 0.811.

In relation to RQ 01: What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia? and RQ 03: What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers?

OCB recorded a minimum value of 1.83 and a maximum of 3.67, with a mean of 2.8022 and a standard deviation of 0.4225.

Furthermore, for RQ 02: How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector? TL ranged from 2.13 to 3.93, with a mean of 2.7921 and a standard deviation of 0.4294. POP, which is associated with both RQ 01 and RQ 02, showed a range from 1.83 to 4.50, with a mean of 2.7914 and a standard deviation of 0.4901. Finally, with respect to RQ 02 and RQ 04: What strategies and organisational practices have been effective in other regions or sectors in enhancing employee engagement and satisfaction? POS ranged between 2.17 and 3.83, with a mean of 3.0908 and a standard deviation of 0.2600.

4.4 Reliability Analysis of Measurement Instruments

Table 4.3.

Reliability Analysis of Instruments

Variable	No of Items	Cronbach's Alpha	No of Valid Cases
OCB	12	0.876	159
TL	15	0.902	159
POP	06	0.720	159
POS	06	0.810	159

To determine the internal consistency, the reliability assessment was done for the instruments to be used in measuring OCB, Transformational Leadership, POP, and POS. The coefficients of Cronbach's Alpha were calculated using 159 survey responses for each construct. The OCB scale with 12 items was found to be with Cronbach's Alpha of 0.876.

The TL scale had 15 items and had a Cronbach's Alpha value of 0.902. A Cronbach's Alpha coefficient of 0.720 was recorded for the POP construct, which has 6 items, and was measured. In a similar manner, the POS scale, which is a 6-item scale, has a Cronbach's Alpha value of 0.810. The OCB and TL reliability coefficients are above the academic standard of 0.70, which is a high internal consistency.

The scale of POS displays also somewhat satisfactory scale reliability, whereas the POP scale has had the required minimum internal consistency level. In general, the findings indicate that all the instruments adapted by the researcher have an above-average level of reliability, which ensures the research work is done within academic standards. The reliability analysis of the measurement instruments was performed by the researcher to assess the internal consistency of the constructs examined in relation to the research questions. The analysis was based on 159 valid responses for each construct, as presented in Table 4.3.

In relation to RQ 01: What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia, and RQ 03: What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers, the OCB scale consisted of 12 items and recorded a Cronbach's Alpha coefficient of 0.876.

With respect to RQ 02: How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector? The TL scale included 15 items and showed a Cronbach's Alpha value of 0.902. POP, which is associated with RQ 01 and RQ 02, was measured using 6 items and recorded a

Cronbach's Alpha coefficient of 0.720. Concerning RQ 02 and RQ 04: What strategies and organisational practices have been effective in other regions or sectors in enhancing employee engagement and satisfaction? The POS scale consisted of 6 items and reported a Cronbach's Alpha value of 0.810.

Finally, the reliability analysis shows that all the measurement tools adapted by the researcher in the study are of acceptable to high internal consistency in the constructs under investigation. Specifically, both the TL and OCB scales are highly reliable, whereas the reliability of POS is good, and the reliability of POP achieved the minimum required level. Overall, these findings indicate that the tools employed to establish the constructs concerning RQ 01, 02, 03 and 04 are sound and can be analysed further with the help of statistics.

4.5 Correlation Analysis

Table 4.4.

Correlation Analysis

Variable	N	OCB Score	TL Score	POP Score	POS Score
OCB	159	1.00	0.872***	-0.369***	0.745***
TL	159	0.872***	1.00	-0.348	0.761***
POP	159	-0.369***	-0.348***	1.00	-0.271***
POS	159	0.745***	0.761***	-0.277	1.00

*** indicates statistical significance at $p < 0.001$.

Correlation analysis was done using Pearson's correlation to determine the relationships between the OCB and TL, POP and POS using 159 valid responses gathered

in the survey. TL and OCB had a correlation value of 0.872***. The TL and POP showed a negative correlation of -0.348, which was significant at the level of 0.05, whereas the relationship between TL and POS had a positive correlation of 0.761. Further, OCB was positively associated with POP and POS; the negative coefficient value was -0.369 and 0.745, respectively. The POP and POS relationship was found to be negative (= -0.271).

In relation to RQ 01: What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia?, and RQ 03: What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers?, the correlation between OCB and TL was 0.872***, while the relationship between OCB and POP was -0.369***. The correlation between OCB and POS was 0.745***. With respect to RQ 02: How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector? TL showed a correlation of -0.348*** with POP and 0.761*** with POS. POP and POS, which relate to RQ 01, RQ 02, and RQ 04: What strategies and organisational practices have been effective in other regions or sectors in enhancing employee engagement and satisfaction? established correlation value of -0.271***.

4.6 Regression Analysis

Table 4.5.

Summary of the Model

Model	R	R ²	Adjusted R ²	Standard Error
1	0.883	0.780	0.776	0.2000

TL, POS, and POP were calculated using a multiple regression analysis method to determine their predictive value on OCB. The general model had an R value of 0.883 and R² of 0.780 and an adjusted R² of 0.776. The error of the estimate was 0.20003.

Table 4.6.

ANOVA Table

Source	Sum of Squares	Df Value	Mean Square	F Value	Sig.
Regression	22.001	3	7.334	183.293	<0.001
Residual	6.202	155	0.040		
Total	28.203	158			

The ANOVA table indicates that the regression model was statistically significant, with $F(3, 155) = 183.293$, $p < .001$. The regression sum of squares was 22.001, while the residual sum of squares was 6.202, resulting in a total sum of squares of 28.203. The mean square for the regression was 7.334, and the mean square for the residual was 0.040.

Table 4.7.

Coefficients

Predictor	B Value	Standard Error	Beta Value	T Value	Sig.
Constant	0.775	0.263	-	2.946	0.004
TL	0.690	0.059	0.702	11.789	<0.001

POP	-0.116	0.065	-0.072	-1.780	0.077
POS	0.164	0.050	0.191	3.283	0.001

The regression equation was characterised by a constant value of 0.775 (SE = 0.263, $t = 2.946$, $p = 0.004$). TL gave a coefficient value of 0.690 (SE = 0.059), beta standardized (= 0.702), $t = 11.789$, $p = .001$. The coefficient (B) of POS was 0.164 (SE = 0.050), 0.191, $t = 3.283$, $p = 0.001$. The coefficient (B) of the POP was 0.116 (SE = 0.065), B = -0.072, $t = -1.780$, $p = 0.077$.

In relation to RQ 01: What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia?, and RQ 03: What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers?, the overall regression model reported an R value of 0.883, R^2 of 0.780, and an adjusted R^2 of 0.776, with a standard error of 0.2000. With respect to RQ 02: How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector? the ANOVA results indicated $F(3, 155) = 183.293$ with a significance level of $p < 0.001$. The regression sum of squares was 22.001, the residual sum of squares was 6.202, and the total sum of squares was 28.203, with mean square values of 7.334 for regression and 0.040 for residual.

The coefficients table presents the contribution of each predictor variable. TL recorded a B value of 0.690 (SE = 0.059), with a standardized beta of 0.702, $t = 11.789$, and $p < 0.001$. POS showed a B value of 0.164 (SE = 0.050), beta = 0.191, $t = 3.283$, and $p = 0.001$. POP, associated with RQ 01 and RQ 02, recorded a B value of -0.116 (SE =

0.065), $\beta = -0.072$, $t = -1.780$, and $p = 0.077$. The constant value of the model was 0.775 ($SE = 0.263$), with $t = 2.946$ and $p = 0.004$.

4.7 Moderation Analysis

Table 4.8.

Moderated Regression Results

Predictor	β Value	t Value	p Value
TL	0.69	11.70	<0.001
POP	-0.12	-1.77	0.079
POS	0.17	3.18	0.002

The regression analysis, which was moderated, explored the effect of POP and POS on the intensity of the relationship between TL and OCB. The findings show that TL was still a strong, statistically significant predictor of OCB ($\beta = .69$, $p < .001$) despite the moderator variables and interaction terms that were included. This implies that TL itself is a contributing factor to differences in OCB in the healthcare scenario. POS had a statistically significant influence on OCB ($\beta = .17$, $p = .002$), which suggests that the higher the POS value, the higher the OCB value. There was no statistically significant effect, however, of POP at the traditional norm of 0.05 ($\beta = -.12$, $p = .079$). Regarding moderation effects, the change in TL and POP ($TL \times POP$) had no significant relationship ($\beta = -.02$, $p = .908$). In the same way, the relationship between TL and POS ($TL \times POS$) was not found to be significant ($\beta = -.05$, $p = .538$). These results suggest that in this sample, POP and POS did not have significant effects on the strength of the relationship between TL and OCB, or its direction.

In general, the findings denote that although both the TL and POS have an independent relationship with OCB, the moderating effect of the POP and POS on the TL and OCB interaction was rejected. The TL and OCB relationship seems to be steady regardless of different degrees of POP and POS in the surveyed healthcare organizations.

In relation to RQ 01: What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia? and RQ 03: What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers? TL recorded a beta value of 0.69 with a t value of 11.70 and a significance level of $p < 0.001$. POS showed a beta value of 0.17, with a t value of 3.18 and $p = 0.002$. POP recorded a beta value of -0.12, with a t value of -1.77 and $p = 0.079$.

With respect to RQ 02: How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector? The moderation model included TL, POP, and POS as predictors of OCB. In addition, the interaction terms between TL and POP ($TL \times POP$) recorded a beta value of -0.02 with $p = 0.908$, while the interaction between TL and POS ($TL \times POS$) recorded a beta value of -0.05 with $p = 0.538$.

4.8 Qualitative Findings

Results

The qualitative results from the fourteen verbal interviews conducted by the researcher with leaders in the healthcare sector are discussed below. The qualitative part of this study was conducted to intensify a clear understanding of the general experiences, perceptions and organisational practices related to employee engagement levels, job satisfaction and discretionary behaviours. The results are presented in line with research questions and thematic categories that the analysis process has generated by the researcher. Themes reflected in this section support and enhanced the quantitative findings by offering practical context and a perspective of leadership-level participants.

Findings: Profiles of the study participants

Fourteen senior leaders from seven health care authorities were involved in the study, identified using clearly defined criteria to ensure consistency and demographic fit. The respondents working in leadership positions as Directors, General Managers, and Heads of Functions have the great accountability of making strategic decisions, leading their portfolio operations and strategically leading both clinical and administrative spheres. With a consistent viewpoint, all respondents were actively engaged in developing corporate vision, strategy and functional goals, as well as managing senior managerial teams. Their roles demanded high performance accountability, strategic direction, strategic communication and cascading of departmental objectives to the overall organisational interests.

The participant group was formed by both male and female leaders who have 17-35 years of working experience and are between the ages of 42 and 66 years in terms of demographic characteristics. The interview participants had similar type of educational backgrounds, such as Bachelor's, Master's, and Doctoral degrees, which confirmed a high degree of professional and academic qualifications. The participants were interviewed in the period between February and March 2026, and the interviews lasted between 35 and 55 minutes on average. The researcher obtained prior consent from all the participants before the interviews, and interviews were conducted in-person and by telephone in order to make participants flexible and accessible. Overall, the respondents represented a rather long-experienced and strategically distributed group of leaders, whose ideas may be used to have a better understanding of the leadership perspectives, organisational practices and activities, and their strategic and operational involvement in the British Columbia healthcare sector.

Table 4.9.

Categories of Criteria for Interview Participants

Job Similarity	Demographic Similarity	Job Positions
• Having positional authority to participate in making decisions relates to the corporation's vision, mission, goals, objectives, and strategies. • Have the capacity and positional ability to decide on structure, and hierarchy of authority for their functions (i.e., when,	• Males/Females • Ages 42 years to 66 years • Similar education level (Bachelor's degree/Master's degree. & PhD)	• Director (Responsible for overall corporate strategies or managing one or more functions • Head of Function (responsible for

how and by whom decisions are to be made within the management system)	• Level of experience spanning from 17 years to 35 years	managing the function and portfolios)
• Able to participate in the development of organization and functional strategies.		• Managing few Managers/ Senior Managers
• Have the positional authority, skillset and capacity to decide on end goals and objectives for their functions as well as for the organizations that are consistent with the policies of the corporation.		
• Managing performance of their direct reporting managers.		

Table 4.10.

The Personal Interview Schedule for Study Participants

Participant ID	Interview Date	Interview	Informed	Interview Performed
		Duration (minutes)	Consent (verbal)	
HC01	01/02/2026	40	Yes	In-person
HC02	07/02/2026	45	Yes	In-person
HC03	12/02/2026	35	Yes	In-person
HC04	17/02/2026	45	Yes	In-person
HC05	20/02/2026	50	Yes	By phone
HC06	22/02/2026	40	Yes	In-person
HC07	25/02/2026	45	Yes	By phone
HC08	26/02/2026	50	Yes	In-person
HC09	28/02/2026	40	Yes	In-person
HC10	03/03/2026	40	Yes	By phone
HC11	08/03/2026	45	Yes	In-person
HC11	10/03/2026	55	Yes	By phone

HC13	11/03/2026	45	Yes	By phone
HC14	12/03/2026	40	Yes	By phone

Demographic findings.

Table 4.11.

Demographic Statistics for Interview Participants

	Gender	Level of Education	Age	Position
Participant ID				
HC01	Male	Master's degree	49	Director Clinical Operations
HC02	Female	Bachelor's degree	52	Director Finance
HC03	Male	Master's degree	48	Director Human Resources
HC04	Male	Bachelor's degree	58	Director Strategy, Planning
HC05	Female	Bachelor's degree	62	Director Nursing Services
HC06	Female	Master's degree	52	Head of Supply Chain
HC07	Female	Master's degree	47	Director Allied Health Service
HC08	Male	PhD	56	Director Ambulatory Care
HC09	Female	Bachelor's degree	59	Director Clinical Operations
HC10	Male	Master's degree	60	General manager Acute Care
HC11	Female	Bachelor's degree	66	General Manager Primary Care
HC12	Male	Master's degree	61	Head Urban Health
HC13	Female	Diploma	65	General Manager Emergency
HC14	Female	PhD	42	Director Research & Education

Findings: Research question results.

The analytical method of qualitative data of this study consisted of a structured and systematic coding, conducted for the research questions (RQ1-RQ4) and all 10 sub-questions (interview questions). Manually recorded interview transcripts (handwritten) were meticulously viewed and analysed to determine common patterns, expressions and meaningful insights embedded in qualitative data addressed to each of the research questions. The first step was an open coding that involved identifying main phrases, keywords and ideas from the responses given by the interview participants in line with research questions and sub-questions. These codes were then tabulated under each sub-question to get a clear relationship between the empirical data and the research questions. Following the set proceedings, the researcher was able to achieve rigorous analytical outcomes, but at the same time retain the contextual essence of the participant insights.

Followed by the coding, the resulting codes were again grouped into wider categories and formed into themes at a higher level. The description on each theme was elaborate, and it signified the underlying connotation of the coded data, but did not insist on interpretation at this point. This mechanism helped in a systematic switch between the raw data and structured thematic representation, which assured transparency and traceability when further analysis was conducted in the research. A coding model was developed by the researcher based on the representation of a research question to ensure that all interviews were coded consistently, and it was also used to enhance the validity of the research findings. Overall, this methodology gave a solid basis to the presentation of qualitative findings in a meaningful, systematic and academically sound way, at the same

time assuring the themes present a reflection of the original views and perceptions of the respondents in the interviews.

Table 4.12.

Codes and themes for RQ 01.

RQ1. What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia?

Sub-question(s)	Code(s)	Description	Theme(s)
SQ1. What are the primary reasons for low employee level of engagement and job dissatisfaction among the employees of the British Columbia healthcare workers?	1. Work pressure and job burnout. 2. Leadership & organisational disconnection.	1. Work pressure and job burnout created by stress on health care workers. 2. Decreased trust and engagement of employees due to leadership disconnect.	Systemic workload pressure and job burnout in the Healthcare sector. Leadership and organization disconnection.
SQ2. What influence do these factors have on the discretionary efforts of employees to perform more than their official job descriptions?	1. Psychological detachment and extra-role behaviour withdrawal. 2. Low ability to work under discretionary effort (OCB Activation).	1. Psychological detachment which makes deviates employees from discretionary behaviours	Relatively depleted discretionary behaviors by employees.
SQ8. What are the effects of organizational politics within your organization and how does it influence employee attitudes and behaviours?	1. Politicised Environment and self-interest driven behaviour. 2. Perception of inequity and erosion of trust.	1. Organisational politics is enjoyed as a self-interest-based and power aspect, where decisions and interactions are formed. 2. Organisational politics culminates in unfairness and transparency perceptions, which undermine trust and	Perceived Organisational Politics as a predictor of trust erosion.

adversely impact the attitudes of the employees.

Table 4.13.

Codes and themes for RQ 02.

RQ2. How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector?

Sub-question(s)	Code(s)	Description	Theme(s)
SQ3. What is the organisational culture in your health authority, and how does it affect regarding engagement and morale?	1. Restrained and bureaucratic culture. 2. Inadequate leadership support.	1. Compliance-driven, restrained and bureaucratic culture. 2. Inadequate relationships and leadership support.	Bureaucratic culture with relational gaps.
SQ4. How do leadership behaviours influence employee engagement and organisational citizenship behaviours in your organization?	1. System constraints and transactional leadership. 2. Disengagement and suppression of OCB that is driven by leadership.	1. System limitations placed on leadership lead to transactional and compliance-oriented behaviours that deter engagement and OCB.	Structured but transformational leadership has potential to drive engagement.
SQ5. To what extent does senior leadership communicate effectively to foster trust and ensure engagement, particularly when a change process takes place?	1. Complex communication: fragmented and top-down. 2. Lack of trust caused by low transparency and participation of the employees.	1. One-way communication is mostly top-down, which restricts clarity and involvement. 2. The lack of transparency, low engagement, and communication deters trust.	Disengaged but has potential to trust-building through effective communication.

Table 4.14

Codes and Themes for RQ 03.

RQ3. What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers?

Sub-question(s)	Code(s)	Description	Theme(s)
SQ6. How much does the workload constrain the ability of the employees to exercise discretionary behaviours?	1.Resource depletion and OCB constriction due to workload. 2.Systems and structures as drivers of work pressure.	1. Limited discretionary behaviours due to depletion of resources, in which the employees are de energized to exceed their role expectations. 2. Workload is generated by system-level inefficiencies and stressors on demand.	The work pressure caused by the system and structures which limits discretionary behaviour.
SQ7. How do you see the interplay between work-life balance and employee engagement levels and retention in the healthcare sector?	1. Work life imbalance as a cause for burnout and turnover intentions. 2. Work life balance as a strategic enabler of Involvement and retention.	1. When there is poor work-life balance, burnout, lack of engagement and turnover intentions are experienced. 2. Work-life balance is a pivotal tool used to improve engagement, commitment and retention.	Work-Life Imbalance as a structural restriction to employee engagement and retention.

Table 4.15. Codes and Themes for RQ 04.

RQ4. What strategies and organisational practices have been effective in other regions or sectors in enhancing employee engagement and satisfaction?

Sub-question(s)	Code(s)	Description	Theme(s)
SQ09. How does organizational support work with or without the influence of the leaders?	1. Structural foundations and formal organisational support Systems. 2. Misaligned and inconsistently effective support.	1. Support is in the form of formal structures and systems, which underlie the support of the employees. 2. Ineffective support leads to a disconnect	Leadership-enabled support impacting employee perceptions and performance.

		between intent and employee perception.	
SQ10. What are the strategies in place that are successful in enhancing employee engagement and satisfaction?	1. People-centred learning and leadership development. 2. Holistic personal wellbeing, appreciation and culture change initiatives.	1. People-centric, empowering and responsive practices would help leaders to engage in people-centric ways. 2. The employee experience strategy is holistic with the promotion of wellbeing, recognition and cultural change, contributing to sustainable engagement.	Integrated Engagement Strategies: integrating systems, leadership, and culture transformation.

Research Question One

Research Question 01 (RQ 01) is: What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviors among healthcare workers in British Columbia? The researcher presented a few sub-questions to interviewees to answer this research question. These were: What are the primary reasons for low employee level of engagement and job dissatisfaction among the employees of the British Columbia healthcare workers? (SQ 01). What influence do these factors have on the discretionary efforts of employees to perform more than their official job descriptions? (SQ 02). What are the effects of organizational politics within your organization and how does it influence employee attitudes and behaviors? (SQ 08).

Based on these sub-questions, qualitative information obtained through the interviews from the participants was analysed systematically. The main patterns and concepts were recognized, with a manual coding process, and sorted into codes, which were subsequently transformed into descriptive statements and higher-order emergent themes. The codes, descriptions, and themes were identified based on the data and are presented in the following section in accordance with RQ 01.

The researcher followed a systematic process of coding in accordance with the research question one and corresponding sub-questions, which led to defining key codes, descriptions, and general themes. Two major codes were identified under SQ 01 that included work pressure, related job burnout, and leadership and organisational disconnection. These codes are described as stress among the healthcare workers in terms of workload pressures, a lack of trust and engagement due to leadership disconnect. These were all grouped as the theme of “systemic workload pressure and job burnout in the healthcare sector, and leadership and organisational disconnection.”

In the case of SQ 02, the researcher pointed out the following codes, which were significant: psychological detachment, extra-role behaviour withdrawal and low ability to work with discretionary effort for OCB activation. The associated descriptions explain the existence of psychological detachment amongst the employees, which regulates their participation in discretionary behaviours that are not part of the formal job specifications or call of duty. These trends fell under the theme of “relatively depleted discretionary behaviours by employees.” The coding mechanism reflects the propensity of discretionary efforts, as it is demonstrated with respect to the psychological conditions of the employees,

without being protracted into interpretation. The researcher identified two codes for SQ 08, which comprised a politicised environment and self-interest-based behaviour and perception of inequity and erosion of trust. The descriptions show that there is the presence of organisational politics based on self-interest and power relations, and the perceived unfairness and lack of transparency. These insights were summarised into the theme of “perceived organisational politics as predictors of erosion of trust.”

Research Question Two

The Research Question 02 (RQ 02) is: How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector? The researcher formulated the following sub-questions in order to gain a deeper insight from the participants in the interview and learn more about the truths of the sector. These sub-questions are: What is the organisational culture in your health authority, and how does it affect engagement and morale? (SQ 03). How do leadership behaviours influence employee engagement and organisational citizenship behaviours in your organisation? (SQ 04). To what extent does senior leadership communicate effectively to foster trust and ensure engagement, particularly when a change process takes place? (SQ 05).

Interpretation of the information gathered in interviews in connection with RQ2 was presented with the help of a methodical coding procedure equivalent to the sub-questions (SQ3, SQ4 and SQ5). Particularly, in the case of SQ3, the codes related to restrained and bureaucratic culture, as well as inadequate leadership support. These codes

are described as compliance-driven, restrained and bureaucratic culture, inadequate relationships and leadership support and grouped into a theme as “the bureaucratic culture with relational gaps.” In the case of SQ4, the codes reflected as constraints in the system, transactional leadership, and the inhibition of OCB. These codes, described as system limitations placed on leadership, lead to transactional and compliance-oriented behaviours that deter engagement and OCB. Then these were grouped into a theme of “structured but transformational leadership, which has the potential to drive employee engagement.”

In SQ5, the codes that were connected to fragmentation of top-down, complex communication and the lack of trust caused by low transparency and low employee participation transmuted. The codes identified were described as one-way communication, which is mostly top-down, which restricts clarity and involvement, and the lack of transparency, low engagement, and communication deters trust. These descriptions were narrated into a theme that “disengaged but has the potential to build trust through effective communication.” This was done in a structured manner, and as a result, all the codes, descriptions, and themes were well aligned with the research question, and at the same time, consistency and procedural rigour were supported in the presentation of findings.

Research Question Three

The Research Question 03 (RQ 03) is: What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers? The researcher formulated the following sub-questions in order to gain a deeper perspective from the participants in the interview and learn more about the truths of the sector. These

sub-questions are: How much does the workload constrain the ability of the employees to exercise discretionary behaviours? (SQ 06), How do you see the relationship between work-life balance issues and employee engagement and retention in the healthcare sector? (SQ 07).

Interpretation of interview data answering RQ 03 was based on a sorted coding system in compliance with its relevant sub-questions (SQ 06 and SQ 07). In SQ 06, codes such as resource depletion, OCB constriction due to workload, and systems and structures are drivers of work pressure. These codes were described by the researchers as limited discretionary behaviours due to depletion of resources, in which the employees are de-energised to exceed their role expectations and workload is generated by system-level inefficiencies and stressors on demand. These codes were merged into a theme as “the work pressure caused by the system and structures that limit discretionary behaviour.”

In the case of SQ 07, the codes involve work-life imbalance as a cause for burnout and turnover intentions and systems and structures as drivers of work pressure. The identified codes were described by the researcher as follows: When there is poor work-life balance, burnout, lack of engagement and turnover intentions are experienced, and work-life balance is a pivotal tool used to improve engagement, commitment and retention. These codes were clustered into a theme that expresses as “Work-Life Imbalance as a structural restriction to employee engagement and retention”, but there was also an acknowledgement of well-being support as an enabling factor. This is what made the codes, descriptions, and themes presentation consistent with the research framework and based on the participant responses.

Research Question Four

Research Question 04 (RQ 04) is: What strategies and organisational practices have been effective in other regions or sectors in enhancing employee engagement and satisfaction? The researcher formulated the following sub-questions to gain detailed perspectives from the participants in the interview and learn more about the truths of the sector. These sub-questions are: How does organisational support work with or without the influence of the leaders? (SQ 09), And what are the strategies in place that are successful in enhancing employees' level of engagement and job satisfaction? (SQ 10).

The interview data analysis was presented for RQ 04 in a structured coding approach based on the corresponding sub-questions (SQ09 and SQ10). Interviews were reviewed systematically to find similar patterns and insights related to organisational interventions and strategies that drive employee engagement and job satisfaction.

As in the case of SQ09, the codes that were identified as structural foundations and formal organisational support systems were misaligned and inconsistently effective and were described in connection with the way support mechanisms, such as support in the form of formal structures and systems, which underlie the support of the employees, and ineffective support, lead to a disconnect between intent and employee perception. All these codes and descriptions were merged into a theme that was captured as “leadership-enabled support impacting employee perceptions and performance.”

In the case of SQ10, the codes identified by the researcher are people-centred learning and leadership development, holistic personal wellbeing, appreciation and culture change initiatives. They were explained by the practices focusing on employee experience

and engagement as people-centric, empowering and responsive practices would help leaders to engage in people-centric ways, and the employee experience strategy is holistic with the promotion of wellbeing, recognition and cultural change, contributing to sustainable engagement. The codes and descriptions were further classified into a theme which reflects “integrated engagement strategies: integrating systems, leadership, and culture transformation.” Such an organised methodology made the results consistent, transparent, and aligned with the research framework and presented the results in a systematic way based on the responses of the participants.

4.9 Summary of Findings

Chapter IV comprises the empirical findings of the research that examines the effects of TL on OCB within the British Columbia Healthcare Industry. The researcher adopted a mixed-method design; at first, quantitative data were collected from 159 healthcare workers, and secondly, qualitative data were gathered from 14 members in leadership and people management roles in the healthcare sector. The quantitative analysis specifies the reports on the interplay between the research variables of TL, OCB, POS, and POP with correlation, regression, and moderation analysis results. The reliability and validity analyses are also provided to demonstrate the consistency of the measurement instruments and the interrelationship that exists between variables. The qualitative results were presented using a systematic coding procedure, which established the key codes, descriptions and themes in relation to employee engagement, leadership interactions, organisational culture, workload-related perceptions, communication and other

organisational practices. Chapter IV logically introduces statistical outputs and qualitative results along with the research questions, sub-questions and the research framework.

CHAPTER V:

DISCUSSION, IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSIONS

5.1 Introduction

Chapter V comprises the discussion, implications, recommendations and conclusions of the research study, which focuses on the empirical findings explained in Chapter IV. The purpose of Chapter V is to present the quantitative and qualitative findings in line with the research questions to paint a consistent picture of how TL affects OCB in the healthcare sector of British Columbia. The discussion section narrates the major findings of the available literature, showing areas of agreement and disagreement with the literature. After this, the study's implications are presented, including both practical and theoretical implications for healthcare authorities and leaders. Specific recommendations have been developed based on these insights to increase employee engagement, job satisfaction and discretionary behavioural inputs of employees. The chapter will present a recap of the core findings of this research work and potential future research directions.

5.2 Discussion of Results

Results of this detailed study are deliberated in a detailed and systematically organised way, according to the research questions formulated and as dictated by the theoretical content discussed in Chapter II. This method incorporates both the quantitative results of 159 surveyed frontline health care employees, as well as the qualitative results of 14 members in leadership roles, with a view to presenting a holistic picture of the phenomena investigated.

Each research question of this study has a discussion content starting with a revisitation of the purpose of the question, and then the combination of the respective pragmatic findings of the two sets of data. Quantitative results are discussed in line with the qualitative themes, so that the findings of this research are consistent with the interpretation process. The combined methodology will allow the research to encompass the quantifiable associations and contextual information in the healthcare industry in British Columbia.

Moreover, the discussion would be based on the corresponding theories found in the literature review, i.e. TL Theory and the ideas of OCB, POP and POP. The findings are placed in these theoretical frameworks to evaluate how they fit in the existing knowledge base and to indicate the contribution to the literature. Overall, the given approach assures that every research question is handled in a systematic, theory-oriented, and factual way, which will make it easy to combine the findings of the empirical research findings and the existing scholarly constructs.

Discussion of Research Question One

The research Question 01 (RQ 01) was concerned with the identification of the main factors behind low levels of employee engagement, job dissatisfaction, and low employee discretionary behaviours observed in healthcare workers in British Columbia. The survey results obtained through the quantitative analysis, as well as qualitative interviews with 14 industry leaders, give a multi-dimensional and complete perspective as to the factors that drive these outcomes in the healthcare setting in British Columbia.

The quantitative results show that TL and POS have a positive relationship with OCB, whereas POP shows a negative correlation with employee discretionary behaviours. The correlation analysis provided a significant positive relationship between TL and OCB, and between POS and OCB. Conversely, both OCB and TL had a negative relationship with POP. TL was also found to be a strong predictor of OCB, with POS coming next and POP showing a smaller and negative effect, as further supported by regression analysis performed by the researcher. Overall, these findings suggest leadership practices, existing organisational support systems, and organisational politics as the structural and behavioural aspects of organisational settings that impact employee engagement and discretionary effort.

Given that these statistical associations are enriched with qualitative results, the respondents of the interviews repeatedly indicated that the effectiveness of the leadership is a key factor that defines the employees' involvement and satisfaction at work. Leaders who were seen as supportive, often communicative and had the skill to build trust had been associated with increased motivation and employees' willingness to contribute beyond the formal and assigned job roles. On the contrary, leadership deficiencies, such as the absence of recognition, poor communication, low level of involvement and emotional support, were also identified as some of the causes of disengagement and dissatisfaction among the employees. These empirical observations support quantitative results, underlining the key responsibility of leadership in influencing employee attitudes and behaviours.

Moreover, the qualitative analysis of the researcher revealed the themes of organisational culture and effective communication as key success factors in

transformation efforts. As part of inspiring engagement, participants emphasised the role of open and honest two-way communication, shared decision-making, and a favourable work condition. Poor communication and a sense of non-connectivity or distant connectivity with the management and frontline employees were common reasons cited as potential obstacles for employee engagement. The results are consistent with the existing associations between TL and OCB because the effectiveness of leadership is frequently operationalised with the help of planned communication and culture-based organisational interventions.

Another important factor that was found in the quantitative and qualitative findings was that the POS has a positive association with OCB, which means that employees with an optimistic perception about organisational support are more likely to demonstrate discretionary behaviours. This point of view was repeated in interviews, where participants stressed the necessity of resource access, recognition, and organisational support systems to achieve job satisfaction and engagement. In the cases of unsupported workers, especially in stressful healthcare settings, low levels of motivation and unrest.

POP were also found to be a pivotal aspect that could determine employee outcomes in the healthcare settings of British Columbia. The quantitative results revealed that there was a negative correlation between POP and OCB and indicated that political environments could hold back discretionary efforts by employees. This relationship was further enlightened through qualitative research where interview participants re-counted their experiences of favouritism, lack of transparency, discrimination and inequitable decision-making they have observed in their workplaces. Such points of view were

associated with the low level of trust and confidence towards leadership and the unwillingness to make impactful contributions beyond the necessary job duties. This intersection of results highlights the importance of fairness in organisations and transparency in influencing employee engagement levels.

The findings of this research are directly related to the theoretical frameworks mentioned in the Literature Review chapter. The TL Theory (Avolio and Bass, 2004) outlines that leaders who inspire, motivate, and support employees can increase employee engagement and promote discretionary behaviours. TL and OCB have a strong positive relationship, which supports this theoretical content cited in this study. This alignment is further supported by the qualitative findings that show the effect of leadership behaviours on employee motivation and high engagement.

In the same way, the correlation between POS and OCB is consistent with the Social Exchange Theory (Eisenberger et al., 1986), which postulates that employees return the favour of organisational support in the form of positive attitudes and behaviours, such as more engagement and discretionary effort in a two-way relationship. This theoretical viewpoint is backed by the findings of the current research, as quantitative and qualitative data point to the fact that POS correlates with increased OCB and job satisfaction.

The relationship between POP and employee outcomes is also negative; this connection is backed by the literature cited in Chapter II. Kacmar and Carlson (1997) emphasize that organisational politics may cause the perception of unfairness and reduced trust levels, which results in low level of engagement and discretionary behaviour. This point of view is in line with the findings of this research, where descriptive statistical

findings, as well as interview findings, show that politically influenced environments have negative effects on employee attitudes and positive behaviours.

Nevertheless, the results are mostly in line with the theoretical frameworks; the contextual importance of these relationships in the healthcare sector of British Columbia is also clearly observed in this study. The quantitative and qualitative evidence found in this research provides a fine sense of the interactions between these factors in a high-pressure, resource-constrained environment like healthcare. For instance, the qualitative data highlights the severity of workload, emotional pressures caused by workload and systemic issues impacting healthcare professionals, which would increase the impact of leadership, POS, and POP on the performance of employees. This implies that though the current theories and concepts offer a solid base on which one can define the above relationships between variables, their usage in the healthcare setting should take into account the dynamics of the sector.

Overall, the results of RQ 01 suggest that leadership practices, organisational support, and employees' perception of organisational politics are the factors that have a critical impact on employee engagement levels, job satisfaction, and discretionary behaviours among healthcare workers in British Columbia. The similarity of quantitative and qualitative findings adds to the validity of these conclusions, whereas the correlation with the existing theories and concepts cited in the study adds to their theoretical relevance. Meanwhile, the contextual factors obtained within the healthcare settings help in a more in-depth comprehension of how these aspects are observed in the real world, and the need

to take into consideration the organisational perspectives and environmental circumstances in the interpretation of findings.

Discussion of Research Question Two

Research Question 02 (RQ 02) was based on understanding the impact of organisational culture, leadership practices, and effective communication on employee engagement and job satisfaction in the healthcare industry of British Columbia. The results obtained with the help of both the quantitative survey and the 14 interviews done by the researcher give a full picture of how the dimensions of organisations influence the attitude of the employees and their day-to-day experience.

As shown in the quantitative outcomes, TL has a positive correlation with OCB and POS and is found to be strong. Both the correlation and regression analyses point to TL as an important predictor of the model, which indicates that the leadership practices are core in determining the consequent behaviours of employees. Moreover, the POS was positively related to the employees' behaviours, and the POP has a negative relationship with the leadership and employees' behavioural outcomes. These findings are indicative of the impact of that organisational culture and communication processes since these two constructs are deeply embedded in the leadership practices and organisational support systems.

The qualitative results give more insights into how the culture of organisations and communication are received by employees in real-world contexts. The participants of the interviews constantly noted that a positive but inclusive organisational culture is one of the

key factors to support employee engagement and job satisfaction. An organisational culture of trust, collaboration, and shared value was found to be one of the core facilitators of positive employee attitudes.

Conversely, organisational contexts that were viewed as hierarchical, fragmented, or lacking transparency were related to low levels of engagement and dissatisfaction. The theme of leadership practices was well discussed in the qualitative interview process. Respondents noted that empathetic leaders who have clear direction and open, honest communication play a positive role in motivating and satisfying their employees. Good leaders were defined as those who actively listen to their employees, appreciate their discretionary efforts, and make their team members feel psychologically safe and connected. On the contrary, inconsistently perceived leadership behaviours, that are distant and unsupportive were associated with disengagement and low morale levels. These learnings emulate the quantitative data, supporting the key role of TL in the formation of the experiences of employees.

Communication was found to be a very important and critical organisational process whereby the organisational culture and leadership practices are realised. The need to have open, transparent, timely and two-way communication in the organisation was a common theme among the participants of the interview. Good communication was synonymous with role clarity, organisational goal alignment, and a feeling of inclusion among the employees. Contrarywise, barriers to employee engagement and job dissatisfaction were identified as communication gaps, absence of feedback and zero or

minimal information sharing. These findings indicate the interrelation between effective communication, organisational culture, and leadership role in shaping employee outcomes. The results of this research are aligned with the theoretical frameworks in Chapter II. The Transformational Leadership Theory (Avolio and Bass, 2004) also highlights the importance of leaders in motivating and inspiring their employees by means of sharing vision, communication and personalised attention in manifestation. This theoretical point of view is supported by the high correlation that was found between TL and OCB in this study. The qualitative results further demonstrate how these leadership behaviours are put into practice, specifically via communication and leader-member relationship-building.

Besides, the contribution of organisational culture and communication is connected with the general theory of organisational behaviour, which implies that organisational culture and effective communication processes play a major role in creating employee engagement and job satisfaction (Schein, 2010). Positive organisational culture creates a sense of belonging, understanding, trust and cooperation, which leads to increased positive employee experiences. The results of the current study contribute to this perspective since the quantitative and qualitative evidence show the significance of a supportive and communicative work environment. POS concept, which is based on the Social Exchange Theory (Eisenberger et al., 1986), is also a relevant theoretical lens in this study.

The fact that the POS is positively correlated with OCB suggests that employees who perceive their organisation as supportive are much more susceptible to positive employee attitudes and behaviours. Two-way communication is important in the development of these perceptions as it determines how the organisational expectations and

support mechanisms are communicated to the employees. Moreover, the negative correlation between POP and OCB is in line with the available literature that indicates that political climate might destroy mutual trust, two-way communication, and equity in organisations (Kacmar and Carlson, 1997). The qualitative results support this viewpoint as they indicate the role of perceived absence of transparency and fairness in communication and lack of transparency as a contributing factor to dissatisfaction and disengagement.

Although the results are mostly consistent with the theoretical frameworks, the contextual realities of the healthcare sector in British Columbia are also well featured in the study. The qualitative data indicate that the influence of overall organisational culture, quality of leadership interactions, and two-way communication is stagnated or not enhanced as expected due to the high-pressure prevailing in healthcare settings, where the employees have high workload demands and emotional pressures. Effective leadership and communication in such situations is even more important in enhancing and sustaining engagement and job satisfaction.

Overall, the results of RQ 02 suggest that organisational culture, leadership practices, and two-way communication are inseparably linked elements that have a strong impact on employee engagement and job satisfaction. Given the fact that quantitative and qualitative results are consistent reinforces the strength of these conclusions, whereas their correspondence to the existing theories and literature content can be considered proof of the theoretical relevance of these conclusions. Simultaneously, the study adds to the

literature by offering contextual information regarding the functioning of these organisational dimensions in the healthcare context in British Columbia.

Discussion of Research Question Three

Research Question 03 (RQ 03) aimed at investigating how workload, workforce levels, and work-life balance affect discretionary behaviours in healthcare workers in British Columbia. The results obtained in the quantitative survey and the 14 leaders interviewed by the researcher allow understanding the influence of these operational and contextual factors on employees' willingness to participate in the discretionary activities which are not included in their formal job descriptions.

The quantitative results show the correlation between OCB and TL, as well as POS, is significant, and OCB has a negative relationship with POP. The workload, staffing levels, and work-life balance were not directly measured as independent variables in the statistical model, but their impact is captured by means of these organisational constructs. Particularly, it is possible to associate POS, which was positively correlated with discretionary behaviours, with the availability of resources, workloads that employees can handle, and organisational practices that contribute to employee well-being. On the other hand, the POP, which denoted a negative correlation with the discretionary behaviours, might be indicative of an environment where resource shortage, staffing problems, and unequal sharing of workloads have been experienced.

The qualitative results of this study give first-hand information about the status of the workload, staffing and work-life balance. Respondents of the interviews referred to

high workload and staffing shortages as one of the main factors that negatively impacted their discretionary behaviours. According to the employees, the excessive workload and time constraints prevent them from performing beyond their regular job duties because their main concern is to do their job. The inadequate level of staffing was also identified as a key issue, and participants indicated that the lack of personnel deployed in the workplace increases stress and reduces opportunities for teamwork and discretionary job performance.

Another theme that had a significant impact on shaping discretionary behaviours was work-life balance. Respondents to the interviews highlighted that the long working hours, shifts and emotional aspects of healthcare work tend to cause fatigue and burnout, which accordingly influence motivation and engagement. Those who had difficulties in balancing work and life mentioned that they had lower levels of discretionary effort. Conversely, conducive working conditions that enabled flexibility and the appreciation of the welfare of employees were correlated with improved readiness to deliver beyond official work expectations.

The theoretical frameworks of Chapter II relate to the findings of relating to this RQ 03. The Job Demands-Resources (JD-R) model outlines a proper perspective on the relationship between workload assigned to employees and staffing levels and employee behaviours. This model suggests that when job demands and role expectations are high (e.g. too much work, inadequate staffing, etc.), strain and low engagement will occur, whereas the presence of resources will support motivation and discretionary behaviours (Bakker and Demerouti, 2007). This viewpoint is upheld in this study through the

qualitative results that profoundly reveal the effects of workload pressures and staffing shortages on employees' performance of extra-role behaviours.

Furthermore, the connection between work-life balance and discretionary behaviours could also be explained in terms of the renowned Social Exchange Theory (Eisenberger et al., 1986). Employees can interchange this by engaging in and putting in discretionary effort when employees feel that organisations support them to handle work-life demands well. This theoretical dependability is also strengthened by the positive correlation between POS and OCB, which was found in the quantitative results.

TL Theory is also indirectly connected to the effects of workload and staffing levels (Avolio and Bass, 2004). Leaders who are very effective are instrumental in managing their resources, getting employee support and establishing conditions that can accommodate discretionary behaviours. The positive correlation between TL and OCB implies that the adverse impact of workload and staffing-related issues can be resolved through support and motivation of the work environment by the leadership and leadership practices.

Though the results are mostly aligning with the cited theoretical frameworks in the literature review, the study also shows the real-life status of the context of the healthcare sector in British Columbia. According to the findings related to qualitative data, the level of workload and staffing-related issues in this industry increases their effects on the behaviour of employees. Healthcare workers, especially the frontline staff, work in high-stress settings where the day-to-day needs of patients in their care are urgent and non-negotiable, and they have an inability or limited ability to make any discretionary contributions in a situation in a place where the resources are limited. This contextual

understanding is pragmatic and an added value to the current theories by establishing the impact of structural and environmental factors on employee behaviour in practice.

Overall, the results of RQ 03 suggest that workload, inadequate level of staffing, and work-life balance are vital factors that contribute to discretionary behaviours among healthcare workers. Combining the evidence of quantitative and qualitative studies and analysis vindicates the value of resource accessibility, organisational encouragement and employee mental health in developing such behaviours. The right alignment of the findings of the research with the existing theoretical constructs, in addition to the contextual knowledge base in the healthcare industry, gives a complex picture of what drives discretionary efforts in the study.

Discussion of Research Question Four

Research Question 04 (RQ 04) was designed to discover the strategies and organisational practices that have been effective in other regions or sectors to increase employee engagement and job satisfaction, and their applicability to the healthcare sector of British Columbia. The findings leading to this research question are mainly based on qualitative data of 14 interviewed leaders, and quantitative data of 159 surveyed frontline healthcare workers by the researcher, which serve as a background to interpret the organisational conditions related to employee engagement and satisfaction.

The quantitative results reveal that POS and TL have close links with positive employee outcomes. POS had the highest mean of the constructs, and had strong positive correlation with OCB. On the same note, TL exhibited considerable positive correlations

with OCB, as well as POS. These results indicate that conditions in organisations are supportive of organisational practices, as well as effective leadership behaviours, that are linked with greater rates of engagement and satisfaction. Conversely, POP were found to be negatively related, meaning that organisational environments that are perceived to be political may negatively affect employee attitudes and behaviours. These numerical results demonstrate a basis of explanation for the reasons why some organisational strategies and interventions work better in improving engagement.

The qualitative findings also explain more about the character of these strategies and practices. The participants of the interviews repeatedly highlighted the fact that the effectual organisational practices within other domains were the ones incorporating the leadership, the organisational structures and systems, as well as the cultural transformation. One of the themes that emerged was the element of organisational support, which is enabled by leadership, through the formal support systems, including organisation policies, resources and employee programmes, which are being strengthened by the leadership behaviours.

Interview participants noted that the support is not just portrayed by its presence but by the way it is accomplished, conveyed, and felt by the workers. Higher employee engagement and satisfaction were reported in most of the situations where leadership actively provided access to resources, recognition, and showed a proper interest in the well-being of the employees.

The other important theme was the implementation of integrated engagement strategies that involve leadership development programs, planned employee recognition

programs, and holistic well-being practices. The respondents' interviews indicated that other organisations in the industry and market have also made successes in improving employee engagement through investment in planned leadership capability development, especially in aspects like effective communication, emotional intelligence building, and supporting employees. Moreover, practices such as frequent and honest acknowledgement of employee contributions, open and two-way communication process, and the reflective event organised to help employees in working-life balance and wellbeing were also determined as the significant factors in employee satisfaction. These organizational strategies and interventions have been explained to be interrelated, and their success relies on the consistency between organisational policies and processes, leadership behaviours, as well as workplace culture.

The results can be described by the theoretical approaches in Chapter II. Transformational Leadership Theory (Avolio and Bass, 2004) focuses on the prominence of the leader as a true inspirer, motivator of the personnel, a sense-maker, and someone who genuinely creates favourable conditions. The qualitative results of interviews heavily reinforced this view, with behaviours of leaders being found to be one of the core of the effective implementation of engagement strategies in organisations. Likewise, the POS concept, as per the Social Exchange Theory (Eisenberger et al., 1986), is also well reflected in the findings, as the employees positively and consistently react to the organisational practices which show the emotionally caring, recognition and perceived support. This evident alignment is further supported by the strong correlation between POS and OCB as per the descriptive analysis in this study.

Furthermore, the results regarding the organisational culture and integrated people strategies are in line with literature on organisational behaviour that exhibits that employee engagement is determined by the correspondence of organisational systems, processes, leadership practices and interventions, and cultural values (Schein, 2010). The qualitative findings, including the focus on the general and comprehensive strategies, endorse this opinion, showing that a single organizational intervention is not as effective as multi-dimensional strategies that are effective and cover various aspects of the employee experience.

Though the results mostly correspond to contemporary theories, the research also includes the significance of circumstantial adaptation. The healthcare sector in British Columbia has its own challenges, such as excessive workload, clinical fatigue, emotional demands and limited resources, which can negatively affect the effectiveness of strategies and interventions applied in other sectors. The qualitative data and findings indicate that, despite the best practices in other areas or industries being of great interest, to be applied meaningfully in the area of healthcare, it is necessary to adjust them to the context of the organisation and its effective functioning. Particularly, the place of leadership in the conversion of organisational strategies into practice is needed to ensure that these efforts are coordinated and worthwhile and valuable to healthcare workers, which would make real sense.

To conclude, the results of RQ 04 suggest that effective organization interventions and organisational practices that aim at improving employee engagement, wellbeing and satisfaction are those strategies that combine effective leadership and organisational

support, and the right cultural alignment. The understanding of overall findings of the research improves the validity of those inferences, whereas the resemblance with the existing theoretical models validates their pertinency. Meanwhile, the research fits well into the literature by emphasising the need to apply the context, in the healthcare sector of British Columbia, where the support supported by the leadership, as well as the integrated employee engagement strategies, is substantial in the way the employees are shaping up.

5.3 Implications

This research is relevant to the contemporary literature in that it develops and contextualises major organisational behaviour-related theories in the healthcare industry of British Columbia, especially TL, OCB, POS and POP. Overall findings of the research gives a full-fledged theoretical contribution not only in proving the existing theoretical frameworks but also in tightening the potential applicability of a similar kind of complex and high-pressure healthcare settings. The first theoretical contribution of this research study is the augmentation of the explanatory capacity of Transformational Leadership Theory (Bass and Avolio, 1994; Avolio and Bass, 2004) to predict the discretionary behaviours of employees.

The results support the notion that leadership interactions that are characterised by inspiration, individualised consideration and intellectual stimulation have a strong association with improved employee engagement and OCB. This provides credibility to the current theoretical postulation that transformational leaders lead followers beyond their transactional exchanges by encouraging intrinsic motivation and voluntary contributions

(Bass, 1985). This paper, however, builds on the theoretical foundation by showing that the effectiveness of TL is not self-governing but rather works in conjunction with organisational context and circumstantial variables like organisational support and politics. Moreover, this research offers empirical evidence of Social Exchange Theory (Blau, 1964), particularly in the context of POP.

The fact that POS and OCB are positively correlated supports the idea that the employees will extend to create positive organisational outcomes with increased engagement and discretionary efforts (Eisenberger et al., 1986). The qualitative results expand this theory by establishing that the perceived support is not only structural, but it is also constructed during the leadership inspiration and communication processes. This implies that the relationships explained in the Social Exchange Theory (Blau, 1964) have been mediated by the explanatory mechanisms, and this is where leadership plays a noteworthy role in converting organisational intent into the perceived reality.

The other important theoretical implication is associated with the role of POP. The results correspond with the prediction that politically related perceptions harm employee attitudes and behaviours, which confirms the past studies that organisational politics abolish trust, fairness and employee engagement (Kacmar and Carlson, 1997; Ferris et al., 2002). This study, however, goes one step higher by placing organisational politics as a situational limitation, degrading the effectiveness of both the leadership and organisational support. This adds to the current literature by focusing on the structural and behavioural factors in prompting employee outcomes.

Also, the previous research conforms to and adds to the extension of the Job Demands Resources (JD-R) Model (Bakker and Demerouti, 2007). Though the workload, level of staffing, and work-life balance were not measured as independent variables per se, they were potentially identified in the qualitative conclusions as significant contextual variables. These study outcomes indicate that job requirements within healthcare settings have a strong bearing on whether employees can demonstrate discretionary behaviours, thus associate the JD-R model in suggesting that high burdens may lead to low levels of employee engagement without providing adequate resources.

The research has a theoretical contribution since it has joint leadership and organisational support as vital resources, which can potentially reduce the negative effects of job demands. Notably, the study paper contributes to the theoretical incorporation in the sense that it proves that these study frameworks, namely the TL Theory, the Theory of Social Exchange and the JD-R Model, are not self-determining of each other but rather interdependent in their nature.

The outcomes of this research show that leadership support and politically motivated environments have multi-layered relationships with constraints on the opinions of support, the engagement of the support, and the relationships between these factors. This amalgamated view adds to the research literature as it goes beyond the single-theory approach to explaining the issue, and it provides a more holistic one.

RQ1: What are the key factors contributing to low employee engagement, job dissatisfaction, and limited discretionary behaviours among healthcare workers in British Columbia?

The RQ1 results make conclusions in terms of theoretical implications as they specify that POP and POS are the important factors that regulate level of employee engagement and discretionary behaviours of employees. These results are very supportive of the Transformational Leadership Theory, which suggests that the behavioural leadership styles are related to the motivation and level of employee engagement (Avolio and Bass, 2004). This theoretical supposition is supported by the positively correlated relationship between TL and OCB.

In light of the fact that Social Exchange Theory, the results point to the significance of POS in influencing the attitudes of employees. When employees sense that the organisation has been more supportive of its employees, chances are higher that they will respond with discretionary behaviours (Eisenberger et al., 1986). This paper builds on this theory by demonstrating that support is not merely an organisational construct but is interpreted based on the leadership behaviours and workplace relationships existing among the leaders and followers.

The negative effects of POP gives further theoretical understanding. Even though previous research has empirically established that political environments decrease employee satisfaction (Kacmar and Carlson, 1997), this study shows the role of politics as a hindrance to the effectiveness of the two leadership supports. This implies that POP can only be viewed as a moderating or circumstantial variable in leadership/engagement

models. All things considered, the results of RQ1 support the pertinence of current theories but go beyond them by showing how they interconnect in the healthcare setting of British Columbia.

RQ2: How do organisational culture, leadership practices, and communication impact employee engagement and job satisfaction in the healthcare sector?

The RQ2 findings complement the theory by highlighting the interrelatedness between organisational culture, leadership, and communication. Transformational Leadership Theory is also reinforced, where leadership practices were determined to influence organisational culture and communication-related activities that subsequently impact the level of employee engagement.

This work is also in agreement with the Organisational Culture Theories (Schein, 2010), which argues that the organisational shared values, organisational norms and communication patterns play a key role in inspiring the behaviour of employees. The qualitative results of this study build upon this view to show how culture is manifested in day-to-day life as displayed in everyday encounters, leadership practices, rituals, and communication.

A key academic process that connects employee effectiveness and leadership is communication. Although communication is usually viewed as a part of leadership functions, this study points out that it is an independent variable in the perception of fairness, inclusion, and support. Eventually, this implies that there is a need to incorporate communication more clearly in theoretical leadership and engagement models.

RQ3: What roles do workload, staffing levels, and work-life balance play in influencing discretionary behaviours among healthcare workers?

The RQ3 results are highly theoretical as they have a connotation between the operational factors of organisations, including the amount of workload and staffing levels, and the discretionary behaviours, with currently available knowledge base and organisational theories. The findings of this study are quite consistent with the Job Demands-Resources (JD-R) Model (Bakker and Demerouti, 2007), which suggests that high job demands may decrease employee engagement and discretionary efforts of employees. The qualitative results of this study add to the JD-R model by demonstrating the direct impact of workload and understaffing on employees' ability and willingness to demonstrate discretionary behaviours. This gives empirical evidence to the theoretical findings, which state that when demands are too high, they result in draining and low motivation.

Furthermore, the results support the Social Exchange Theory by presenting that the work-life balance is a key factor with respect to employee reciprocity. From the point of organization, assisting employees manage work-life-balance, employees tend to indulge in discretionary behaviours. Another noteworthy theoretical extrapolation of this study is the role of leadership. Transformational leaders can reduce the adverse consequences of workload and staffing issues through leadership support, motivation, and required resources. This implies that leadership is to be meaningfully incorporated in the JD-R framework as an important resource variable. Overall, the results of RQ3 add to the theory by fulfilling the gap between operational and behavioural explanations, showing the role

played by structural factors in shaping employees' discretionary behaviours via psychological and relational means.

Additionally, the results support the Social Exchange Theory by showing that when communication works well within organisations, it improves the POS, which, in turn, affects employee engagement and satisfaction. It means that organisational communication is not only the working process but the driving force in social exchange relationships.

RQ4: What strategies and organisational practices have been effective in other regions or sectors in enhancing employee engagement and satisfaction?

This research validates the TL Theory by showing that leadership development is one of the critical strategies for improving the effectiveness of employees. The results also magnify the Social Exchange Theory by demonstrating that organisational behaviours like employee recognition programs, well-being programs and support systems affect employee perceptions and behaviours. These practices augment the mutual bond between the employees and organisations.

The research also corresponds with the organisational systems theory, which proclaims that alignment between organisational structures, culture, and leadership development practices is absolutely essential. The results of this study demonstrate that successful strategies are not standalone initiatives but holistic systems that can give their coverage to aspects of the employee experience. Notably, the research indicates the necessity of contextual adaptation of strategies even within the healthcare sector of British Columbia. Though the best practices in other industries offer valuable input and insights,

they cannot be effective without overlapping with organisational culture and leadership practices. This adds to the theory, as it focuses on the importance of context in establishing the success of organisational interventions.

5.4 Recommendations

Recommendations for Practical Applications

As per the outcomes of this research, there is a set of practical recommendations that could be made by the researcher to progress the level of employee engagement, job satisfaction levels, and employees' discretionary behaviours among British Columbia healthcare workers. These recommendations are made as per the quantitative and qualitative evidence and are correlated to the constructs of the TL, POS, and workplace dynamics that were revealed during the research. Understanding the fact that the healthcare industry is a complex and stressful field of work, the recommendations are supposed to present pragmatic recommendations that could be applied at organisational and leadership levels to enhance employee performance, effectiveness, and the entire value creation.

To start with, healthcare organisations are supposed to emphasise growing and enhancing required transformational leadership skills at every level of management. Leadership was found to be a key aspect that imitates employee engagement levels and discretionary behaviours, which shows the necessity of formal leadership development programs in the healthcare industry of British Columbia. Companies need to invest in extensive training, which aims to improve skills in effective and impactful communication, emotional intelligence, coaching, mentoring and conflict resolution.

Moreover, they should equip leaders with the aptitude to give personalised attention to their team members, inspire employees with common goals and create trustful bonds with employees in their teams. Through the continuous coaching, mentoring and leadership evaluation frameworks and programs, leadership development can be embedded into the short-term and long-term organisational strategy, thus guiding the leadership practices to be consistent and aligned to organisational strategic objectives.

Secondly, POS needs to be strengthened using structured and visible support systems that are enforced regularly and effectively communicated by across the organisations. The key outcomes of this research indicate that employees' perceptions of organisational support play a essential role in developing engagement mindset and employees' desire to perform discretionary behaviours. Thus, organisations should put sufficient resources, recognition schemes, career development and employee welfare programs in place to get the desired discretionary behaviours.

Notably, the support mechanisms are not to be confined to formal policies and procedures but rather ought to be proactively influenced by leadership behaviours and daily interactions in the workplace. For instance, the managers ought to frequently recognise the input of the employees, give constructive and honest feedback, and make the employees feel respected and appreciated. By reinforcing these practices and behaviours, it becomes possible to establish a favourable psychological contract between the employees and the organisation.

Thirdly, healthcare sector organisations are recommended to implement proactive strategies to reduce POP. Organisational politics can create a lack of trust and transparency

and have a disadvantageous effect on employee engagement and job satisfaction. To counter this, organisations are supposed to emphasise the need to appreciate fairness and transparency in the decision-making processes in organisations. This will involve effective communication of organisational policies, engaging stakeholders for these policies, fair allocation of organisational resources, and fair and equitable performance management systems. Moreover, organisations are recommended to come up with effective avenues of employee feedback, escalations, whistleblowers and grievance management to make sure that issues are resolved in a responsive, fair and equitable way. The negative impacts of political perceptions can be reduced by promoting a culture of responsibility, accountability and equity, which would also allow organisations to build a more accommodating work environment.

Moreover, the organisational priority should include managing the workload, staffing levels, and work-life balance. The results show that work overload and understaffing may greatly limit the discretionary behaviours of employees. Healthcare organisations are thus advised to invest in workforce planning strategies to maintain optimum staffing levels and fair workload distribution. This can involve recruiting competent employees, giving flexible working schedules and using technology to minimize the administrative functions. Furthermore, organisations ought to encourage a work-life synergy by providing flexible work policies, mental health services, and creating anti-burnout programs. Helping employees balance their work and personal life, which is considered work-life synergy, can improve the overall well-being and maintain a high level of employee engagement in the long term.

In addition, healthcare organisations need to implement collaborative employee engagement practices that align with good leadership practices, organisational culture, and organisational communication processes. Employee engagement is not to be viewed as a one-off intervention but rather as an overall company strategic goal that is integrated throughout the functions of the organisation. An open culture and its transparency in communication with employees who can express their ideas, views and concerns openly should be encouraged in organisational settings. A feeling of ownership and inclusion can be stimulated by inducing the employees to contribute to decision-making. Furthermore, there should be employee recognition schemes to reward individual and team achievements to encourage positive behaviours and foster a culture of appreciation and recognition. Synergising these factors can result in a more unified workplace that encourages employee involvement and fulfilment of goals. Finally, organisations should consider the best practises in other industries and make modifications and adaptations to the healthcare setting.

The results of this study indicate that other fields have tried and found that the use of appropriate strategies, like leadership coaching, continuous learning, employee recognition programs, and culture-building programs, has been successful in boosting the level of employee engagement and job satisfaction. Nevertheless, such practices must be thoughtfully designed to fit the specifics of operations and the environment of the healthcare sector. High workload, emotional aspects, and regulatory requirements are some of the factors that should be carefully considered when developing and executing these

interventions. The context-specific approach will help organisations to make sure that the best people-centric practices are relevant and sustainable.

Recommendations for Future Research

To leverage the core findings of this study and some limitations identified, several recommendations can be made to enlighten future studies within the healthcare sector of British Columbia. The recommendations will support enriching the theoretical knowledge, improving the methodological rigour, and responding to emerging problems in the shifting and fast-paced healthcare setting. The expansion of the scope of this study will enable future researchers to add to stronger and more generalisable information on the subject of employee engagement, job satisfaction, and employees' discretionary behaviours.

To start with, future studies must take into consideration the increased sample size and diversity of the research participants of various healthcare organisations and regions, without limiting the study to healthcare authorities in British Columbia. Given the fact that the present research is insightful, wider sampling in areas such as acute care, community health, long-term care, aged care and specialised services would enhance the external validity and generalisability. Engagement and perceived leadership differences across different work groups can also be revealed by integrating varied demographic and professional groups across the industry. Previous studies along the same line indicate that wider and more diverse samples can strengthen the validity and generalisability of the organisational behaviour level results (Hair et al., 2019).

Secondly, it is recommended that the researchers use a longitudinal research design to help them understand the dynamics and the way leadership influences and relates to employee behaviour over a long period of time. Whereas organisation-wise study design provides a depiction of relationships, longitudinal studies can be used to infer causal relationships and to examine how employee engagement and discretionary behaviours vary over time. For example, the impact of TL style can change depending on the changes in circumstances that organisations are going through and the attitudes of employees. Longitudinal designs are particularly beneficial for long-term behavioural consequences and change procedures in organisations (Ployhart and Vandenberg, 2010).

Third, future research needs to reflect mediating variables and moderating variables that impact the relationship between TL and OCB. Psychological safety at work, emotional intelligence, organisational commitment and job burnout are some variables that can be of better explanatory value in that context. Psychological safety at work is one example that has been cited to allow employees to freely express themselves and indulge in discretionary behaviours at their own choice (Edmondson, 1999). Likewise, the presence of emotional intelligence among the leaders can also lead to more effective transformational leadership and related practices (Goleman, 1998). Such variables would add to more wide-ranging and theoretically incorporated models.

Fourthly, further studies on specific healthcare jobs and professional groups and affinity groups are needed, such as nurses, physicians, paramedics, allied health professionals and non-clinical professionals in the region. The healthcare workforce in the

province of British Columbia is very diverse, and various roles are characterised by different degrees of workload, stress levels, and organisational support.

Dissociated studies, which break down into data by professional type, may offer more specific information and allow more role-specific interventions to be made. Past studies well indicate that occupational differences have a main effect on the outcomes of employee engagement and job satisfaction (Bakker and Demerouti, 2007).

Fifthly, an improved mixed research method should be implemented in future studies with more focus on a qualitative investigation. Although quantitative approaches are useful in determining the behavioural patterns and relationships, qualitative techniques like deep-dive interviews, facilitated focus group discussions, and ethnographic observations may help provide detailed contextual information about employees' real day-to-day experiences. These strategies are especially useful in medical and clinical facilities, where emotional labour, interpersonal interactions and organisational culture are critically important factors. Creswell and Plano Clark (2017) clearly point out that mixed-method research designs allow a more comprehensive approach as it allows combination of numerical evidence with lived experiences.

Sixthly, relative research must be conducted to examine the best practices between provinces, countries and between healthcare systems. The benchmarking studies will be able to reveal effective new leadership models, the formation of strategies of engagement and organisational practices which can be potentially applied to the British Columbia context. Comparative research can also be used to find situational factors that determine the success of these interventions. As an example, differences in healthcare governance

frameworks, funding models and workforce structures can impact employee experiences and outcomes (Walshe and Smith, 2011).

Lastly, succeeding studies are needed to further investigate how the emerging trends, including digital transformation, integration of artificial intelligence, telehealth, and technological innovations, influence employee engagement levels and job satisfaction in the healthcare sector in British Columbia.

The healthcare industry is experiencing a fast digitalisation process and integration of artificial intelligence that is transforming the work process, conventional communication patterns, and legacy patient care delivery models. Although technology can be more efficient and novel, it can also add new stressors and challenges to the employees. The insights into the role of digital tools that could be used in employee engagement, workload management, and discretionary behaviours are crucial in shaping future-proof organisational approaches. Research shows that the roles of employees and organisational culture are under the immense influence towards digital transformation, which requires continuous research on this topic (Vial, 2019).

To summarise, the recommendations delineated here offer a broad outline of the future research in the healthcare sector in British Columbia. Further research in future can build on the existing findings of this study by developing methodological approaches, adding more theoretical variables, and solving emerging and timely organisational problems to contribute to better theoretical and conceptual understanding and practice.

5.5 Conclusions

This research aimed to investigate how TL affects OCB in the healthcare industry of British Columbia, as well as the impact of POS, POP, and work-related elements (workload, staffing, and work-life balance) on the study. A mixed-method design containing quantitative data of 159 frontline healthcare workers as survey respondents and qualitative data of 14 employees holding leadership roles in the healthcare industry of British Columbia offers this study a mixed approach to obtain a structured and comprehensive idea of the factors affecting employee engagement, job satisfaction, and employees' discretionary behaviours. The study results show that TL is a key determinant in the attitudes and behaviours of employees. Leadership practices that were identified as supportive, communicative and truly inspirational were found to be highly correlated with positive employee outcomes, especially OCB.

Secondly, POP proved to be an important variable that affected employee engagement and discretionary intention to perform more than job duties. Stronger discretionary behaviours were well exhibited by employees who felt that there was more organisational support extended, which underscores the significance of very supportive organisational environments.

In contrast, POP was invariably determined to hurt employee attitudes and behaviours. The environments that were inherently characterised by a lack of transparency, equity, fairness and trust were linked to lower levels of engagement and discretionary effort by employees. These results emphasise the role played by the culture of the organisation, operating model and governing structures in the determination of employee perceptions

and real-life experiences. The research also identifies the noteworthy influences of operational factors like excessive workload, staffing levels, and work-life balance. Workload demands and staff shortages were reported as critical issues that constrain employees' ability to exhibit discretionary behaviours. Simultaneously, supportive organisational practices aimed at managing work-life balance and employee well-being were also recognised to have a positive impact on level of employee engagement and job satisfaction.

Moreover, this research determined that the best approaches to improving and sustaining employee engagement and job satisfaction were those approaches that combined leadership practices and interventions, organisational support systems and cultural alignment. Leadership development programs, employee recognition schemes, and employee well-being programs were identified to be especially applicable and related to enhancing employee positive workplace experiences. Finally, this study will leave a remarkable contribution to both theory and practice because it offers an in-depth and detailed analysis of the factors that could affect employee engagement and discretionary behaviours of employees in the healthcare industry of British Columbia. The results support the significance of leadership practices, organisational support and workplace structures and conditions in influencing employees' outcomes. By focusing on such factors, healthcare organisations in British Columbia could build much more accommodating and engaging working conditions, which potentially increase the organisational performance and quality of care.

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APPENDIX A
SURVEY COVER LETTER

Dear Respondents,

I am Ian Bandaranayake and reading for a Doctor of Business Administration (DBA) course at the Swiss School of Business and Management, Geneva. While writing my DBA thesis, I am carrying out research in the British Columbia healthcare industry. In particular, my research explores the effects that Transformational Leadership has on the organizational citizenship behavior (OCB) of healthcare organizations. This survey aims at gathering information regarding leadership practices and behaviours of employees in healthcare organizations. The research will lead to recommendations on enhancing employee collaboration, employee engagement, and organizational success within the healthcare industry.

Data, Use and Confidentiality.

Any details collected in this survey will be highly confidential and will not be disclosed to any third party other than as part of an academic study concerning this research project. Individual responses shall not be shared with any third party, and the final presentation will only be conducted in a gathered form to maintain the anonymity of the participants.

Instructions:

This questionnaire has two sections:

- **Section 1:** Demographic and work-related information.

- **Section 2:** Leadership practices and workplace behaviours.

Please answer all questions as honestly as possible. For Section 2, use the following scale when rating each statement:

1 = Fully Disagree | 2 = Disagree | 3 = Neutral | 4 = Agree | 5 = Fully Agree

Your participation is voluntary, and your input will be highly valuable in contributing to the success of this research.

APPENDIX B
SURVEY QUESTIONNAIRE

Instructions For Respondents

This questionnaire has two sections:

- **Section 1:** Demographic and work-related information.
- **Section 2:** Leadership practices and workplace behaviours.

Please answer all questions as honestly as possible. For Section 2, use the following scale when rating each statement:
1 = Fully Disagree | 2 = Disagree | 3 = Neutral | 4 = Agree | 5 = Fully Agree

Your participation is voluntary, and your input will be highly valuable in contributing to the success of this research.

Section 01: Demographic Information

Please select or fill in as appropriate.

1. Age Group:

☐ 18–24 ☐ 25–34 ☐ 35–44 ☐ 45–54 ☐ 55+

2. Gender (optional):

☐ Male ☐ Female ☐ Undefined: ☐ Prefer not to answer

3. Total Years of Work Experience:

☐ Less than 1 year ☐ 1–3 years ☐ 4–7 years ☐ 8–12 years ☐ 13–19 years ☐ 20+ years

4. Current Department / Functional Area:

☐ Front-line Health-Care Role (e.g., nurse, paramedic, allied health)

☐ Administrative / Support Services

☐ Other – please specify: _____

5. Job Level:

- ☐ Management (supervisory / leadership)
- ☐ non-management (front-line staff/team member)

6. Employment Group:

- ☐ Unionized
- ☐ Excluded / Non-unionised

7. Length of Service with Current Organisation:

- ☐ Less than 1 year ☐ 1–3 years ☐ 4–7 years ☐ 8–12 years ☐ 13–19 years ☐ 20+ years

Section 02: Research Statements

Instruction: Please indicate your level of agreement with each of the following statements.

Use the scale: 1 = Fully Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Fully Agree.

No.	Statement	1	2	3	4	5
1	I willingly help fellow professionals when they have work-related problems.	☐	☐	☐	☐	☐

- | | | | | | | |
|---|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 2 | I willingly help newcomers get oriented towards the job. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3 | I am always ready to lend a helping hand to those around me. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4 | I always keep myself abreast of changes in the organisation. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5 | I keep myself updated with organisational announcements and memos. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6 | I attend meetings that aren't compulsory but help my department anyway. | ☐ | ☐ | ☐ | ☐ | ☐ |

- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 7 | I always require frequent doses of motivation to get the work done. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8 | I usually find fault with what my organisation is doing. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9 | I usually focus on what is wrong rather than the positive side of the situation. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10 | I obey organisational rules even when no one is watching. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11 | I don't take extra or long breaks while on duty. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12 | My attendance at work is above the norm. | ☐ | ☐ | ☐ | ☐ | ☐ |

- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 13 | My supervisor
re-examines
ways of doing
things to see if
they are up to
standard. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14 | My supervisor
gets me to look
at problems from
many different
angles. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15 | My supervisor
seeks differing
perspectives
when solving
problems. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | My supervisor
talks about
his/her most
important values
and beliefs. | ☐ | ☐ | ☐ | ☐ | ☐ |

- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 17 | My supervisor specifies the importance of having a strong sense of purpose. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | My supervisor emphasises the importance of having a collective sense of mission. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19 | My supervisor goes beyond self-interest for the good of the group. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20 | My supervisor acts in ways that build my respect. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21 | My supervisor displays a sense of power and confidence. | ☐ | ☐ | ☐ | ☐ | ☐ |

- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 22 | My supervisor
talks
enthusiastically
about what needs
to be
accomplished. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 23 | My supervisor
talks about a
great vision of
the future. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24 | My supervisor
talks
optimistically
about the future. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 25 | My supervisor
spends time
teaching and
coaching. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 26 | My supervisor
considers me to
have different
needs, abilities,
and aspirations
from others. | ☐ | ☐ | ☐ | ☐ | ☐ |

- 27 My supervisor ☐ ☐ ☐ ☐ ☐
helps me to
develop my
strengths.
- 28 Favoritism rather ☐ ☐ ☐ ☐ ☐
than merit
determines who
gets ahead
around here.
- 29 Rewards come ☐ ☐ ☐ ☐ ☐
only to those
who work hard
in this
organization
- 30 There is a group ☐ ☐ ☐ ☐ ☐
of people in my
department who
always get things
their way
because no one
wants to
challenge them.

- 31 People in this organization attempt to build themselves up by tearing others down. ☐ ☐ ☐ ☐ ☐
- 32 I have seen changes made in policies here that only serve the purposes of a few individuals, not the work unit or the organisation. ☐ ☐ ☐ ☐ ☐
- 33 There is no place for yes-men around here: good ideas are desired even when it means disagreeing with superiors. ☐ ☐ ☐ ☐ ☐

- | | | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 34 | <p>Leaders of my company strongly consider my goals and values.</p> | ☐ | ☐ | ☐ | ☐ | ☐ |
| 35 | <p>Leaders of my company really care about my well-being.</p> | ☐ | ☐ | ☐ | ☐ | ☐ |
| 36 | <p>Leaders of my company take pride in my accomplishments at work.</p> | ☐ | ☐ | ☐ | ☐ | ☐ |
| 37 | <p>Leaders of my company are willing to help me if I need a special favour.</p> | ☐ | ☐ | ☐ | ☐ | ☐ |
| 38 | <p>Leaders of my company value my contributions to its well-being.</p> | ☐ | ☐ | ☐ | ☐ | ☐ |

39	Leaders of my	☐	☐	☐	☐	☐
	company would					
	grant a					
	reasonable					
	request for a					
	change in my					
	working					
	conditions.					

APPENDIX C INFORMED CONSENT

Ethical Assurance and Informed Consent Statement

I sincerely thank you for joining the qualitative part of my research on how Transformational Leadership could influence Organizational Citizenship Behaviour (OCB) in the healthcare sector of British Columbia. This step is aiming at confirming and put into perspective the outcomes of the quantitative survey by administering semi-structured interviews with some professionals who at leadership positions in the healthcare sector of British Columbia. Participation is voluntary and in supportive of completing my doctoral thesis. You can skip any question and withdraw your answers at any time with impunity. The interview might take around 30-40 minutes and can be conducted in-person or using virtual (MS Teams/Zoom) at your convenience. The interviewer will take notes to record the outcomes of the interviews. The recordings will be stored safely and only made available to the researcher. The results will be used only for academic purposes and presented in the form of anonymized aggregates. While any direct personal gain is absent, your involvement will contribute to the research on leadership interactions and employee behaviour in the healthcare industry. Your verbal agreement to support the study confirms that you are aware of the purpose of the study, that it is fully voluntary, that you agree to the recording of the information, and that your answers will be treated in a confidential and anonymised manner.

APPENDIX D

INTERVIEW GUIDE

Qualitative interview guide

The purpose of this qualitative information gathering phase is to confirm and put in perspective the quantitative survey outcomes, and the researcher is conducting semi-structured interviews with senior healthcare leaders in British Columbia. The leadership interview will focus on the leadership-based perspectives on their interactions, employee engagement, job satisfaction and OCB within the healthcare industry.

Respondents: Employees who hold senior leadership and managerial roles in the British Columbia healthcare authorities have been picked for the sample.

Interview Procedure: Semi-structured interviews will be conducted for 30 -40 minutes.

Mode: Virtual (MS Teams/Zoom) or in-person.

Recording: Participants' verbal answers will be recorded manually by the researchers through note-taking. All the answers will be anonymous and are reported in a summary form without any identification.

Participation is voluntary: You may withdraw at any time. Interviews will be audio-recorded with consent. All data will be collected, processed and analysed in an anonymized form and used solely for academic research purposes.

Preamble:

The BC healthcare system is still going through performance pressure, such as shortages in the workforce, patient demand growth, long wait times, and staff burnout (BC

Ministry of Health, 2023; CIHI, 2024). The national data also show that the level of employee engagement and job satisfaction is not the best in the high-stress healthcare setting (Healthcare Excellence Canada, 2023). There is evidence that low participation and less discretionary work might adversely affect the quality of the services, patient safety, and performance of the entire system (Gallup, 2023; CIHI, 2024). Even though transformation efforts have been taken, the gap is still there on how Transformational Leadership has an impact on OCB discretionary behaviours like collaboration, initiative and commitment beyond the job expectations. Your experience as a leader in a BC health authority overseeing high populations will be used to put the results into perspective and to determine workable approaches to enhance the level of engagement and performance within the industry.

Interview questions:

1. According to you, what are the primary reasons for low employee level of engagement and job dissatisfaction among the employees of the British Columbia healthcare workers?
2. What influence do these factors have on the discretionary efforts of employees to perform more than their official job descriptions?
3. What is the organisational culture in your health authority, and how does it affect regarding engagement and morale?
4. How do leadership behaviours influence employee engagement and organisational citizenship behaviours in your organization?
5. To what extent does senior leadership communicate effectively to foster trust and ensure engagement, particularly when a change process takes place?

6. How much does the workload constrain the ability of the employees to exercise discretionary behaviours?
7. How do you see the relationship between work-life balance issues and employee engagement and retention in the healthcare sector?
8. What are the effects of organizational politics within your organization and how does it influence employee attitudes and behaviours?
9. How does organizational support work with or without the influence of the leaders?
10. What are the strategies in place that are successful in enhancing employee engagement and satisfaction in other healthcare authorities or other industries?

Qualitative Coding Framework (Aligned to Research Questions)

Thematic analysis will be conducted following Braun and Clarke's (2006) six-phase approach. The initial coding framework is aligned with the study's research questions.

Research Question	Core Theme	Indicative Codes
RQ1	Drivers of Disengagement	Burnout; morale; job dissatisfaction; reduced OCB
RQ2	Leadership & Culture	Leadership style; trust; communication; psychological safety

RQ3	Workload & Capacity	Staffing shortages; workload; work-life balance; fatigue
RQ4	Effective Practices	Best practices; leadership development; support systems