THE EFFECT OF ROLE CLARITY ON THE RELATIONSHIP BETWEEN TRANSFORMATIONAL, TRANSACTIONAL AND LAISSEZ-FAIRE LEADERSHIP STYLES AND COMMITMENT TO SERVICE QUALITY

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ABSTRACT

The effectiveness of leadership style initiatives resulting in sustainable competitive advantage and enhanced commitment to service quality has been a major subject of interest for business and academia alike. past research frequently cites the importance of leadership style (transformational, transactional, and laissez-faire) and commitment to service quality, but only little research has been done to evaluate the linkages between leadership styles and commitment to service quality. Drawing upon cognitive dissonance theory and path goals theory, this study examined the relationship between the transformational, transactional and laissez-faire leadership style and commitment to service quality. This study also examine the moderating effect of role clarity on the relationships between three leadership styles (transformational, transactional, and laissez-faire leadership styles) and commitment to service qualityin public hospitals of Sindh Pakistan. A quantitative research design was adopted to collect data, test hypotheses, and answer the research questions. A cross-sectional survey method was used to conduct this study.Using the multi-stage cluster sampling technique, a total of 315 survey responses were collected from the medical officers working the 43 public hospitals in Sindh, Pakistan. The data was analyzed using SmartPLS 2.0 software. The findings of the study revealed supports for the hypothesized three direct influences of transformational, transactional, and laissez-faire leadership style on the commitment to service quality. While role clarity was found to moderate the relationships of two leadership styles, namely transformational leadership and laissez-faire leadership with commitment to service quality, significant moderating effect was not evident for the association between transactional leadership and commitment to service quality. The present study had also discussed the theoretical and practical implications.

Keywords: Commitment to service quality, Transformational leadership, Transactional leadership and Laissez-faire leadership styles, Role clarity, Hospitals of Sindh Pakistan.

ABSTRAK

.Keberkesanan inisiatif gaya kepimpinan ekoran daripada kelebihan saing mampan dan peningkatan komitment terhadap kualiti perkhidmatan telah menjadi suatu subjek hangat untuk perniagaan dan akademik. Kajian lepas sering merujuk-pakai kepentingan gaya kepimpinan (transformasi, transaksi, dan gaya bebas) dan komitment terhadap kualiti perkhidmatan, tetapi hanya sedikit kajian telah dilakukan untuk menilai perkaitan antara gaya kepimpinan dan komitment terhadap kualiti perkhidmatan. Berasaskan teori percanggahan kognitif dan teori haluan matlamat, kajian ini meneliti hubungan antara gaya kepimpinan transformasi, transaksi, dan gaya bebas dengan komitment terhadap kualiti perkhidmatan. Kajian ini juga mengkaji kesan penyederhanaan ketepatan peranan ke atas hubungan antara tiga gaya kepimpinan (transformasi, transaksi, dan gaya bebas) dengan komitment terhadap kualiti perkhidmatan di hospital-hospital awam Sindh Pakistan. Suatu rekabentuk kuantitatitif telah digunakan untuk mengumpul data, menguji hipotesis, dan menjawab soalan-soalan kajian. Pendekatan survei rentas-seksyen digunakan untuk kajian ini. Dengan menggunakan teknik persampelan kelompok berperingkat, sebanyak 315 respon soal-selidik telah dikumpul daripada pegawai-pegawai perubatan yang berkhidmat di 43 hospital awam di daerah Sindh, Pakistan. Data ini dianalisis dengan menggunakan perisian SmartPLS 2.0.Dapatan-dapatan kajian ini mengemukakan sokongan ke atas tiga kesan langsung yang dihipotesis antara gaya kepimpinan transformasi, transaksi, dan gaya bebas dengan komitment terhadap kualiti perkhidmatan. Sementara ketepatan peranan didapati menyederhana hubungan antara dua gaya kepimpinan, iaitu gaya kepimpinan transformasi dan gaya bebas, dengan komitment terhadap kualiti perkhidmatan, kesan penyederhanaan yang signifikan tidak ditemui untuk hubungan antara gaya kepimpinan transaksi dengan komitment terhadap kualiti perkhidmatan. Kajian ini turut membincangkan implikasi-implikasi teoritikal dan praktikal.

Kata-kata kunci:

komitmen kepada kualiti perkhidmatan, Gaya kepimpinantransformasi, Gaya kepimpinantransaksi, Gaya kepimpinanbebas, Ketepatanperanan, Hospital-hospital di Sindh Pakistan

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LIST OF ABBREVIATIONS

AVE	Average Variance Extracted
CSQ	Commitment to service quality
CR	Composite Reliability
CMV	Common Method Variance
COB	College of business
CUSTOMER	Patient
f^2	Effect Size
FATA	Federal Administered Tribal Area
LFLS	Laissez-fair leadership
Medical officer	Doctor
PIMS	Pakistan Institute of Medical Sciences
PK	Pakistan
PhD	Doctor of Philosophy
PLS	Partial Least Squares
Q^2	Construct Cross validated Redundancy
R^2	R-Square
SEM	Structural Equation Modeling
TSL	Transformational Leadership
TS	Transactional Leadership

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

At present, service organizations are undergoing the process of improvising their service features in order to offer optimum value to their customers (Peccei & Rosenthal, 1997). Organization‟s main focus has remained over delivering high quality services to fully satisfy customer needs and create good will (Punnakitikashem, Buavaraporn, Maluesri & Leelartapin, 2012; Irfan, Ijaz, & Awan, 2012). Similarly, according to Torres and Guo (2004), the central objective of service based organizations is meeting or even exceeding customer satisfaction. In this connection, Reichheld and Sasser (1989) forwarded that service based organizations could only survive in the competitive markets today through pay attention to their fundamental strategies for promoting service quality. Worldwide customers‟ demand is increasing day to day therefore it brings a higher expectation for the quality of service in the markets (Irfan & Ijaz, 2011).

With respect to this Schneider, White and Paul (1998) suggest that most of the organizations are focusing on the customers‟ perceptions regarding the quality provided in their services. In a service organization, employees‟ behavior is very important related to what the customer needs and wants in the service (Sergeant & Frenlel, 2000; Bitner, Booms & Tetreault, 1990). The biggest issue in the service sector is the attitude of direct service providing employees, who regularly meet their

customers and deliver services to customers (Bowen, Siehl & Schneider, 1989). That attitude and guideline to provide services to customers is referred as commitment to service quality (Peccei & Rosenthal, 1997). Furthermore, the commitment to service quality is deeply rooted into the attitudes and behaviors of employees. Researchers describe that when service is delivered there occurs the interaction between customer and employee, and the behavior of service provider influences on the perception of the services receiver. The service provider employee‟s attitude and behavior influences on the operation of all over services, they are presenting their organization in front of the customer (Hartline & Ferrell, 1996). Employee play very important role in delivering services (Shostack, 1977).

Employee commitment to service quality is essential in service organizations as it positively effects customer perceptions (George & Gronroos, 1989). Similarly, Ellinger *et al*., (2013) argued that employee‟s higher level of commitment provides direction to them for improving on commitment towards service. Researchers have principally agreed that employees‟ commitment leads towards improvements in service quality (Wong & Cheung, 2014). In the similar fashion, Schroder (2008), stated that committed employees are devoted and organized; they work more than what a particular job requires. Also researchers have agreed that committed employee meet and even exceed requirement of service standards (Ghiselli *et al*., 2001; Karatepe *et al*., 2006). This notion is also supported by Varela and Garazo (2006), stating that employees commitment towards service is vital as it affects positively the work and attitude towards work in a service organization.

Past studies have highlighted that organizations loose customer due to their poor service orientation (Schultz, 2002; Boulding et al., 1993; Shaw-Ching, Liu, Sudharshan & Hamer, 2000; Zeithaml, Berry & Parasuraman, 1996). Further adding these scholars have also claimed that many organizations does not pay due attention to their human resources directly responsible for service provision to their valued customers. Additionally these scholars have also argued that commitment to service quality is a current challenge for service-based organizations.

More importantly, the increasing educational and technological trends have broadened the customer choices and expectations, ultimately creating a more challenging environment for service based organizations (Saeed *et al*., 2013). The competition in the service industry is increasing day to day due to the incorporation of modern management philosophies and practices. Similar like others, the health sector is also experiencing a fast change in the service orientation and customer expectations due to increased awareness (Saeed *et al*., 2013). The customers are more concerned about their health and this makes them more cautious about quality of services provided to them (Saeed *et al*., 2013). Thus health sector needs to pay more attention on the quality of service delivery to their customers.

As the competitiveness of healthcare sector has been high recently, therefore, customers‟ perception and expectations have become the key indicator in order to measure the service quality in health organization (Irfan & Ijaz, 2011; Cronin & Taylor, 1992). Therefore, service quality delivered to customers should be able to meet or exceed customer‟s perceptions and expectations (Parasuraman, Zeithaml &

Berry, 1985; Zeithaml, Berry & Parasuraman, 1993). Also it is essential for organizations to meet customer satisfaction and expectations through investing in long term customer relationship to gain sustainable advantage (Fornell, 1992; Storbacka, Strandvik & Gronroos, 1994). Similar to the global challenges with regards to commitment to service quality, the health sector of Pakistan is also experiencing service quality delivery issues. Specifically, Irfan and Ijaz (2011) and Mustaq *et al*., (2012) have recommended to organizations and scholars to pay more attention towards commitment to service quality in the health sector of Pakistan.

Apart from that, the constitution of Islamic Republic of Pakistan has assured that the health sector should provide high quality services to customers. According to Irfan and Ijaz (2011) the federal and provincial governments are responsible for all actions about providing health facilities and developing long term health policies to provide improved services, but public hospitals have failed to meet the quality as per expectations.

Convincingly, the health sector is more important in every country, as it maintains the human capital to accomplish national aims (Jabnoun & Chaker, 2003). On the contrary, researchers have evidently reported that the medical officer of the public hospital of Pakistan avoids taking responsibility in providing better service quality to save customer lives. Moreover, according to Mushtaq, Mirza and Asghar (2012) the health facilities that have been provided by public hospitals in Pakistan does-not match with the customers‟ expectations and needs. Conclusively, the above evidence

suggests that the health sector of Pakistan needs a rapid change to ensure quality services to customers as per their expectations.

In summary, the committed employees deliver service to customers that help in satisfying needs and want. That is why this study focuses on employee commitment to service quality in health sector in Pakistan.

1.1.1 Pakistan Health System

Pakistan has four provinces namely Sindh, Khyber Pakhtunkhawa, Baluchistan and Punjab. It also consists of other Federal Administered Tribal Area (FATA), Azad and Jammu Kashmir and North Area. Every province is divided in different number of Divisions. Every division has Districts and the Districts are further divided into Tahsils and Union Councils. According to Ministry of Health (1991), the Union Council (a body of people in lower level) is the bottom level of administration which comprises of ten (10) villages.

Public health sector is managed by the provincial health department and it consists of teaching hospitals, medical colleges, registered hospitals, units, and specialized hospitals (Ministry of Health, 1991). The health services at the District level facilities are there. Each district has a big district government hospital, which provides health services to people. In district Tehsil hospitals, Units of health care also provide health services (Ministry of Health, 1991).

Therefore, the Pakistan government puts efforts to introduce new administrative and financial legitimacy with the cooperation of WHO called district health management model (Tarimo, 1991). On August 2001, Pakistan government decided to introduce a new decentralization plan reorganizing districts, local health system of a country under the administrative authority of the district. Government of Pakistan took initiative as promises made already, to strengthen the health system and also considered local accountability about health service delivery in the district in all provinces. Table 1.1 explains the overall health system of Pakistan which consist on the 1207 public hospitals, 5382 dispensaries, 5404 basic health units and 696 maternity and child health care system.

Table 1.1

Overall health sectors in Pakistan

Public hospital	**Dispensaries**	**Basic health units**	**Maternity and child health care**
1207	5382	5404	696

Source: Economic Survey of Pakistan 2015

It is essential to pay attention towards the health sector of Pakistan as recent research has pointed out an urgent need to investigate the lack of service orientation and professionalism in the public hospitals specifically (Mumtaz, Levay, Bhatti & Salway, 2013). In this regards, studies have confirmed that public hospitals provide poor health services to customer in Pakistan and private sector highly dominates the public hospitals due to better services delivery (Mumtaz, Levay, Bhatti & Salway, 2013). In order to further understand the poor quality services in the health sector of Pakistan, the present study draws upon the work of Meghani, Sehar and Punjani

(2014) that compared the service quality provided in Pakistan and China‟s public hospitals. The results of this study revealed that Pakistan public hospital provides less satisfactory services to customer. Surprisingly, only 20% to 30% population of country avail health services from public hospitals (Meghani et al., 2014).

Specifically, recent studies have highlighted that the province of Sindh, Pakistan reports relatively higher level of dissatisfaction among the customers of public sector hospitals (Aijaz *et al*., 2013). These and other studies are highlighted a higher concern regarding lack of professional attitude of employees working in these hospitals and lack of their utmost commitment towards providing service (Mumtaz *et al*., 2013; Meghani *et al.,* 2014). Studies have suggested that this concern related to medical officer in the hospitals has remained a matter of concern through the country (Mumtaz et al., 2013; Meghani *et al.,* 2014; Aijaz *et al*., 2013; Mushtaq *et al*., 2012). Hence, these and other researchers have collectively encouraged further research in this domain.

The provincial health departments have been reported into very bad position, as these departments do not provide any clear picture about functions and responsibilities of the department and their employees. It has been noted that these departments have largely relied on short term plans and failed in providing standardized polices, regulation, procedure and documentations (Abdullah & Shaw, 2007).

Further stating, Abdullah and Shaw (2007) reported that the National Reconstruction Bureau (the founder of this policy) and the Provincial Health Departments are still

not having a clear picture on their exact functions and responsibilities as there is no standardized policies, procedures and regulations and they also lack proper documentations. Additionally, due to conflicts between health departments, polices units, resources and finance departments all are losing control (Abdullah & Shaw, 2007) and they fail to meet customer satisfaction. In order to prevent societies from common and deadly diseases, it is very important for hospitals to develop human capital.

As health care is one of the basic needs for human therefore the state must provide health care facilities at minimum cost, easily assessable with appropriate services (Irfan, Ijaz, & Farooq, 2012). Usually, a developing country is always categorized as having low grade of public sector hospitals, for example, having lower productivity, inefficient management resources, and unfriendly behavior of medical officer, rigid structure, unprofessional customer services, ineffective management and low performance (Saleem, Saeed, Ahmad & Ch, 2013). Similarly to this, researchers have indicated that Pakistan public hospitals also face the same issues.

Apart from that, it is commonly believed that public sector hospitals provide poor services; they have mismanaged and politicized units (Punnakitikashem *et al*., 2012). Therefore, low confidence and distrust in government hospitals is there due to their low quality services delivery, as they lack responsiveness, less of staff commitment. These kinds of issues usually lead to overcrowding and hence a sharp decline of result in the quality of services occurred in Pakistan hospitals (Abro & Jalbani, 2013;

Mushtaq, *et al.*, 2012). Saeed *et al.,* (2013) claim that hospitals‟ customer has a negative perception about public hospitals and service providers.

Certainly, Pakistan is a developing economy, there are 188,144,040 people in this country and sadly, the healthcare facilities provided are not enough to meet the requirements of its citizens and also less commitment of medical officer increase the issues of service delivery. According to Mushtaq *et al.,* (2012) there is no effort taken place for improving the level of service and quality of public hospitals in the Pakistan. Same results are revealed by another study conducted in public hospitals suggesting that poor service quality is delivered to the customer by medical officer (Meghani, Sehar, & Punjani, 2014; Aijaz *et al*., 2013). Furthermore, less information is provided by medical officer of hospital to customer (Mahar, Kumar, Rizvi, Bahalkani, Haq & Soomro, 2012). In short, the above studies clearly indicate that the medical officer of Pakistan‟s public hospitals is not willing to deliver services to customers.

1.1.2 Empirical Studies in Pakistan's Hospitals

Different studies have been conducted on the level of services provided in the Pakistan‟s hospitals (Khan, Iqbal & Waseem, 2012; Saifulsyahira, Juni & Salmiah, 2015; Stewart, *et al*., 2015; Yasin & Anjum, 2015; Shahnaz, Jan, Lakhani & Sikandar,2015; Dey & Filieri, 2015). These studies have raised issues pertaining to the service quality in the public hospitals in Pakistan. But most of these studies have highlighted customer perception with regards to hospitals management. There have

been no or at least lack of research highlighting commitment to service quality. The research conducted over the hospitals in Pakistan have emphasized on differing perspectives for example Irshad, Hashmi, Hassan, Zahid, and Hassan (2013) declared that customers‟ perception of service quality does bring an impact over the profitability of an organization. Aijaz *et al*., (2013) have revealed that customers are satisfied with regards to time provision of public hospitals. Additionally, to better understand about customer satisfaction Mukhtar, Saeed and Ata (2013) conducted a survey of dental hospitals with regards to service quality the resulted reported a gap between customer expectations and their perceptions. This survey has further reported that the customers ranked service quality at an average level. In suggesting a solution, Mattoo, Rehman and Rashid (2013) suggested that usage of information technology could help the medical professionals in improving customer‟s perception with regards to service quality.

Besides this prior literature, studies have reportedly worked on public sector hospitals in Pakistan through focusing on aspects including job satisfaction, customer satisfaction, quality, training, behavioral prospects and aspects of autonomy (Abdullah & Shaw, 2007; Ali & Wajidi, 2013; Khan Shaikh, Ahmed, Zafar, Tahir & Shaikh, 2014; Zaidi, Mayhew, Cleland & Green, 2012; Razzak, Ahmed, Saleem & 2009; Saeed, et al., 2013).

Furthermore, scholars have also attempted to examine patient care aspects including health care delivery, role of HR practices towards patient care and contemporary

health issues (Ali, 2009; Khan, Ahmad, Aleem, & Hamed, 2011; Saeed & Ibrahim, 2005).

Despite of these evidences, there have been no or at least lack of research over the importance of commitment to service quality in public hospitals in Pakistan. The present would be amongst the earliest ones highlighting the crucial nature of commitment to service quality. There has been a lack of research pertaining to commitment to service quality and this issue is even more complicated. Accordingly, PIMS report of August 2013, suggested that medical officer neglects to deliver appropriate service to customers, reported further added the death of one person due to unavailability of medical officer in a public hospital in Pakistan. Hyder (2013) reported in one of the leading English newspaper of Pakistan, (the Dawn, June 29, 2013) that women lost her life in a public hospital due to carelessness of medical officer. Further adding, the report mentioned that the doctors in public hospitals always try to earn more money by engaging themselves in private hospitals and therefore remain absent from their duties. In addition to this, another news report published in Dawn newspaper (December 13, 2013) reported that PMDC suspended many doctors form duties due to their negligence in delivering in responding to patients (customers). Surprisingly, the Bureau of Emigration and Overseas Employment (2008) reported that around 1150 medical doctors leave country every year to service in other countries.

The above facts point towards an urgent need to look into the causes that hinder medical officer in delivering appropriate services required. One of the concerns, in

this relation is the lack of medical officer‟s commitment towards service quality. The empirical studies discussed below have suggested that the medical officer of public hospitals is not committed towards providing service quality. For example, Irfan *et al*., (2012) reported that medical was not found active in providing better services to customers. Similarly, Naz, (2012) reported that the medical officer of public hospitals neglects to attend customers with better attention. Adding further, Naz described that even medical officer‟s behavior has been reported very harsh with the customers.

Above all, medical officer is very important as it directly deals with the customers and their interaction drives customers perception of service quality. Therefore, the attitude of medical officer should be courteous, polite, caring as well as emphatic (Saeed et al., 2013). There is an enormous evidence in the literature that commitment to service quality is vital in bringing excellent service quality (Elmadag, Ellinger & Franke, 2008; Clark, Hartline & Jones, 2009; Hartline, Maxham & McKee, 2000; Babakus, Yavas, Karatepe, & Avci, 2003; Hashim, & Mahmood, 2011). These studies supported that commitment to service quality is most important in the service sector.

Accordingly, there were many studies conducted in order to assess the perceptions of customers on the service quality performance in the hospitals of Pakistan (Shabbir, Kaufmann & Shehzad, 2010; Mushtaq *et al*., 2012; Mir & Gull 2012; Gull & Iftikhar 2012; Shaikh, Haran, & Hatcher, 2008; Sadiq, 2003). Besides that, Hasin (2011); Sabita (2013) and Vandamme and Leunis (1993) emphasized that a plethora of

literatures was also pragmatic in the other portions of the globe that concentrated on the perception of service quality in hospitals. The researchers are mostly more focused on the service quality in hospitals by studying about the customers‟ perspective on the reasons of dissatisfactions of the customer with the service provided to them. Apart from that, Ramez *et al*., (2012) studied the relation between service quality dimensions and the overall customer' satisfaction and also analyzed the behavioral intention of customers in their study. Yogesh and Satyanarayana (2012) also proposed a conceptual model to measure the customer perceived service quality in health care where it should be treated as a business. Based on these studies conducted, there were various views regarding the context and setting of the service quality problems, but none of them had clearly explored the state of commitment of the hospital‟s medical officer to service quality. Similarly, researchers have agreeably pointed out that commitment to service quality is one of the essential elements, where service organizations should pay more attention (Bowen, Siehl & Schneider, 1989; Peccei & Rosenthal, 1997; Clark *et al*., 2009; Hashim & Mahmood, 2011).

Therefore, it is not sufficient to measure service quality with the perspective of customers alone whereby research efforts should also focus on the state of the hospital medical officer commitment to service quality which needs more attention. Sahney, Banwet and Karunes (2004) supported this claiming that commitment to service quality by internal customers is a precondition to customer orientation and satisfaction of the external customer. Therefore, it is crucial to conduct specific

studies regarding current state of commitment of hospital‟s medical officer in order to ensure a better service quality.

In the other service industry, commitment to service quality is also limited only to the management level analysis as what had been revealed by past studies (Hartline & Ferell, 1996; Reeves & Hoy, 1993; Hartline, *et al*., 2000; Babakus *et al*., 2003; Subramony, Beehr & Johnson, 2004; Malhotra & Mukherjee, 2004; Murmann, & Perdue, 2012; Ashill, Carruthers & Krisjanous, 2006; Rod, & Ashill, 2010; Barnett, Tavitiyaman & Kim, 2009; Mikic, Little & Dean, 2006; Martin, & Billy, 2015; Lau, 2014; Karatepe, & Karadas, 2012). These studies show that the management is committed to service quality which in turn has brought about positive organizational commitment among the employees. However, none of these studies had specified for the suitable type of leadership style that can be used in order to bring about hospital staffs‟ commitment to service quality. According to Clark *et al*., (2009) and Hashim, and Mahmood (2011, 2012), transformational leadership style has been indicated in the past to have impact for customer contact personnel behavior and commitment to service quality in different service contexts. On the other hand, the other type of leadership style is the transactional leadership which has supported the notion that subordinate perceptions of their leadership, contingency rewards and punishment behavior are likely to be positive in attitude, perception and behavior (Podsakoff, Bommer, Podsakoff, & MacKenzie, 2006). In fact, there is another leadership style called Laissez-faire where leaders who are practicing this kind of leadership are always avoiding themselves to involvement of making decisions, abdicates responsibility (Antonakis, Avolio & Sivasubramaniam, 2003). As a whole,

leadership is the ability to drive or bring the group towards targeted goals successfully and it is one of an organization to practice the best leadership style to have interaction to the staffs of the organization effectively (Chaudhry, & Husnain, 2012). Hashim and Mahmood (2012) concluded that leadership style has a positive effect on staff to increase the commitment of employees in the service sector. Another study conducted in hotel industry using directive, participate and empowering leadership style described that leadership and commitment to service quality has negative relationship (Clark et al., 2009). Role clarity provides way how to complete a job and give the best and quick service to the customer (Kelly & Hise, 1980). During service delivery to a customer, employee must have a clear role and will not depend on the supervisor's advice to transform service (Suan & Nasurdin, 2013). Terje, Göran and Sander (2011) state that employee who lack role clarity is likely to provide less service and have a negative effect on customer service. Role clarity is more important for service employees to transfer services to customers and also commitment of employees (Clark *et al*., 2009). It‟s more important for hospital‟s medical officer to have clear role because staff most of the time provide service in an emergency so need more empirical study on hospital medical officer and commitment to service quality in the Pakistani context.

1.2 Problem Statement

Nowadays customer is very conscious about services in the health organization and day by day customers need better and quick services with accuracy in the health care organizations (Mushtaq *et al*., 2012). The medical officer of public hospitals working

under government of Pakistan is responsible to provide prompt services to their customer (Ministry of Health, 2015). Role and responsibility of medical officer in promoting the organizational service to their customer is important, but medical officer of the public hospitals of Pakistan are not willing to provide service to customer and taking pain to face his/her or individual cares about the customer and medical officer show low responsibility and less commitment to provide service to the customer (Irfan & Ijaz, 2011).

More ever recently, study reported that there is less response from medical officer concerned about services and they avoid providing quick service to customers (Nisa, Sadaf & Zahid, 2012). Furthermore empirical study indicating commitment of medical officer in health sector of Pakistan revealed that the medical officer of public hospital show harsh attitude towards customers and less commitment (Naz *et al*., 2012). Medical officer does not treat well to their customers and avoid to delivering appropriate services to them (Ahmad *et al*., 2013). In addition to these evidences, the past research regarding services provided by the medical officer in public hospitals in Pakistan suggest medical officer had lack of commitment towards providing quality services (Irfan *et al*, 2012; Abro & Jalbani, 2012). According to Mushtaq *et al*., (2012) reported a gap and mismatch between customer‟s expectation and the level of service provided by medical officers of public hospital in Pakistan. Abro and Jalbani, (2012) and Khattak et al., (2012) stated that the public hospitals are losing their customers due to the low standard of delivery of service by medical officers. Most of customers were dissatisfied with the attitudes of medical officer in public hospital of Pakistan (Hamad, 2015). Prior studies clearly defined that medical

officer was not committed to provide the service to customers in public hospitals of Sindh, Pakistan.

In supporting this notion, Mushtaq *et al*., (2012) reported in their survey that 55.9% of the population was not willing to recommend their peers or others for getting treatments from medical officers of public hospital. This shows that 55.9% of the population in the given survey does not feel good about services provided by the medical officers. Additionally, 68.1% of the survey participants have negative perception about medical officers. In addition to this, Social Living Standard in Pakistan survey (2010-11) reported that 71% people do not prefer to take medical service from medical officer in public hospital of Sindh Pakistan. Similarly, Meghani *et al*., (2014), reported that only 20 to 30 percent customers are availing health services from medical officers of public hospitals in Pakistan. Furthermore, survey participants were of the opinion that medical officer does not deliver appropriate services to customers (Ahmed *et al*., 2013). Ahmad *et al*., (2013), reported that the common customers are not treated and examined well by the medical officer.

These survey reports provide sufficient evidence that the medical officer in the public hospitals of Pakistan is not committed to deliver quality service. Hence it calls for further research to suggest effective solutions to the public hospitals top management and to health ministry as a whole. This also has highlighted that commitment to service quality is a major concern in the public hospitals of Pakistan.

Very little is known in the research domain concerning to commitment to service quality regardless of its importance and promising outcomes. There are major concerns on commitment to service quality of medical officers in public hospitals of Pakistan that seemed empirically unattended. Particularly in the hospital sector, lack of focus and importance on the need of commitment towards service quality has been evidently reported amongst the medical officers (Irfan & Ijaz 2011; Natalisa & Subroto, 2003).

According to Peccei and Rosenthal (1997) attention has not been paid to employees‟ commitment to service quality, especially in the service industry, particularly when the concern is on continuous improvement in meeting customer expectations (Worsfold, 1999; Hartline *et al*., 2000). Moreover, the research focus has been very limited on commitment to service quality. There is only little evidence in the education and hotel industry (Clark *et al*., 2009; Hashim & Mahmood, 2011, 2012). Researchers have ignored the other potential service based industries. Particularly, in this notion very limited empirical evidence is available with regards to investigation of commitment to service quality in the hospital sector. For example, the research focus of Hashim and Mahmood (2012) was centered on educational sector, whereby these scholars have recommended a further investigation of commitment to service quality in the hospital sector. In another study Ellinger *et al*., (2013) also recommended that commitment to service quality will affect perceptions in service sector. Similarly, recommendations are there to study the commitment to service in other occupation (Sun, Hsu, & Wang 2012).

Since leadership roles have the authority to formulate goals, direct individuals and ensure continued provision of resources; there seemed a possibility that leadership mechanism could facilitate commitment to service quality (Hartline et al., 2000; Natalisa & Subroto 2003; Clark et al., 2009; Hashim & Mahmood, 2012). The leadership literature in the past has also associated transformation, transactional and laissez-faire leaders to commitment for service quality delivery (Avolio, Bass, & Jung, 1999; Northouse, 2010; Jabnoun & Rasasi, 2005). These studies have comprehensively evaluated the link between leadership styles and commitment. (Hamdi & Rajablu, 2012; Majoka, 2011; Sawati, Anwar, Majoka, 2011; Liao & Chuang, 2007). In addition, Clark *et al*., (2009) conducted a study on leadership styles and commitment to service quality. The empirical result of their study indicated that there is negative relationship between leadership styles and commitment to service quality. Another study conducted by Hashim and Mahmood, (2012,2011) on the relationship between leadership style and commitment to service quality revealed a positive relationship among leadership style and commitment to service quality.

Due to these inconsistent results between leadership style and commitment to service quality, the present study proposed the further investigation of this relationship in the health sector of Pakistan. Further, following Nawaz and Bodla (2010), Hashim and Mahmood, (2012) and Sun *et al.,* (2012), the present study proposed further investigation of the leadership styles and commitment to service quality. In addition to this, the present study proposed role clarity as a moderating variable on the relationship between leadership styles and commitment to service quality due to

inconsistent relationships. The assertion of proposed moderating variable on the inconsistent relationship is in line with recommendations of Barron and Kenny, (1986).

In addition to this, role clarity is necessary for services of staff looking for supervisory guidance. Mukherjee and Malhotra (2006) also argued that the role clarity is most important variable in the service sector, which has positive effect on employees in the service sector. According to, House, (1971) role clarity is an essential variable that could potentially influence leader and subordinate commitment. However, they further added, there is need for further investigation of this relationship. Furthermore role clarity has a positive influence on commitment to service quality (Clark *et al*., 2009).

Taken together, first the investigation of the commitment to service quality and leadership styles has been very limited. Second, the investigation has solely been made in the developing countries contexts. Third, this relationship is still reported with inconsistent findings. Fourth, the investigation with regards to hospital settings has been recommended in the past. Lastly, there have been no or at least very limited investigation of the proposed relationship in the public hospitals in Pakistan. Therefore, the present study proposed the investigation of the moderating role of role-clarity on the relationship between leadership styles (specifically transactional, transformational, laissez-faire leadership styles) and commitment to service quality.

1.3 Research Questions

On the basis of problem stated above, the present study seeks to address the following research questions:

I. Does transformational leadership influence commitment to service quality?

II. Does transactional leadership influence commitment to service quality?

III. Does laissez-faire leadership influence commitment to service quality?

IV. Does role clarity moderate the relationship between transformational leadership and commitment to service quality?

V. Does role clarity moderate the relationship between transactional leadership and commitment to service quality?

VI. Does role clarity moderate the relationship between laissez-faire and commitment to service quality?

1.4 Research Objectives

In line with the above research questions, this study is to examine the effects transformational, transactional and laissez-faire leadership style on the commitment to service quality the objectives of the study are:

I. To examine the relationship between transformational leadership style and commitment to service quality.

II. To examine the relationship between transactional leadership style and commitment to service quality.

III. To examine the relationship between laissez-faire leadership style and commitment to service quality.

IV. To examine the moderating role of role clarity on the relationship between transformation leadership style and commitment to service quality.

V. To examine the moderating role of role clarity on the relationship between transactional leadership style and commitment to service quality.

VI. To examine the moderating role of role clarity on the relationship between laissez-faire leadership style and commitment to service quality.

1.5 Scope of Study

This study investigated relationship between leadership styles and commitment to service quality in the presence of the moderating effect of role-clarity. Based on practical issues in public hospitals of Sindh Pakistan the present study"s main focus was public health sector due to the fact that the past literature has paid less attention on the public sector of Pakistan.

This study focused specifically on medical officer (doctors) commitment to service quality and perception about their leader in the hospitals of Pakistan. The present study employed quantitative cross sectional study and the unit of analysis for the present was medical officer (doctor).

The research model of this study was developed on the basis of the support from the literature. The details pertaining to research framework and hypotheses development process are further explained in detail in Chapter 3.

1.6 Significance of Study

The findings of this study has contribution for researchers, scholars, practitioners and also organizations as its value comes from the expansion of the existing literature related to theory of Festinger"s cognitive dissonance (1957) and path goals (House, 1971) by examining the relationship between leadership styles and commitment to service quality in the presence of role clarity as a moderating variable. From the theoretical point view, findings of the present study offer empirical evidence that leadership styles influences commitment to service quality with the moderating effect of role clarity, thus enriching the existing literature. However, this interdisciplinary study is also able to contribute significantly to the existing body of the knowledge related to the influence of leadership style on commitment to service quality. Therefore, further paragraphs will discuss more on the originality and theoretical and practical value of this study.

There was of course lack of research regarding the literature on the relationship between leadership style and commitment to service quality. Therefore, there is still a huge gap where less attention has been paid. Hence this study is being conducted in the health sector and in the perspectives of medical officer in Pakistan to contribute in the body of knowledge and to further fill the gap between leadership style and commitment to service quality relationship by incorporating role clarity. The variables considered in this study have been used in different fields of research with different models as well as with different theories (Clark *et al.,* 2009, Hashim & Mahimood, 2012). Therefore, study suggested that to investigate the relationship

between leadership style and commitment to the service quality in the health sector to come up with the suggestions that can be helpful in improving the commitment of medical officer to improve service quality. Furthermore, this study also contributes in the literature by presenting empirical findings on role clarity as moderating variable on the relationship between leadership styles and commitment to service quality. This study would be helpful to management of public hospital of Pakistan in understanding how leaders could influence medical officer toward commitment to service quality.

The moderating influence of role clarity on relationship of transformational, transactional, laissez-faire leadership styles and commitment to service quality was investigated in the light of path goal theory (House, 1971). According to path goal theory (House, 1971) role clarity is most significant for leaders and subordinates. Leaders must clarify the subordinate‟s goals. Present study provided evidence that the role clarity is most important for staff to influence commitment to service quality.

Literature had attempted studies about the influence of leadership style on employees‟ commitment to service quality but results of studies were inconsistent (Hayward, Goss, Tolmay, 2004; Lo, Ramayah, & Min, 2009; Ramachandran, & Krishnan, 2009; Chandna, & Krishnan, 2009; Hahim & Mahmmod 2012; 2011; Pahi & Hamid, 2015; Emery & Barker, 2007; Erkutlu, 2006; Barnett, Mccormick, & Conners, 200; Liao & Chuang, 2007). Apart from that, on the basis of previous literature there is still need to examine empirically the level of transformational, transactional and laissez-faire leadership styles that have effect on commitment to

service quality. The literature has also provided support for the investigation of the moderating influence of role clarity on the relationship between leadership styles and commitment to service quality. Present study attempted to fill the literature gap by incorporating role clarity. It provides sufficient the evidence that role clarity is most important for medical officer it has high level influence on commitment to service quality. The medical officer‟s commitment to service quality is necessary for providing appropriate service to the customers and to attend organizational overall goals.

Moreover, this study attempted to examine the postulated relationship in the context of service organization, especially in the health sector. Reviews conducted of past studies suggest that most of the studies regarding commitment to service quality were conducted in developed countries whereas there were only few studies that have been conducted in developing countries. Therefore, this study will provide basic evidence for future research on how leadership styles and commitment to service quality could help in providing better service to customers.

Furthermore, this study is significant to the practitioner as it has emphasized on the role of leadership style and commitment to service quality in increasing the performance of medical officer in the organization. In addition, this study has helped in providing guidance for medical officers to understand role of jobs through high service to customer. This study has also helped in scientifically confirming the importance and dire need for Pakistan‟s health sector to exercise and focus on nurturing leadership styles and commitment to service quality.

This study clearly describes that leaders can exercise behaviors like direction, communication, motivation, feedback, rewards, role clarity, and freedom which would ultimately lead them to enhance medical officer‟s commitment to service quality. The leader of a hospital should know how to clear the goal of medical officers and motivate them to commit to service quality.

Next, policy-makers would get the advantage from the significant value of this study as it has clearly emphasized over the crucial influence of role clarity and leadership styles in advancing commitment to service quality with regards to service sector and particularly in hospital sector. Policy makers may utilize the findings to understand which leadership style is appropriate across various work scenarios in connection to medical officers in the public sector hospitals of Pakistan.

Moreover, this study would help the management of an organization, especially for the leaders and policy makers of the public health sector as they get to know better information and further understanding about the contributions and support of their hospital staff to deliver better service through the commitment to service quality. Besides that, this can ensure that the hospital‟s reputation will be enhanced due to high service delivery and attracting customers and satisfaction.

The main advantage of this study for the health sector of Pakistan from this study is that it can assist the administrators and policy makers of the health sector to optimize the allocation of the best facilities and resources in the training and hiring of their

future leaders so that it can enhance the quality of service given to customers. Moreover, it can increase the competitive edge over the other competitors and contribute to its success in building a market niche. Besides that, this study also would help the hospital‟s management to build up their confidence, especially when their reputation begins to soar.

In terms of the economic prosperity, bringing better service standards in public sector hospitals would help in enhancing the quality of patient care. This in parallel would also enable the hospitals` management authorities to operate efficiently hence, saving cost and other related resources. In a nutshell, this study may lead hospitals to have financial stability resulting in the long term survival.

1.7 Operational Definitions

There are five variables contained in the theoretical framework, identified on the basis of past literatures. The definitions are as follows:

1.7.1 Commitment to service quality

Commitment to service quality can be defined as the willingness or dedication of hotel staff in trying to provide the best service more than what had been expected from them in achieving excellence in the service quality by satisfying the needs of customers (Clark *et al.,* 2009).

1.7.2 Transformational leadership

Transformational leadership emphasizes emotions and gives appropriate importance to them; it also encourages creativity in employees and subordinates. Hence, this leadership-facet attempts to create emotional relationship with subordinates to motivate, encourage, and provide direction to them and encourage subordinates to higher performance (Bass & Avolio, 2000a; Bass, 1999; García-Morales, *et al*, 2008).

1.7.3 Transactional leadership

According to Burn, (1978), transactional leadership is the one who the leader who approaches subordinates for an exchange. Further stating Burns, stated that this leadership process is based on the exchange process between leaders and subordinates. This style encourages employees by fascinating them with rewards against performance (Den Hartog, Muijen & Koopman, 1997; Berson & Linton, 2005). Moreover, in rewarding his or her followers, the leader will depend on an extensive monitoring performance system (Bass, 1990; Antonakis *et al*., 2003; Kirkbride, 2006).

1.7.4 Laissez-faire leadership

The laissez-faire leadership style is also known as the "hands-off˙ style. The laissez-faire leader avoids accepting responsibilities, is absent when needed, fails to follow up on requests for assistance, and resists Proceedings of the expressing his or her views on important issues (Bass 1985; Northouse, 2001).

1.7.5 Role Clarity

Service provider staff performance needs role clarity which requires to know that how they perform their job with efficiency (Bush & Busch, 1981; Teas, Wacker, & Hughes 1979). Role clarity refers to the degree to which employees receive and understand information that is needed for them to perform their jobs well (Rogers, Clow, & Kash 1994).

1.8 Organization of Thesis

The first chapter provides background information on the subject of the study. The chapter discusses research problem along with objectives of the study. Furthermore, the chapter also states the significance and scope of the study followed by definition of key terms. The second chapter reviews previous studies on commitment to service quality whereby, it explains the three leadership styles namely, transformational, transactional, and laissez-faire leadership styles. Furthermore, the chapter highlights role clarity as a potential moderator. Accordingly, chapter three discusses research methodology in detail including research design, conceptual framework, underpinning theory, hypotheses, and scales used for measurement. The chapter also discusses population, sampling and unit of analysis of the current study. Pilot study results and initial screening approaches are also discussed in this chapter. Chapter four explains the data screening, data analysis, and tests of hypothesized relationships. Lastly, chapter five discusses the findings followed by reflection upon the concerned literature on the studied predicting variables. Moreover, the chapter also summarizes the findings and study conclusions followed by recommendations for future researchers.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The core objective of this chapter was to critically review the past literature and theories pertaining to the variables of the present study, path goal theory and cognitive dissonance theory. Particularly, this chapter reviewed the concepts of transactional leadership, transformational leadership, laissez-faire leadership, role clarity and commitment to service quality. Subsequently, the studies that evaluated the relationships pertaining to criterion, moderating and predictor constructs were reviewed for developing the research model.

2.1 Concept of Commitment to Service Quality (CSQ)

The concept of commitment to service quality came from two perspectives, organization commitment and service quality. Both areas are related with commitment to service quality. Past researchers have described that commitment to service quality has been conceptualized from commitment of organizational literatures (Porter, Steers, & Boulian, 1973). Their study was generally based on the assumption that organizational commitment is the root to the individual‟s attitude in an organization. This links to the definition of attitude by Tosi and Mero (2003), which reflects a person‟s like and dislikes towards other persons‟ events and activities in their surroundings. The authors have agreed that attitude; especially

regarding one`s work cannot be conveniently altered due to the fact that they are principally connected with many events. However, the attitude is still changeable if condition changes. According to Davis and Newstrom (1989), attitude is defined as feelings and beliefs which chiefly determine on how the workers view their own surroundings. According to them, it is more an individual view point regarding something.

In any organization, commitment of employees is very important during service delivery. Porter *et al*., (1974) has categorized organizational commitment to three factors: i) firm belief in the acceptance of organizational goals and values; ii) readiness to give effort in work for the organization; and iii) definite desire to maintain organizational membership. Their initial study focused on the aspects of organizational commitment given by psychiatric technician trainees‟ in relation to the aspect of their behavior where they were to decide whether to stay or exit from the training course. The study found that commitment seems to play the most promising role in decision making particularly when it comes to staying or leaving the work. Since then, commitment theory has been given a good support from various contexts, jobs, work teams, programs and also organization (Kroth, 2007).

Meyer and Allen (1991) have worked on theorizing a more comprehensive conceptual model for organizational commitment. Their model has received a good support over the past two decades in different domains, perspectives, and settings (Kroth, 2007). Their work has also forwarded three dimensions of organizational commitment which includes affective commitment which dnotes to the emotional

inclination of an employee towards the work or job. The second type of commitment is consinuance commitment which refers to identification and engagement with the organization. Lastly, normative commitment refers to sense of belonging that pushes an employee to remain in the organization.

In addition, they had claimed that organizational commitment refers to mindset that connects employee with a certain course of action. The commitment may result differently for example, the decision of staying or leaving the organization (Herscovitch & Meyer, 2002). Singh (2007) has suggested that the concept forwarded by Mayer and Allen (1999) is realistic and accuate due to the fact that it takes both, individual attitude and how it links with his/her behavior into account. Studies (Wong, Ngo, & Wong, 2002; Malhorta & Mukherjee, 2004; Suliman, 2001; Emery & Baker, 2007; Clark *et al.,* 2009; Wallace, de Chernatony & Buil, 2013; Yee, Lee, Yueng & Cheng 2013; Dhar, 2015) have highlighted that affective commitment has received better support as it has been inferred to having the same effect as commitment to service quality. Therefore, it is related to "desire" or "emotional attachment" of the employees to their organizational goal in providing the best quality service for effective attainment of customers‟ expectations. In addition, commitment of hospitals` medical officer has to be explained in relation to service quality so that, commitment to service quality in the health setting can be examined.

Therefore, the development of GAP model has been found highly supported in this regard (Parasuraman, Zeithaml & Berry, 1985; Zeithaml, Parasuraman & Berry,

1990). Numerous scholars have adopted this model as it is based on comprehensive service quality literatures. A twenty two (22) item scale which is grouped into five (5) dimensions, namely; tangibility, reliability, responsiveness, assurance and empathy has been developed and validated extensively. In fact, the theory suggests that the relationship between expectation and the outcome of service quality should match as only then, the customers can be satisfied.

Service quality plays the most important role in the service sector. It focuses on the two aspects; customers‟ expectations and service provided by staff of organization (Brady & Cronin, 2001). Employees also play an important role as they are the ones who interact and serve the customers (Sureshchandar *et al*., 2002). Relationship of service quality and employees commitment has been defined by various authors (Zheng, 2009; Dhar, 2011). Success of a service organization relies upon the delivery of high quality service but it also relies on the commitment of employees. When staff members are emotionally attached with their organization, they tend to perform better whilst providing high service quality to customers (Paulin *et al*., 2006). In simple words, commitment of employees renders high service quality (Allen & Grisaffe, 2001). Furthermore, committed employees take extra responsibilities, efforts and strive harder to increase customer satisfaction and deliver high service quality (Dhar, 2015). Therefore, employees` commitment was found to be positively linked with service quality (Gounaris, 2005). Additionally, Malhotra et al., 2013 indicated that limited attention on organization commitment and service quality.

Porter *et al*., (1974, p.603) defined employee commitment as "the strength of an individual‟s identification with and involvement in a particular organization and their willingness to exert more effort to work collaboratively and become members of the organization in order to achieve the organizational goals". In accordance with their work, researchers have studied organizational commitment from different national and international perspectives. For instance, it was found that employees‟ commitment to service quality has a deep impact on the customers‟ satisfaction, (Clark *et al*., 2009) and (Hui, Chui, Yu, Cheng; & Tse, 2007; Hashim & Mahmood, 2012). Furthermore, Wallace *et al*., 2013; Mayer & Allen, 1991) who had defined employee commitment as an employee‟s emotional attachment to, identification with, and involvement in the organization, found it congruent with affective commitment of employees. Meyer and Allen (1991) argued that commitment to service quality and effective commitment of organization has same influences to that of employee emotional attachment, identification and involvement.

Similarly, the studies on commitment to service quality in literatures are parallel to the general definition whereby, according to Schroder (2008) employees who are committed will always work productively and independently whilst exceeding the job requirements. Whereas, and less inclined towards leaving the job. According to Witt and Steward, (1996), Martin (1986) and O‟Neil and Palmer (2004) commitment to service quality is the essential for organizations to achieve excellence in service prospects (Peters & Waterman, 1982). In addition, Ellinger *et al*., (2013) have defined employee‟s commitment as a person who is highly committed to the service quality and able to help fellows in any situation. According to Pahi and Hamid,

(2015) committed employees play vital role in the organization in delivering service beyond requirements. Furthermore, Hashim and Mahmood, (2012) have defined committed staff to be positively influencing upon customers services. Other than that, it is also defined as a concept of building relationships between a customer and the organization (Kandampully, 2002). Even so, Kandampully, argues that a commitment to the delivery of service quality is bounded by time, which can be temporary, permanent, day-by-day, moment-by-moment, between individuals or even between groups. Therefore, the important basis to assess quality is through an individual‟s experience in his or her services which comes from the internal quality service of the internal customers. Kandampully (2002) added that commitment and the willingness to give quality service to customers is a prerequisite in achieving service quality. Hence, it will help organizations to support and develop service employees‟ commitment and service quality (Ellinger, Musgrove,Ellinger, Bachrach, Elmadağ Baş, & Wang 2013).

2.1.1 Defining Commitment to Service Quality

Equally important, commitment was defined in service quality as “employees‟ dedication to bring service quality and ready to give service beyond what expectation‟‟‟(Clark *et al*., 2009, p 216). Peccei and Rosenthal (1997) have explained it as efforts in employees‟ jobs for the benefit of customers through ongoing improvement process. Pahi and Hamid (2015a) found that committed employees provide the best service and strive to reach the expectation of customer in a service organization. Ellinger *et al*., (2013) when employees are highly committed they, tend

to express high commitment towards service direction level going to high commitment towards service and also facilitate others in doing the same. Another research focused on commitment to service quality and concluded that right way to enhance the service delivery through committed employees on service encounter and committed employee provide numerous benefits to an organization (Wong & Cheung, 2014). Accordingly, to Schroder (2008) described that committed employee are devoted with the organization and work more than what is expected out of them.

Its consideration of association between service quality and commitment of employees, it refers to employee response and employee attitude towards the workplace (Grebner, Semmer, Faso, Gut, Kälin, & Elfering, 2003). Employee willingness transforms into commitment which motivates them to perform better with maximum efforts (Malhotra & Mukherjee, 2004; Pahi & Hamid; 2015a). During the critical time service encounter, their willingness of service employee will effect on customer (Zeithaml *et al*., 1990). Research reports (Ghiselli *et al*., 2001; Karatepe *et al*., 2006) have highlighted that committed employees are more effective in meeting service standards and job requirements. González and Garazo (2006) have suggested that service employees are commitment when positive effects of work and service are aligned.

Moreover, Hartline *et al*, (2000); Clark *et al*, (2009) and Elmadag *et al*., (2008) have claimed that committed employees of an organization will always be loyal and are inversely related to turnover. Such employees are known to spend more time and effort to help their organization in achieving goals as well as they put aside their self-

interest to offer greater service (Sohail & Shaikh, 2004; Porter *et al*., 1973; Yiing & Ahmad, 2008; Tsai, 2008). Besides, Rashid, Sambasivan and Johari (2003), added that these employees subscribe themselves to the idea of being a citizen of the organization and remain fully committed to the goals of the organization. In short, based on the various definitions about service quality, it can be deduced that hospital‟s staff commitment to service quality can be referred as dedicated and ready to give beyond than what is expected from them in achieving excellence in service quality by meeting customers‟ satisfaction and needs (Clark *et al*., 2009). Therefore, this definition will be applied throughout this study.

Organizations can be recognized on the basis of their services delivery (Peccei & Rosenthal 1997). In a service organization, employees` behavior is very important and highly related to what customers in terms of service quality (Sergeant & Frenlel, 2000; Bitner, Booms & Tetreault, 1990). Employees in the service sector become more important due to their constant customer interaction (Sun *et al*., 2012). In service organizations issues and concerns of the direct service providing employees should be dealt with great consideration to enable them to provide quality service on daily basis (Bowen & Schneider, 1988). According to Peccei and Rosenthal (1997), employees‟ needs should always be taken into consideration in order to motivate them to provide better service. Attitude and behavior of employee plays an important role in the interaction between employees and customers (Sun et al., 2012). Furthermore, the behavior of service employees also influences on the operation of services and directly influences on the customers (Hartline & Ferrell, 1996) Researcher have empirically approved this notion that employees` behavior is most

important particularly when it comes to service delivery in the service organization (Shostack, 1977; George & Gronroos, 1989).

Most of the service organizations deliver low quality services to customers which are mainly because of lack of employees` commitment (Ellinger et al., 2013). Patawayati, Djumilah, Setiawan and Mintarti Rahayu, (2013) have highlighted that service organizations deliver poor services which leads them to not fulfilling customer expectations. Low service deliveries by employees damages sustainability and image of the organization (Michel & Muter, 2008). Rosenthal, Hill and Peccei, (1997) have also supported the notion that behavior and attitude of front line employees helps in achieving customer satisfaction. Therefore, such behaviors and feelings can significantly help in providing greater service features to customers (Peccei & Rosenthal, 1997). Notably, commitment to service quality has received the less attention from the scholars preiously. Pahi and Hamid (2015) have also indicated that commitment of service quality has remained ignored in the service and commitment literatures. Henceforth, there are very few studies supporting the reaction of employees towards customers. Peccei and Rosenthal (2000) have stated that time of delivery of service as a link with the commitment of employees towards the organization (Shostack, 1977). Employees` commitment and involvement are essential for service organization survival and customer retention (George & Gronroos, 1989). Front line employees understand customer behaviors through which they handle and deliver the services as his/or her (Henning-Thurau & Thurau, 2003). Committed employees have found to be delivering services beyond the organizational expectations.

From previous studies, it has been evident that positive affective organizational commitment has a strong link with effective leaders at the workplace. Affective commitment is defined as the synonym to commitment to service quality, having the same effect (Rowden, 1999; Clark *et al*, 2009; Hashim & Mahmood, 2011). It is also stated that affective commitment can be more crucial compared to job satisfaction in determining the service quality of customer contact employees which are empirically testified by Malhorta and Mukherjee (2004) in their study on banking call centers. Suliman (2001) and Wong *et al*, (2002) claimed that such outcomes can be translated into better customer service delivery and higher productivity.

Furthermore, internal customer commitment is also helpful for gaining competitive advantage especially for service based organizations, according to O‟Neil (2000). This outlined that, when external customers are satisfied, they probably act as a powerful marketing tool, spreading positive word of mouth for the business and its services (Cuthbert, 1996).

Furthermore, internal customers‟ (employees) commitment is also important as a precondition to customer satisfaction, (Sahney, Banwet, & Karunes, 2008). Internal employees represent the organization to customers. Internal employee‟s commitment is very important for organization; nevertheless Worsfold (1999) argued that an employee is necessarily committed to the organization, even though he or she has shown an excellent in the delivery of service quality. This is because employees view task delivery to be similar to job demands for continuous improvements for meeting customer satisfaction. Apart from that, Huang and Hsiao (2007) suggested that

employees‟ commitment to service delivery can be largely influenced through improving working conditions. Peccei and Rosenthal (1997) suggested a model which discusses both employees "willingness" to engage in continuous improvement and the "capacity" of doing so.

Consequently, if the frontline employees perceive that their leaders are focused towards continuous improvements in terms of service quality, they too become more committed to service quality; as study by Hartline et al., (2000) concluded in the hospitality industry. Similarly, Clark *et al*., (2009) studied the same context in order to confirm the statement and insisted that transformational leadership is ideal in managing frontline employee commitment to service quality. The findings have also been supported by Tsai (2008) mentioning that leader should always be concern about their employees‟ needs whilst striving to provide necessary support to help build employees‟ loyalty and commitment in pursuance of customers‟ satisfaction. According to Hashim and Mahmood, (2012) leader has the ability to motivate employees for commitment to service quality.

To test it, majority of the past studies have used the organizational commitment questionnaire (OCQ) developed by Mowday *et al*. (1979). The original scale by Mowday *et al*, (1979) comprised of 15 items, designed to solicit a measure of a degree to which the subjects felt committed to the employing organization. Three dimensions were formed in internalizing the items which are; (i) loyalty towards the organization, (ii) willingness to exert a great deal of effort to achieve organizational

goals, and (iii) the acceptance of organizational values. Internal consistency (coefficient alpha) of the scale in previous studies has been between 0.82 and 0.93.

Later on, the (OCQ) was reworked by Hartline and Ferrell (1996) where they linked their commitment to service quality scale to it for the purpose of examining management level commitment. However, from the fifteen items in the organizational commitment scale, they adapted only nine and used 5-point likert scale whereby 1 referred to "strongly agree" and 5 as "strongly disagree". Based on this, if the score is lower it will be considered that the commitment to service quality is higher. There is an adaptation of this scale in order to assess the internal customers" perspective concerning to their commitment to service quality in the hotel industry which was studied by Clark *et al*., (2009). The scale"s result reliability was reported to be 0.82. Hashim and Mahmood (2012) also used the questionnaire of commitment to service quality in their study on the education sector with 5 with five points likert scale and reported reliability score of 0.841. Similarly, study conducted by the Asgari (2014) also used similar point scale to examine commitment to service quality in the banking sector and reported reliability of 0.90. All these above studies have indicated that commitment to service quality questionnaire is highly reliable in the different research areas. Following the same pattern, the current study has deployed the scale to examine commitment to service quality in the healthcare sector. The literature thus has outlined that service quality has been comprehensively investigated whereas, commitment to service quality has not been investigated particularly in the healthcare sector. More importantly, the state or status of hospital staff"s commitment to service quality or in health sector, especially in relation to

Pakistan hospital has never been revealed examined. Also, none of the past studies investigating leadership and their influence on commitment to service quality have never tested the relationship on individual level of employees.

2.1.2 Worldwide Studies on Commitment to Service Quality

There has been a lack of investigation on commitment to service quality over the globe, more importantly; there have been only a few studies that were conducted in the service sector. Studies are using variable commitment to service quality in service organizations. Ellinger *et al*., (2013) stated that commitment to service quality is an important aspect. Further stating these researchers have elaborated that it is necessary to pay attention towards service provides (employees) and service receivers (customers) while investigating the social capital investment and work related behaviors and attitudes relationship. Furthermore, commitment to service quality explained by Hashim and Mahmood, (2011) that transformational leadership style influence on commitment to service quality in education industry. Clark *et al.,* (2009) conducted research on commitment to service quality by using leadership styles (such as participate, directive and empowering) for further explanation of an understanding on the significant influence of leadership styles over commitment to service quality. Apart from this, another study was conducted by Sun, Hsu, and Wang (2012) over the Starbucks stores in Taiwan; this study examined the relationship between reward system and commitment to service quality. The results of the above study reported positive relationship between reward system and commitment to service quality. Furthermore study conducted on front line employees

in logistics service provider defined different approaches to enhance employee commitment to service quality by using moderator as management to commitment to service quality (Elmadağ, Ellinger & Franke, 2008). Similarly, the investigation of the effectiveness of commitment to service quality in the banking sector was recently conducted by Asgari (2014). Although the research in this domain has been very limited but most of these studies have concluded that commitment to service quality is an important factor. Particularly there has been a lack of investigation of the role of commitment to service quality in health sector. Therefore, the present study has attempted to address this knowledge gap by addressing the commitment to service quality in the health sector of Pakistan.

2.2 Recommendation from Literature for this study

The present study followed recommendations from literature on leadership styles, commitment service quality and role clarity. For instance, Nawaz and Bodla (2010) conducted research on the leadership style in education sector and suggested further investigation of leadership styles in the hospital sector. Similarly, Hashim and Mohmmood (2012) conducted study in education sector and examined leadership style and suggested further investigation in the hospital sector.

Commitment to service quality also received recommendation from literature, Sun *et al*., (2012) conducted study in service sector to examined commitment to service quality as mediating variable with specific occupation and recommended further investigation to different occupation in the service sector. Ellinger *et al*., (2013)

recommended that examine the commitment to service quality with employee‟s perception in the service sector.

In addition to these recommendations from the literature, the scholars have also provided that role clarity has potential to influence commitment to service quality particularly in the service sector (Mukherjee, & Malhotra, 2006). Similarly, Pahi and Hamid, (2015a) have recommended the further investigation of commitment to service quality with leadership styles by incorporating role clarity as a moderating variable.

Furthermore, the incorporation of role clarity as a moderating variable on the relationship between leadership styles and commitment to service quality has also been supported by path-goal theory (House, 1971). Finally, the research on the influence of leadership styles on commitment to service quality has been conducted in the developing countries. There have been no or at least very few studies that have highlighted the influence of leadership style on commitment to service quality. Therefore, the presented study attempted to address this knowledge gap by investigating the influence of leadership styles (transactional, transformational, and laissez-faire) over commitment to service quality with the moderating influence of role-clarity.

2.3 Leadership Styles

Leadership is a practice of social influence in which one person is able to enlist and aid and support of others in the accomplished of a common task (Chemers, 2014).

Leadership is a comprehensive concept, which is composed of the leader‟s personality, the ability to deal with complains, influence on employees, a powerful action or behavior, a capability of persuasion, an centripetal force to achieve goals, a key role in organization development (Hersey & Blanchart & Johnson, 2001). The concept of leadership is defined, according to Hersey and Blanchard (2001), the influence individual or a group in the organization in performing the activities by leaders toward achieving the organizational goals.

Leadership style is one of the most important human resource-related outcomes. It is one of the most studied topics in management and industrial psychology. Although the topic of leadership is contentious, it is still the core issues in organizational research (Hogan & Kaiser, 2005). Leadership Styles reflect the process by which the leader interacts with others to get the job done (Yagambaram, 2012). Leadership style controls interpersonal, reward and punishment that related to employees‟ behavior, motivation and attitude which impacts organizational performance (Puni et al., 2014).

Leadership is one of the most important issues in the management arena. It cannot be denied that the study of leadership is meaningful in the development of organization specifically and society generally. In organization, leaders' role is extremely vital. They confront many difficulties inside their organizations, particularly in developing to become good quality and productive workers. Good quality workers, in this regard, can be a prerequisite in establishing good human capital which will positively contribute to the development and achievement of the organization. Good quality

workers, both in soft and hard skills could easily understand the mission and vision of the organization. Hence, it is easier for the leaders to lead them towards achieving the organization‟s goals.

The capacity of moving the subordinates, empowering them and developing their feeling of responsibility are some of leader‟s key missions (Rukmani, Ramesh, & Jayakrishnan, 2010). Apart from that, in this turbulent situation, ever changing and volatile environment, leadership effectiveness should be a paramount concern by the organization. Competent leader is needed to cope with this uncertainty surrounding in which due to his or her innovativeness and strategic thinking, he or she is able to make an appropriate adjustment or change so that it could suit or meet the requirement of this current surrounding.

Roach and Behling (1984), argue that leadership as the procedure of affecting and arranging employees to achieve organizational objectives. Gerald ,Davis and Michael (2002), leadership is a crucial discussion topic in contemporary society where their power is acknowledged. This is a kind of power enable to leaders to create, think and nurture adaptive organizations.

As indicated by Yukl (1994), the definition of leadership development is a social process. It includes identify leaders, deciding the group and organization's targets, empowering conduct in quest for these destinations, and strong group unity and organization culture (Erkutlu, 2008). Leadership can be characterized as the capacity

to move certainty and help individuals to accomplish organizational objectives (Dubrin, 2007).

Leadership styles are very important in an organization where Limbare (2012) defined leadership as interpersonal influence exerted in a situation and directed using a communication system towards the attainment of specific goals. Another definition of leadership is about setting a direction or developing a vision of the future together with the necessary strategies for producing the changes needed to achieve a vision (Long & Thean, 2011). Besides that, Northouse (2010) and Yukl (2005) proposed that leadership is a process of interaction of a leader who attempts to influence his or her followers to achieve a common goal. Due to this, there are different types of leadership styles from previous studies (Chen & Chen, 2008), which have been adopted by leaders in managing organizations (e.g. Spears & Lawrence, 2003;Hirtz, Murray & Riordam, 2007; Davis, 2003; House, Hanges, Javidan, Dorfman & Gupta, 2004). However, Burns‟ (1978) transactional and transformational leadership styles are among the more prominent leadership styles. Specifically, the transformational leaders seek to align followers‟ aspirations and needs with desired organizational outcomes where they emphasize more on their followers‟ intrinsic motivation and personal development.

Above all, the definitions of leadership are long drawn-out as Eunyoung (2007), claimed a leader as someone who helps his or her followers to act in accordance towards a common goal. Another researcher, Bass (1990), also defined leader, which is about a “working relationship among members of groups” and “active

participation and demonstration of his or her capacity to cooperate tasks to completion". Bass (1990, p.11), also added that perceived leadership is defined as a focus of group process, as a matter of inducing compliance, as a power relation, as an effect of interaction, as initiation of structure, as a matter of personality, as a form of persuasion, as an instrument to achieve goals, as a differentiated role and as many combinations of elements.

The leadership styles play most important role to directing, controlling, communication and encouraging the employees in the organization (Long & Thean, 2011). Leadership skills help employees to accomplish timely goals (Limbare, 2012). The leader possesses the ability to influence the subordinates (Bass, 1990). Researchers has suggested that leadership in any form could influence the attitudes of employees towards work organization and could enhance their commitment towards work (Barnett, Mccormick & Conners, 2001; Clark *et al.*, 2009; Emery & Barker, 2007; Erkutlu, 2006; Liao & Chuang, 2007; Rowold and Heinitz (2007). Hence it is assumed that organizations should pay equal attention towards leadership commitment relationship. Specifically various leadership styles could be considered for enhancing employee commitment towards service quality. The following section presents a detailed view of transformational, transactional and laissez-faire leadership styles with commitment to service quality.

Furthermore, leaders, according to (Bass 1990; Christie, 2002; Jabnoun & Rasasi 2005; Rowold & Heinitz, 2007; Jensen, Vera & Crossan, 2009) that leaders has ability to motivate, direction which bring confident impact needed in creating a

conducive environment that leads linked to the positive attitudes of commitment (Barnett, McCormick & Conners, 2001; Erkutlu, 2006); Emery & Barker, 2007; Liao & Chuang, 2007; Clark *et al*., 2009). Leaders have mission, vision, besides of that leader has the ability to motivate and engage staff in commitment to service quality and leader creates an environment that staff handling organization service reputation portfolios and change the attitude of staff towards commitment to service quality (Hashim & Mahmood, 2012). Leadership play most important role to influence staff towards commitment to service quality and staff provide services beyond requirement of organization and satisfy the customer Pahi and Hamid (2015). In addition, Burn (1978) defined leaders as "agents of change" of the status quo who can facilitate the development and organizational growth through their shared vision and values with their subordinates.

According to Williams, Ricciardi and Blackboum, (2007) and Clark *et al*., (2009), a measured preferred leadership style that would bring about changes and addressed it from different perspectives and contexts in order to facilitate delegation so as to gain support of the staff have been attempted by past studies. In accordance with this, Eunyoung (2007) claimed that transformational leadership style that were known able to exploit their followers‟ potential and also promote a commitment through their potentials and abilities has been recognized to generate benefits for the organization. Wallace *et al*., (2013), similarly leadership behavior most effect able to encourage employee commitment. Transformational leadership style its most important in the service sector and promoting collaboration, inspiring, motivating, and positive attitude towards commitment to service quality (Hashim, & Mahmood

2011). They are also able to inspire their subordinates to do more than what is expected in three ways; i) by increasing the consciousness of their subordinates about the value of the outcome which they are going to accomplish, ii) by using their subordinates for their own importance for the organization, team and members and iii) by raising their subordinates‟ level to a higher order, especially by appealing to their self-actualization needs (Lunenburg, 2003). Another study by Iqbal (2009) had come to a conclusion that leadership adopt new ways to success as well as try to achieve group and organizational goals by motivating other people to move to their own self-interest.

In addition, Boehnke, Bontis, DiStefano, and DiStefano (2003), suggested that transactional leadership is more needed in order to ensure the desired organizational goals are achieved. However, the authors argued that this style of leadership would pave the path to the attainment of goals and would be implicitly understood by the employees' thorough contractual agreements. Indeed, Northouse (2010) added that transactional leaders can satisfy their followers‟ immediate needs as well as gaining legitimacy through the use of rewards, praises and promises. James and Collins (2008) explain the laissez-faire leader as an excessive passive leader who is hesitant to impact subordinates‟ significant independence, to the point of passing over his/her responsibilities.

Furthermore, (Mitchell, 2002) described that employee is more committed in the organization when reinforced by leadership style. Leadership style has capability to increase employee commitment (Wallace *et al*., 2013). Leadership style improves

commitment to service quality with communication, direction and helping to active organization goals (Hashim & Mahmood, 2012). Above all empirical studies described that leadership styles influence on service employee and increase commitment to service quality to deliver better service to customer.

2.3.1 Transformational Leadership Style

Leadership as an act or a concept is a complex skill that takes years to master, regardless of the proposition that some leaders are born while some learn how to lead. Globalization, complexity of organizations, expectations of different stakeholders had impacted on leaders and followers. These impacts had made the leaders and followers nowadays to be under intense pressure to do more with less (Bass, Avolio, Jung, & Berson, 2003). Both the leaders and followers need to be more adaptive to their environment.

To be able to do this, the leader must display transformational leadership skill. Recent leadership theories had shifted attention from leadership approach to leadership power bringing about discussions on transactional and transforming leadership. With the publication of Burns (1978) Leadership, a distinction was made between transactional and transforming leadership. Transactional leadership was seen as being in tandem with exchange theory where a leader and the follower discussed performance expectations and the reward that will follow suit if the requirements were fulfilled. The directives on what to achieve and the reward to be

given might even come from the leader who expected the followers to perform at a specified level (Bass & Bass, 2008).

Burns (1978) pointed out that transforming leadership (later refined as transformational leadership) were leaders who looked for potential motives in followers, sought to satisfy higher needs, and engaged the full person of the follower. Transformational leadership took place when a leader stimulated interest among followers and colleagues with a view to making them view their work from a perspective which was different from their former perspective. The leader ensured that the awareness of the team and organization vision and missions was generated as he motivated colleagues to pursue interests that will benefit the group beyond the individual (Bass & Avolio, 1994; Bass & Bass, 2008). These leaders set challenging expectations (higher purposes) for the followers and provided a conducive environment for its achievement. A transformational leader raised the level of maturity of followers towards pursuing the higher-order level of Maslow hierarch of needs theory. Leadership was usually based on mutual trust and respect between the leader and the follower. Behling and McFillan (1996) described the synthesis of transformational leadership in form of demonstration of empathy; empowerment of followers; projection of self-assurance; dramatization of organizational mission and; affirmation of collective efficacy as the hallmarks of transformational leadership. In fact, they equated charismatic leadership to transformational leadership (Bass, 1999).

This style of leadership enhances awareness of combined interest among the company's associates and helps them to accomplish their combined objectives (Bass,

1985; Judge, & Piccolo, 2004; Avolio, *et al*, 2004; Wang, Tsai, & Tsai, 2014; Chen, Tang, Jin, Xie, 2014). Further stating these researchers have agreed that transformational leadership emphasize emotions and give appropriate importance to them; it also encourages creativity in employees and subordinates. Hence, this leadership-facet attempts to create emotional relationship with subordinates to motivate, encourage, and provide direction to them (Bass & Avolio, 2000; Bass, 1999; Gajcía Morales *et al.*, 2008). Additionally, above researchers have explained that transformational leadership helps employees understand that they are valuable resources of the organization; and this leadership style is found to have positive influence on employees‟ task accomplishment.

Organizations nowadays are facing a lot of challenges as well as difficulties, especially with the constant changes in technology, economic, social, political and legal conditions and internal processes. Therefore, Horner (1997) and Christie (2002) proposed that flexibility is required in resource utilization and in the promotion of continuous learning. Leaders can be of many facets and consequences of their actions towards internal and external stakeholders may be different in terms of their effectiveness. Hence, leaders in organizations should be very smart in pointing out views and ideas as well as handling changes being made by making a right decision. An organization which has this kind of leadership might be able to face the global challenges and also he or she could influence in facilitating creativity, innovation and transform individuals, organization and communities by successfully craft and implement bold strategies in the organization (Jensen *et al*., 2009).

Furthermore, broadly leadership is categorized into two, i.e., transformational and transactional. Transformational leaders are focusing more in developing their followers for examples by addressing their potentials, promoting collaborations, reinforcing positive behaviors, inspiring and motivating them. In contrast, transactional leaders are focusing more on achieving specific goals through economic and social changes (Bass & Avolio, 1990) for example by shaping the character of the organization‟s structures and strategies, rewarding their followers for their commitments or take corrective action from the set standards. Lussier and Achua (2004) added that this kind of leadership will go into contract arrangements with their followers and view them as cultural maintenance. Apart from that, they also claimed that transactional leaders will only have transitory relationships with their followers and they only manage to do daily routine tasks.

From those two leadership styles, Bass (1990) claimed that transformational leadership is more needed than transactional leadership in order for changes to happen in an organization. He also added that, transformational leadership is very important, especially during turbulent times when rapid changes and globalization takes place, whereas transactional leadership is only relevant during stable situation. Apart from that, Kirkbride (2006); Bass (1997; 1990) and Avolio (1999) found the full range leadership model (comprises of transformational, transactional and laissez-faire leadership styles) in his conceptual study and contended that all seven dimensions found in the model were correlated with leadership effectiveness and competencies. Moreover, Barnett *et al*., (2001) and Antonakis, Avolio and Sivasubramaniam, (2003) and Kirkbride (2006), preferred to delineate

transformational leadership based on five factors, which is an adoption from Bass and Avolio‟s (1995, 1997), studies.

On the other hand, there are also researchers (Kent, Crotts & Aziz, 2001; Nemanich & Keller, 2006) who characterized transformational leadership into four factors based on the original studies by Bass (1985a, 1985b). These dissimilar suggestions happen because of the differences in idealizing influence factor that is being theorized into the dual theory consisting of behavior and attributes. (Antonakis *et al*., 2003; Barnett, *et al*,. 2001). The five components as suggested by Barnett *et al*. (2001), Antakonis *et al*., (2003) and Kirkbride (2006) are i) individualized considerations (leaders who show high concern for their followers where they understand well the individual differences by treating them individually as well as promoting self-enhancement), ii) intellectual stimulation (leaders who encourage their followers to be able to solve problems and ready to take risks as well as avoid negative thinking to any aspect that could harm organization by emphasizing on the re-examine technique for any problem in the first step), iii) inspirational motivation (leaders who are able to inspire and stimulate followers to perform well in accordance to their ability by giving them some sense of purpose whereby they could also articulate their vision for the future by characterizing meaningful objectives), iv) idealized influence or attributes (leaders who display attributes for example charismatic, competence, confident in facing and solving problems and display powers for positive benefits), v) idealized influence or behavior (leaders who shows charismatic behavior accompanied by high sense of morality, honest, have integrity, trustworthy and are set to achieve their mission and purpose.

According to Yu and Jantzi (2002) that transformational leaders are responsible for laying the foundation, changes in the organizational culture, strategies and even giving more empowerment to subordinates to shape initiatives that will bring about the much needed changes as well as development of employees to attain a higher professional level that will directly increase their capabilities and innovativeness. Shockingly, in the hospital industry, it was found out that the turnover rates among employees are high and Ogaard, Mambung and Larsen (2008), claimed that the employees love to work in organic than in a mechanistic organization where leaders use transformational approach rather than bureaucratic approach. In a nutshell, in order to build up loyalty among employees, service, organization should consider changing structurally to be less formal.

There is lack of studies on transformational leadership style and commitment to service quality. However, Hashim and Mahmood, (2011) conducted studies in education sector found that transformational leadership style is the most important leader to influence on commitment to service quality. Transformational leadership style is most important rather than (participative, directive, and empowerment) leadership style and transformational leadership enhances employee commitment to service quality (Clark *et al*., 2009). According to Hashim and Mahmood (2012) transformational leader has the ability to influence employee toward commitment to service quality. Previous literature confirmed that transformational leadership has influence on commitment to service quality.

2.3.2 Transactional Leadership Style

This is a kind of managerial leadership; it concentrates on the part of supervision, organization, and group or organization's performance. In this leadership style the leader advances consistence of his/her employees through reward as well as punishment. Transactional leaders value individual's self-interests by method for contingent reinforcement, positive on account of constructive rewards, praise and guarantees for constituents' achievement in good performance or meeting commitment of the leader and/or the organization (Bass, Avolio, & Atwater, 1996). According to Burn, (1978), transactional leader is the one who approaches subordinates for an exchange. Scholars have asserted that this type of leadership style is based on the exchange process between leaders and subordinates with rewards for performance (Hartog, Muijen & Koopman, 1997; Berson & Linton, 2005). Transactional leaders works well in a structured framework in organization where employees are fully accountable for the job allocated to them, irrespective of whether they have the capability or resources to perform the job (Eunyoung, 2007).

Transactional leadership is interesting in its own way whereby the leaders are the one who initiates “a process of leader-subordinate exchange” (Burn, 1978) and will implicate bargains between themselves and their followers (Hartog, Muijien & Koopman, 1997). Besides, transactional leader is also classified as a leader who approaches their followers with “an eye to exchanging one thing to another” (Burn, 1978). The changes made are viewed as rewards which are exchanged for fulfilling these enticing contractual obligations.

According to Hartog *et al*. (1997), the transactional leadership approach has been grounded by path goal and vertical-dyad theory in the past. For this reason, Eunyoung (2007) suggested that a structured framework organization is so fit for the transactional leader concept where employees are fully accountable for the job allocated to them, irrespective whether they have the capability or resource to perform the job. Moreover, the transactional contingency rewards used in this leadership style were found to have significant effects on quality, climate perceptions (Berson & Linton, 2005). Nevertheless, this relationship will prove otherwise if this transactional leadership is considered a part of transformational leadership as what had been stated by Bass and Avolio (1994), if the transformational leadership is being examined together with transactional leadership, then the effects of transactional contingent rewards will not be significant.

In addition, Antonakis *et al*., (2003) and Kirkbride (2006), came out with three base factors in this transactional leadership theory which are;

(i) Management-by-exception (passive): passive leaders avoid making changes where they prefer the status quo and only making corrections or intervene with problems which had been informed to them or exceptional circumstances problems when the problem arises.

(ii) Management-by-exception (active): active leaders have different characteristics where they have well-structured performance systems in order to closely monitor their performance, but they will coach their followers to correct mistakes or occurrence of any deviation from standards because they

pay close attention to any deviation, mistake or problem their followers may make. However, usually, followers will hide their mistakes or deviation by "burying them" so that it will not be detected.

(iii) Contingent reward: rewards and recognitions are given upon the completion of agreed goals for the followers in exchange for the effort given by the followers. It is a classic association of the transactional leadership style where they identify what is needed to be accomplished by showing the path and providing support. In accordance with this, followers are hoping to be rewarded because of the successful completion of the agreed performance targets.

Rewards encourage the employees to focus on work and perform beyond the expectation. Reward also helps the employees to deliver high service in any situation (Bowen & Johnston 1999; Yavas *et al*., 2003). Money is special for service, employee jobs who deliver services directly to customer Forrester"s (2000). Rewards always impact on employee timely motivate to commit to service quality (George & Gronroos, 1989), because the motivation of service employee depends assessment of work and rewarded when completing all requirements of the job and performed better (Henning-Thurau & Thurau, 2003). Not only financial rewards but also other rewards such as job security and promotion can increase the commitment of employees with organization to deliver high service commitment (Peccei & Rosenthal, 1997).

Past literatures, have focused that rewards given by the organization are positively related to commitment to service quality and boosting employee‟s performance and behavior to deliver better services to customers (Sun, Hsu, & Wang, 2012). Hashim and Mahmood (2012) also study on transactional leadership and commitment to service quality. Results of study suggested that rewards brings commitment and motivates employees to deliver high service to customers. Rewards play an important role in encouraging staff members towards commitment to service quality (Pahi & Hamid, 2015). Transactional leadership style also influences on commitment to service quality by offering rewards in the exchange process to meet standards of performance.

2.3.3 Laissez-faire Leadership Style

Interestingly, the laissez-faire leadership style is characterized as non-leadership or the absence of leadership (Avolio *et al*., 1999; Northouse, 2010; Hinkin, & Schriesheim, 2008; Goodnight, 2004). They further claimed that this kind of leadership always renounces their liability, delays decisions, gives no feedback and offers less attention to assist subordinates to fulfill their needs. Robbins, Judge, and Sanghi (2007) and Luthans (2005, p. 562) proposed similar explanation that laissez-faire style is “abdicates responsibilities to avoid making decision”. Bass and Avolio, (1990) argued that laissez-faire leadership style is considered as the “absence of leadership” in specific if there is neither an agreement nor transaction between the subordinates. Researcher further suggest that this style of leadership is considered as the most passive and least effective form of leadership behavior (Antonakis, Avolio,

& Sivasubramaniam, 2003; Buch, Martinsen & Kuvaas, 2014; Skogstad, Hetland, Glasø, & Einarsen, 2014).

Hence, defending this kind of leadership style is very difficult unless the leader‟s subordinates are someone who is an expert and well-motivated specialist such as scientists because according to Mondy and Premeaux (1995) and Humborstad and Giessner (2015), laissez-faire leaders always let their group members in making all decisions. It is suggested that when subordinates are given total freedom in any field of work, the results will convert in low productivity and also it will affects the commitment (Bass, 1990).

Therefore, laissez-faire leadership can be summarized as the leader with absence of core leadership characteristics. Therein, such a leader avoids involvement in making decisions; abdicates responsibility and also sidesteps from his or her authority. Antonakis, Avolio and Sivasubramaniam (2003) suggested that it is considered as the most passive component and the less effective form of leadership behavior. Apart from that, laissez-faire leaders are considered to be inactive which is different from how transformational and transactional leaders work and behave (Yammarino & Bass, 1990). The literature has outlined that laissez-faire leadership style is an inactive and passive leading approach compared to other leadership styles. Interestingly, some scholars have asserted that in some situations, laissez-faire leadership style is more worthy than other leadership styles and it influences on employees` attitude and commitment towards organization better, compared to the rest.

This kind of leadership style is important when employees or worker who is an expert and specialist such as scientist. This has been fully supported by Sutermeister (1969) and Williams (1987) who said that the laissez-faire style may be effective in certain environments such as in situations where group of specialists are in consideration such as scientists or college professors. However, this leadership style is less practiced in other industries or business sectors. Yet, Ali and Ibrahim (2014) in their study have reported that laissez-faire leadership style has a positive effect on innovation. Another study by Sorenson (2000) shown that laissez-faire leadership style is positively linked with employee commitment. Focusing health organizations is important as sometimes there are many critical situations particularly when patients are handled. This is similar to what had been proposed by Ghorbanian, Bahadori, and Nejati (2012) that, leadership plays a crucial role in many professions, where especially in challenging positions such as emergency medical service jobs and medical officers are skill full employees to take all decision. Henceforth, laissez-faire leadership was selected for further investigation in the current study.

2.4 Perceived Leadership Styles

Perception or perceiving according to Boring (1982) has referred to the process whereby sensory stimulation translates into organized experience. The experience or precepts are the joint product of the stimulation and the process itself. Boring (1982) also added that even though inferences can be developed, but because of the perceptual process is not itself public or directly observable (except to the perceiver

himself, whose precepts are given directly in experience), the validity of perceptual theory can only be checked indirectly.

In an organization, the decisions made are always affected by the perception of individuals. Henceforth, perception as what had been mentioned by George and Jones (1996) plays an important role whereby its purpose is helping individual to select, organize and interpret the input from their senses to give meaning as well as order to the world around them. Besides that, it has been argued by the authors that employees might have their own perception about their leaders, which they strongly believe is right in the employee and leadership relationship. The perception might influence by their feelings, beliefs and even experience. However, the perceptions may differ and vary from one person to another and also inconsistent whereby it will become more positive perception if leaders show fair and equitable leadership (George & Jones, 1996).

There are many definitions about leadership proposed by researchers. One of the definitions is by Eunyoung (2007) who stated that a leader is someone who serves as a catalyst in liberating its follower's potential to act in accordance towards a common goal. Other than that, Bass (1990) announced that leadership is about a work or job associations amongst members of a certain team or group with profound involvement towards task completion with full resource capitalization. The author also added that perceived leadership is defined as a focus on group process, as a matter of personality, as a matter of inducing compliance, as a form of persuasion, as a power relation, as an instrument to achieve goals, as an effect of interaction, as a

differentiated role, as the initiation of structure, and as many combinations of elements.

Other than that, leadership is described as a process of influencing the followers towards the achievement of organizational objectives (Horner, 1997). Boehnke, Bontis, DiStefano and DiStefano (2003) stated that organizations require leaders who can guide and provide direction followers towards a common goal of the organization. Some scholars agree that leaders have certain trails, quality and behavior being born rather than made. According to Leithwood (2008) that right leader does the right thing in every situation that could possibly enhance organizational performance to motivate and encourage employees.

Moreover, Burn (1978) came out with the term *agents of change* of status quo for leaders who are always sharing the vision and values with their subordinates, facilitate development and able to bring about organizational growth. Instead, leaders are the source in creating conducive environment by providing positive impact to their subordinates that had been viewed by many scholars (Bass, 1990; Christie, 2002; Jabnoun & Rasasi, 2005; Rowold & Heinitz, 2007; Jensen,Vera & Crossan, 2009). Therefore, this type of leader was concluded to be able to lead to job satisfaction and link to the positive attitudes of commitment for their subordinates (Barnett, McCormick & Conners, 2001; Erkutlu, 2006; Emery & Barker, 2007; Liao & Chuang, 2007; Clark, *et al*., 2009).

As accordance with the findings, Williams, Ricciardi and Blackboum (2007) and Clark *et al*., (2009) have conducted studies in order to measure a preferred leadership style that would bring about changes and addressed it from different perspectives and contexts, in order to facilitate delegation so as to gain the support of the staff.

There are three main leadership styles transformational, transactional and laissez-faire leadership styles. According to Clark (2009) that transformational leadership provides direction and motivates employees to deliver high service to customer and achieve the targets in the market. Eunyoung (2007) stated that often leader who practice transformational leadership style are known to exploit their followers' to promote commitment through abilities and competence. They are able to inspire their subordinates to do more than what is expected in three ways;

i) Make subordinates realize and understand as well as increase their consciousness about the value of the outcome that they are about to accomplish.

ii) Let subordinates focus on their responsibility by getting them transcend their

iii) own self-interest for the organization, teams and members.

Raise subordinates needs levels to a higher order, especially by appealing to their self-actualization needs (Lunenburg, 2003)

However, Boehnke *et al*., (2003) pointed out that if an organization‟s desire is to ensure the achievements of their goals, transactional leadership style is much needed. This is because, Boehnke *et al*., (2003) believed that this type of leader would pave

the path to the attainment of goals and their employees would be implicitly understood their roles and responsibilities through contractual agreements made.

2.5 Role Clarity as Potential Moderator

Role clarity refers to the degree to which employees receive and understand information that is needed for them to perform their jobs well (Rogers, Clow, & Kash, 1994). Employee‟s performance needs role clarity (Bush & Busch, 1981; Teas, Wacker & Hughes, 1979). Role clarity represents the level to which workers get and comprehend information that is mandatory for them to execute their tasks well (Rogers, Clow & Kash, 1994). Role clarity and role ambiguity are used interchangeably in the literature and are thought to represent opposite ends of a continuum. In situations of high role clarity or low role ambiguity, employees understand what is expected of them in their job, and have knowledge on the available means to carry out their job tasks with in organization. Role clarity represents the degree to which required details about job how employee worker perform his/her job and its clear way to complete without wasting time (Teas *et al*., 1979). In the same context Kelly and Hise (1980) described role clarity was that individual employee receives details and understanding about job what they do and what they do not do.

Role clarity was described as an understanding of the following role components: (a) goals of role efficiency, (b) attitude and behavior necessary for goal accomplishment, (c) role limitations, and (d) behavior predicted by those in roles counters (Meleis,

1975; Meleis & Swendsen, 1978; Sarbin & Allen, 1968). Role clarity was defined understanding of job requirements and come up with performance fulfill job requirements as individually (Van Sell, Brief & Schuler, 1981). Research already found that low level of role clarity of the employee‟s intention to leave the company the company and high clarity employees always trustworthy with the organization (Schaubroeck, Ganster & Fox, 1992).

On the other hand, when the employee‟s role clarity decreases, they usually experience negativity such as job dissatisfaction (Kahn, Brian, John, Snoek & Rosenthal, 1964; Kelly & Hise, 1980). Due to lack of clarifications it negatively influences on employees` commitment to service quality. Terje, Göran, and Sander (2011) also defined when a service employee having a lack of role clarity its negative impact on the outputs are likely to happen such as involved employees may offer incorrect information, which inadequate service for the customers.

In the service sector, role clarity provides chance for service providers to deliver services in a quick and better to their customers without their supervisor any advice, and waiting for any suggestion during a service at encounter, such immediate response is delighted customer result is greater satisfaction and capture customer for always (Suan, & Nasurdin, 2013). Hospital staff must know about role clarification in job what they do and what they do not do because hospital staffs take quick decision about customer health, in emergency situations as. Therefore, when a gets staff touch with customers and clear on what they are expected to do in their job, they are more likely to look at a positive mindset towards their work and show

greater handling, challenging and commitment to provide service to the customer (Suan, & Nasurdin, 2013).

Role clarity has also been shown to effect service employees in service sector occupations (Troyer, Mueller & Osinsky, 2000). Using data from a 1993 national wide research of 5,811 United states telecom employees, Troyer *et al*, (2000) results that a higher level of role clarity, reduced level of real issues, An analysis of 104 sportsmen exposed that those who were clear about their unpleasant and protecting positions performed role better in those positions than those with reduced role clarity (Bray & Brawley, 2002). Furthermore, a research in the service sector in United Empire hospital nursing staff (Blumenthal, Lavender & Hewson, 2001) found that reduced role clarity results in unwanted effects for both company members and for organizational efficiency. Though more common in literary employee, there is limited positive effects of role clarity on efficiency (Singh, 1993). In fact, some studies have even shown a negative relationship between role clarity and purpose and subjective measure of service quality (Jackson & Schuler, 1985; Wetzels *et al*., 2000), showing that a limited amount of role ambiguity always given result as increase better performance (Lyons, 1971). Above researcher clearly defined that less role clarity effective on service employees and organization and ultimate its negative impact on the customer.

Studies resulted that self-evaluation is more appropriate for boarder comprising personnel (Harris & Schaubroeck, 1988; Jaworski & Kohli, 1991; Singh, 1993, 2000; Yilmaz, 2002) especially for schedule and regular transaction where the service

script should well describe (Bitner, Booms & Mohr, 1994). Additional researcher claims that direct service provider staff now becoming a challenging problem as perception drives behavior (Steers & Porter, 1991) it‟s most important which never ignored in the service sector. (Boshoff & Mels, 1995) describes that direct service provider employee; perceptions of service must receive interest, so that service provider employees must know challenges of customer interaction. In addition, role clarity more important for the service employees to satisfy customers in a short time and deliver services quickly without any barrier (Mukherjee, & Malhotra, 2006). However, limited research in the health sector, especially in a hospital staff perception needs more study on role clarity and commitment to service quality.

Many researchers use role clarity with different tools and scales in different fields of research with different variables and different scale result output in different perspectives. The scale has valid and reliable (Rizzo *et al*., 1970; Kelloway & Barling, 1990). Further Troyer *et al*., (2000) measuring role clarity using 5,811 employees sample engaged in service work. Resulting that respondents understand their role, and other researcher also use as perceived role clarity front line employees, they connected to direct provide services to customers and (Boshoff & Tait, 1996, De Ruyter, Wetzels, & Feinberg, 2001, Singh *et al*., 1996).

Role clarity is variable which uses as independent, mediating and moderating variable very flexibility in role clarity to use different approaches. Role clarity used as a moderator in the study of call center and focus on service provider employees and got result of study that positive impact on service quality (Mukherjee, &

Malhotra, 2006). And another researcher Ingram (2006), also using role clarity as moderate retirement and current retirement and internal control findings of this research overall positive on some aspects and moderate relation to future with retirement.

In contrast, in situations of low role clarity or high role ambiguity, employees lack an understanding of what is expected of them in their jobs and what processes they should employ for goal attainment Newman, Allen and Miao (2015). Ambiguous job contexts such as this, where employees have limited understanding in relation to core aspects of their job, have been shown to limit the capacities of employees to match appropriate behaviors with task specific role requirements resulting in lower levels of performance (Tubre & Collins, 2000). A lack of role clarity has also been shown to represent a situational stressor which can result in employees experiencing stress, tension, and anxiety as they struggle to understand the most effective and desired behaviors to engage in (Gilboa *et al*., 2008; Jackson and Schuler, 1985; Jex *et al*., 2003).

There is also substantial evidence linking lack of role clarity to job dissatisfaction and more negative emotions (Abramis, 1994; De Ruyter *et al*., 2001; Jackson and Schuler, 1985; Kahn *et al*., 1964; Kelloway & Barling, 1990; Quah and Campbell, 1994; Von Emster and Harrison, 1998). Evidence also indicates that situations of low role clarity tend to be viewed as hindering employees‟ abilities to attain personal and professional goals leading to less positive work-related emotions and attitudes which

are known predictors of deviant behavior (Fox *et al*., 2001; Judge *et al*., 2006; Spector & Fox, 2002).

Indeed, there is evidence to suggest that low role clarity is often interpreted by employees as a signal that their supervisor is either unwilling or unable to provide support (Kahn *et al*., 1964). Additionally, research evidence indicates that in contexts where subordinates feel they lack support from their supervisor and there message is not seen as genuine or credible, subordinates are less committed (Dalal, 2005; Dineen *et al*., 2006).

In situations of high role clarity subordinates perceive greater levels of support from their supervisor, with this in turn resulting in subordinates being more conscientious about carrying out their work responsibilities (feeling of being more committed towards organization and the work) (Eisenberger *et al*., 1990; Stinglhamber and Vandenberghe, 2004).

Some researchers believe that effective leaders should provide role clarity to their employees for attaining common organizational objectives (Fiedler, 1967; Hersey & Blanchard, 1969; House, 1971). Job context characteristics are, therefore, recognized as potentially important moderators in the relationship between leadership styles and follower behaviors (House, 1996). Situations of low role clarity may indicate that there has been insufficient directive, task-oriented leadership to clarify subordinates‟ performance goals, the means by which subordinates can effectively carry out tasks, and clarify standards against which subordinates‟ performance will be judged. Since,

it has been demonstrated that leader behavior is seen effective by subordinates to the extent that it facilitates their goal attainment (House, 1996); in job contexts where there are low levels of role clarity, a more task-oriented leadership style is required.

Our next line of reasoning for the proposed moderator results from evidence which suggests that the interactions between subordinates and supervisors‟ behavior is critical for alleviating the unpredictability which subordinates feel about their job tasks (O‟driscoll & Beehr, 1994). Indeed, supervisors, as opposed to organizations more broadly, are likely to be the most important provider of role clarity, as many aspects of an employee‟s role (Goals, responsibilities, rules of conduct) are, to a large degree, determined by their supervisors (Chen *et al*., 2002; Panaccio & Vandenberghe, 2011; Stinglhamber & Vandenberghe, 2004). Supervisors can also play a vital role in interpreting rules and procedures that may have been determined by the organization, and in doing so, reduce the levels of role ambiguity experienced by subordinates (O‟driscoll & Beehr, 1994).

In situations where an employee perceives low levels of role clarity their supervisor has potentially failed to perform this important role (Podsakoff et al., 1996). Role clarity encourages the employees toward employee‟s commitment (De Ruyter *et al*., 2001). Mukherjee and Malhotra (2006) also described that role clarity is more important variable as a moderator as compared to other variables. Similarly, Pahi and Hamid (2015a) have suggested role-clarity as a potential moderating variable for improving leadership and commitment to service quality relationship.

As a final argument, we present the assertion of Baron and Kenny (1986) who recommended that when results between the predictor and outcomes variables are mixed or unexpectedly weak; a third variable could be introduced to explain the situation. Looking into the mixed results of the leadership styles and commitment to service quality, the present study proposes role-clarity as a potential moderating variable in the research framework.

2.6 Role Clarity

Role clarity used with different variables and in different fields of research outcome of studies combined perspective about moderator in different area of research. Using as moderator Bray, Beauchamp, Meys and Carron (2005) examine the need for role clarity as a possible moderator of the connection between role ambiguity and satisfaction, techniques defined by Baron and Kenny (1986) were used. Another study using the moderator role clarity relation between role efficacy and role performance, effectiveness, showing result is positive for performance (Bray & Brawley, 2002). Role clarity weakly moderates the relation between ambiguity, satisfaction, and independent sports athletes (Bray *et al*., 2005). Moderator a significant direct negative effect on current working retirement planning, but not significant with direct effect on future work retirement overall result of moderator of role clarity effect on independent and dependent variables its complicated (Ingram, 2006). Role clarity interacted with proficiency to impact employees‟ commitment and interacted with the development of employee, Leaders must know the employee has clear about the job and path career to accomplish goals, using role clarity as a

moderate between leader empowering behavior and psychological empowerment, work engagement result is positive (Mendes, & Stander, 2011). As moderation on relationship between moral behavior and attitude toward values, Relationship of sales person will be strong if great role clarification about job, in study role clarity effect on sales person ethical attitude and behavior (Agnihotri, Rapp, Kothandaraman, & Singh, 2012). Role clarity does not moderator on a job satisfaction and degree of role clarity in any situation (Miles & Petty, 1975).

Using role clarity as moderator has appeared to be a very important variable in relationship to the employee perceived service quality of call center in the service sector, a result of this study showing role clarity has strongest positive effect on perceived service quality as compared to different variables, coefficient regression of role clarity and service quality was significant Mukherjee and Malhotra, (2006). Recently role clarity used by Clark *et al*., (2009) role clarity and commitment to service quality have a positive significant relationship.

2.7 Role Clarity and Commitment to Service Quality

Role clarity refers to understanding of an individual towards his/her current job expectations (Van Sell, & Schuler, 1981). Role clarity is not only vital for service sector employees to satisfy customers but also important for employee commitment productivity (de Ruyter *et al*., 2001). Clark *et al*., (2009) study on hotel employees. Result of study positive relationship between role clarity and commitment to service quality. There is less study found on commitment to service quality and role clarity,

so need more empirical studies to understand the relationship between commitment to service quality and role clarity. How role clarity effect on commitment to service quality. Mukherjee and Malhotra (2006) described that role clarity and commitment of service quality has positive relationship between two. The employee commitment to service quality is the most important in a service organization and now a day delivery of service on expectation of customers is a vital issue (Allameh, Harooni, Chaleshtari & Asadi, 2013). Role clarity and commitment to service quality study on hotel employees Clark *et al*., (2009) described that role clarity has a positive effect on commitment to service quality.

2.8 Summary of Chapter

This chapter has critically reviewed literature on commitment to service quality; leadership styles including transformational, transactional, and laissez-faire. Review of the literature has indicated that leadership styles and commitment to service quality are positively related. However, the results of these studies are inconsistent hence, suggesting the need for introducing a potential moderator variable. Role clarity therefore was proposed as a potential moderator to determine whether it could potentially alter or strengthen the relationships between leadership styles and commitment to service quality.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter explains the research methods and processes applied in the current study. Importantly, this section discusses, framework, underpinning theory, measurement and instrumentation. Similarly, the chapter also discusses sampling technique and matters concerning to pretest, pilot study and data analysis.

3.2 Research Design

As explained earlier, the current study has empirically tested the three different styles of leadership namely transformational, transactional and laissez-faire in connection to commitment to service quality. Following this, the study has also investigated the role clarity as a moderator amongst these variables. The study is quantitative in nature and hence employed survey approach to outline the social phenomenon through numeric data analysis and forward reliable and valid claims.

According to Sharp (2009), social research relies on the logic and empirical observation and therefore, the appropriate research design is very important for responsive conduct of the research (Borden & Abbot, 2011). Similarly, Zikmund (2003) pointed out that different research designs can be implied in doing research.

He further mentioned survey, experiment, secondary data study and observation as four research methods.

The researcher chose quantitative methodology for the study in order to achieve the drafted objectives. The study has followed Kelley, Clark, Brown and Sitzia (2003) and Leedy and Ormrod (2001) who suggested that quantitative research methodology supports in building, validating and provides the relationship among all variables for potential generalizability. Given these arguments, the researcher selected quantitative methodology that has comparable advantage over qualitative.

Numerous benefits could be highlighted while comparing quantitative with qualitative. Quantitative research is cost effective (use less resources, compare to qualitative research), less time consuming (it doesn‟t take much time to compare to qualitative research), and other main advantage is large sample study (Zawawi, 2007). This study has used cross sectional survey because the data was collected only one period of study (Clark & Creswell, 2010). Accordingly Davis, (1996) suggests that quantitative approach is very effective when there is a large sample size of target audience to cover. In a survey approach, the researcher may use internet, mail, telephone and self-administered for data collection. Notably, to test hypothesis, evaluating programs, assessment of the measurement scales and for the purpose of forwarding methodological contributions in the business research, survey research method has been claimed important (Davis, 1996).

3.3 Conceptual Framework

Conceptual model of the present study is established on the premise of social and psychological disciplines. The core aim to this study was to analyze the extent and factors influencing the commitment to service quality in the hospitals. The model was established based on the previous literatures on commitment to service quality in connection to perspective on service quality and organization commitment (Nawaz & Bodla, 2010; Ellinger *et al*., 2013; Clark *et al.,* 2009; Hashim, & Mahmood, 2012, 2011; Elmadağ, Ellinger & Franke 2008; Mukherjee & Malhotra 2006; Khan *et al*., 2011, Bass, 1985; House, 1971; Mowday, Steers, & Porter, 1979; Chonko, Howell & Bellenger, 1986). As shown on Figure 3.1, establishing and proposing a conceptual framework based on established studies is critical and presents the justification for the chosen predictors and proposed hypothesis.

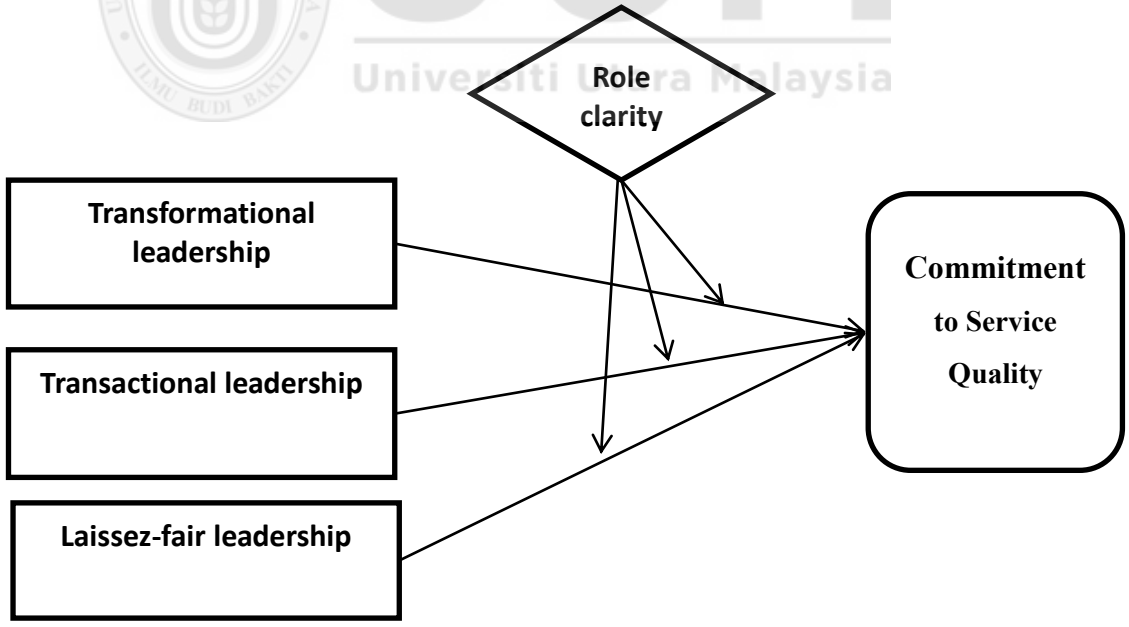

Figure 3.1. Conceptual framework

3.4 Underpinning Theory

The theories employed to develop the research model of this study were adopted mainly from psychological and social disciplines. The main focus of this study has originated from organizational commitment and service quality literatures, is the concept of commitment to service quality.

For the purpose of explaining how leadership styles can potentially influence attitudes and other elements like commitment to service quality in the health sector of Pakistan, cognitive dissonance theory was used. The cognitive dissonance which is a term, coined by Festinger‟s (1957) theory was adopted. The basic idea is that staff members are supposed to be steady and reliable in their thoughts, attitude and behavior towards work. In addition, Arokiasamy, Ismail, Ahmad, and Othman (2007) have claimed that professional relationship between leaders and subordinates is developed during working hours but they are also independent when they are doing extra job at the same time. Henceforth, according to Tosi and Mero (2003) and Morris and Maisto (2009) have forwarded that dissonance means inconsistency and when this occurs, the individuals push and try to give explanations to justify their perception, view, ideas, thoughts or behaviors. This they primarily do in order to minimize their discomforting situations that they are experiencing. This to them, is the highly feasible and smooth way to change their behavior and cut down their levels of discomfort (Morris & Maisto, 2009). Pahi and Hamid (2015) may leaders have ability to reduce discomforting situations of staff and motivate towards commitment to service quality. Hashim and Mahmood (2012) also defining that leadership style help to reducing and resolving discomfort or dissonance experience

due to inconsistencies at work or any situation that staff feels it. The dissonance situation might occur when the staffs encounter leaders who may not be interested in recognizing their efforts, demanding, or have a distant relationship with them or even the staffs themselves who have negative attitudes towards their leaders. Therefore, in order to cope with this situation, sufficient justification should be given by the leaders so that some kind of contingency, rewards, coaching, communication or direction can be given to the staffs. These will, of course, can help reduce staffs‟ dissonance and can change their attitudes to be more positive towards commitment to service quality.

Other than that, both transformational and transactional leadership are expected can help in reducing dissonance. The transformational leaders as what has been explained by Bass (1990) are known to build employees‟ commitment and loyalty whereby they will try their best to perform better than what had been expected. Transactional leaders on the other hand as what had been introduced by Burns (1978) have a relationship with subordinates based on the extrinsic material values. According to William *et al*., (2007) laissez-faire leadership style at times is more important than other leadership style particularly when employees are more skillful. Northouse (2010) has also supported this notion. In active leadership style also effects on the certain environments and in some situation where employees are skillful and expert in their fields (Sutermeister, 1969; Williams, 1987). In such a situation, employees prefer laissez-faire leadership style and express high service commitments. Therefore, these three leadership styles can help in encouraging staff

members to subscribe to organizational goals of commitment towards service quality and reduce dissonance.

Another supporting theory is the path goal theory (House, 1971) which suggests that leader has the obligation to provide essential information and duly support for effective achievement of work goals. This theory focuses on leader, follower and situation whereby, House and Dressler (1974) have explained situational as two class variables i-e environmental and subordinate characteristics followed by the moderation of numerous task characteristics (environmental forces). Based on this theory, the model of the current study indicated the moderation of role clarity (Greene, 1979). Based on it, the model indicates that role clarity and leadership behavior effects on employees (staff) commitment to service quality. Newman, Allen and Miao, (2015) role clarity influence on the subordinates and leadership behavior, clarity clear the path of employees to understand the work and increase performance. Clack *et al*., (2009) using path goal theory and supporting with conceptual models described that role clarity is important for staff understand the job requirement to commitment to service quality another study followed path goal theory of leaders, which describe two categories task related (job design) and supervisor consideration (Jackson & Schuler, 1985). Both important factor effects on role clarity service provider employees (Donnelly & Ivancevich, 1975; Singh, 1993; Armstrong, 2014). According to Emery and Barker (2007) apart from that the leaders must clear the path for employees so that they could enhance commitment to deliver service quality.

3.5 Hypothesis Development

3.5.1 Explanations pertaining to transformational leadership and how it can influence on Commitment to Service Quality

Leadership styles play an important role in helping the organizations to successfully achieve their goals. According to Clark *et al*., (2009) Erkutlu, (2006) Barnett *et al*., (2001) and Liao and Chunag (2007), transformational leadership style is seen leading internal customers to convey high affective commitment. According to Meyer and Allen (1991), affective commitment is an individual or employee`s cognitive and psychological attachment, involvement and bonding with the organization. Accordingly, commitment to service quality is generally referred as an employee or individual`s assertion towards the quality of service in an organization. Transformational leaders are mainly very strong in boosting employee feelings and cultivating emotional attachment with the organization, teammates and superiors.

More importantly, transformational leaders have the competence to push employees to forego their self-interests and work for the organizational betterment (Narimawati, 2007). (Emery & Baker, 2007; Nguni *et al*., 2006; McGuire & Kennerly, 2006; Chen, 2004) stated that people at work generally tend to display higher commitment levels in service organizations when they are working under transformational leaders. It attempts to create emotional relationship with subordinates to motivate, encourage, and provide direction and this type of leadership communicates the importance of creativity in subordinates and makes employees understand that they are valuable of the organization and have positive influence on task accomplishment (Bass &

Avolio, 2000; Bass, 1999; García-Morales *et al.,* 2008). However, the research also suggests mix or contradictory results between the two (See for example, Hayward, Goss, Tolmay, 2004; Chiun, Ramayah & Min, 2009; Ramachandran & Krishnan, 2009; Chandna & Krishnan, 2009; Clarck *et., al* 2009; Mahmood & Hashim, 2011; Ahmad, Majid, & Zin, 2015; Marmaya *et al*., 2011) transformational leaders have the capability to make an impact on employee`s commitment to service quality and transformational leader create approachable environment which encourage the employees toward commitment to service quality (Pahi & Hamid 2015). Mahmood and Hashim (2011) conducted study in the education sector whilst targeting the academic staff whereby, they concluded that transformational leadership influenced commitment to service quality.

Similarly, studies also indicated that transformational and commitment has a positive link. Accordingly, front line employees in hotel industries were studied by Clark *et al.,* (2009) where the research empirically forwarded strong evidence pertaining to the relationship of transformational leadership and commitment to service quality, more than other leadership styles and transformational leaders are known to help building a strong sense of commitment in their employees. In a nutshell, transformational leaders have the potential to increase followers‟ commitment to service quality, especially when they realize that it will give their organization. Hence, the following hypothetical assumption was made for empirical testing:

H1: There will be a positive relationship between transformational leadership style and commitment to service quality.

3.5.2 Explanations pertaining to transactional leadership and how it can influence on Commitment to Service Quality

Transactional is another leadership style that relies on contingency reward approach and takes passive or at times active action in monitoring their performance (Burns, 1978). On temporal grounds, rewarding is the best approach to help an employee boost its quality of service and hence responsively enhance its commitment to service quality in an organization (Sun *et al*., 2012). Effective reward system is not only important for motivating employees for delivering higher services but, it also encourages them to solve customer complaints responsively (Bowen & Johnston, 1999; Yavas *et al*., 2003). Therefore, it is concluded that, it will be able to motivate employees to a higher level of organizational commitment, especially in the service organization where it will be more mechanistic in the future (Emery & Barker, 2007).

Moreover, this type of leadership provides opportunities for employees to be closely supervised and where their roles are clearly defined. Other studies conducted on health care (McGuire & Kennerly, 2006) and education services (Nguni *et al*., 2006) have also supported the notion that transactional leadership is correlated to organizational commitment. These studies have concluded that transactional style of leadership and commitment to service quality can be positively related. Furthermore, Chen (2004) appointed that this transactional leadership can also work responsively in highly bureaucratic or organizations that appreciate and recognize followers‟ commitment with their companies or organizational units. On the contrary, literature

also indicates a mix results between the transactional and commitment of employees (Wolverton, Montez & Gmelch, 2000; Ahmad, Majid, & Zin, 2015; Heck, Johnasrud & Rosser, 2000; Hayward, Goss, Tolmay, 2004; Chiun, Ramayah & Min, 2009; Ramachandran & Krishnan, 2009; Chandna & Krishnan, 2009; Marmaya *et al*., 2011; Waumbwa & Lawler, 2003; Hashim & Mahmood, 2012) the entire above prior studies indication mix results. Notably, Bajunid (2008) has suggested that transactional leadership which has a link to commitment to service quality is best practiced in service especially particularly, in the public sector.

According to Ahmad, Majid, and Zin (2015) that the transactional style of leadership has a potential association with the notion of commitment as people with such style of leadership possess the skill to motivate and influence the staff towards commitment. Lok and Crawford, (2004) and Nguni *et al*., (2006) argued that transactional leader behavior indirectly influences on commitment of organization. Cemaloğlu, Sezgin, and Kilinç, (2012) conducted a study on a primary school and found that transactional leadership and employees‟ commitment were positively related. Study in the education industry (Hashim & Mahmood 2012; 2011) argued that the transactional leadership style and employee commitment to service quality have a statistically significant link amongst them. Jamaludin, Hashim, and Mahmood (2014) described that transactional leadership style can mark a notable impact on employees` commitment to service quality to target goals of the organization. Pahi and Hamid (2012a) have also underlined that transactional leader encourage to commitment service quality by reward and position. Based on these evidences, the following hypothesis was formulated and tested.

H2: There will be a positive relationship between transactional leadership style and commitments to service quality.

3.5.3 Explanations pertaining to laissez-faire leadership and how it can influence on Commitment to Service Quality

Apart from transformational and transactional, laissez-faire is the third most popular leadership style which is characterized as the style with no or deficiency of the skills of a leader (Avolio *et al*., 1999; Northouse, 2010 Spinelli, 2006) Hinkin & Schriesheim, 2008; Goodnight, 2004). The authors have highlighted that this people with this style of leadership always try to run away from their duties and responsibilities, takes time in making effective decisions and provides no feedback to their subordinates. Consequently, Robbins, Judge and Sanghi, (2007) and Luthans (2005, p. 562) have also forwarded similar explanations towards laissez-faire style that it "abdicates responsibilities to avoid making decisions". Furthermore, Antonakis, Avolio, and Sivasubramaniam (2003); Buch, Martinsen and Kuvaas (2014); Chaudhry, and Javed (2012); Buch, Martinsen and Kuvaas, 2014; Skogstad, Hetland, Glasø, and Einarsen (2014) have outlined that laissez-faire style of leadership is the highly less effective form of leadership.

Notably, some studies have forwarded contradictory results from the above mentioned evidences such as Wallace *et al*., (2003) whereby, the study found positive relationship between laissez-faire style of leadership and employee commitment. The study also forwarded a significant relationship between laissez-faire leadership style and commitment of employees, Accordingly, Sorenson (2000)

have empirically studied on a primary school found that effective commitment was positively related with the laissez-faire leadership style due to principal, not interfering in teachers` jobs (Cemaloğlu, Sezgin, & Kilinç, 2012). Huynh (2014) and Lee (2004) conducted a study and found mixed results about the laissez-faire leadership positive relationship with continuous commitment. In the same study less effective on the employee affective commitment.

Regardless of this, the relationship is supported by (Sutermeister, 1969; Williams, 1987) where the researchers have stated that laissez-faire leadership style can prove to be responsive in some situations and professions such as teaching, occupations related to scientific research or jobs where individuals have specialization in their field. This conclusion is similar to what was forwarded by Ghorbanian, Bahadori and Nejati (2012) where laissez-faire leadership was found to play a critically significant role in many professions, especially, in challenging positions such as emergency medical service jobs. Laissez-faire leadership is positively related with employees‟ commitment in different situations.

Accordingly, laissez-faire style of leadership is also seen to have an important role in influencing organization and individual variables. For instance, Ali & Ibrahim (2014) have forwarded that laissez-faire leadership style can dominantly influence on innovation. Similar findings were also reported by (Sorenson, 2000), where the style was found to be positively associated with employee commitment. Hence, the following hypothesis was formulated and assumed for testing:

H3: There will be a positive relationship between Laissez-faire leadership style and commitment to service quality.

3.5.4 Role Clarity and Commitment to Service Quality

According to (Teas *et al*., (1979) role clarity denotes to the extent of information required by an employee in order to perform the job effectively. Role clarity helps the individuals to understand the basic requirements of the job (Kelly & Hise, 1980). The basic objective of role clarity is to provide transparent outlines about the job that could improve the performance and commitment of the organization in a responsive manner (De Ruyter *et al*., 2001). Lower levels of role clarity put a negative impact on employees in terms of organizational commitment and service quality. (Korczynski, 2002). Importantly, some researchers have also outlined the negative relationship particularly in terms of objective, subjective and role clarity measurements and service quality. For instance, (Jackson & Schuler, 1985; Wetzels *et al*., 2000) have underlined that lesser role ambiguity effects on the performance of employees which leads towards betterment and responsive achievement of organization goals (Lyons, 1971). According to Terje, Göran and Sander (2011) when the staff member responsible for providing direct service to the customers, then they require more role clarity otherwise it may potentially affect their outcomes and commitment to service quality.

Essentially, it should be noted that leadership styles can directly as well as indirectly affect employee behaviors and outcomes such as role clarity (Tracey & Hinkin,

1996). The results have shown that leadership style was significantly related with role clarity. According to Nyengane (2007) relationship is not very strong but stands on a positive side thus results in fostering employee commitment and service quality. Theoretical understanding of contingency theory suggests the idea that effective leaders should ideally take measures to provide role clarity to their subordinates in order to achieve organizational goals (Fiedler, 1967; Hersey & Blanchard, 1969; House, 1971). Therefore, job context characteristics are recognized as potentially important moderators in the relationship between leadership styles and follower behaviors (House, 1996). Situations where role clarity is low, it may indicate that there has been insufficient direction and lack of task-oriented leadership which is important for an employee to understand the job, its expectations and effective working to achieve the desired results. As it has been explained that leader`s behavior can positively influence subordinates` role clarity (House, 1996). Therefore, leadership style is important to guide and direct employees when they experience low role clarity.

The interaction between subordinates and supervisors‟ behavior is important towards completion of job tasks (O‟driscoll & Beehr, 1994). Supervisors are likely play a central part in providing role clarity. This is due to the fact that majority of the jobs require an employee to report back to certain authority, normally a supervisor (Chen *et al*., 2002; Panaccio & Vandenberghe, 2011; Stinglhamber & Vandenberghe, 2004). Supervisors can be seen as critical in interpreting rules and procedures and minimize role ambiguity experienced by the subordinates (O‟driscoll & Beehr, 1994).

Occasions where the employee views or perceives lower levels of role clarity from their supervisors then this refers that the supervisor has not responsively performed its job (Podsakoff *et al*., 1996). According to De Ruyter *et al*., (2001) role clarity boosts the employees toward employee‟s commitment .have also described that role clarity is more important variable as a moderator as compared to other variables. Similarly, Pahi and Hamid (2015a) have forwarded role-clarity as a potential moderating variable for improving leadership and commitment to service quality relationship. As a final argument we present the assertion of Baron and Kenny (1986) who have recommended that when the results between the predictor and outcomes variables are mixed or unexpectedly weak; a third variable could be introduced to explain the situation. Hence, the following hypothesis was formulated based on this assumption:

H4 Role clarity moderates the relationship between transformational leadership and commitment to service quality.

H5 Role clarity moderates the relationship between transactional leadership and commitment to service quality.

H6 Role clarity moderates the relationship between laissez-faire leadership and commitment to service quality.

3.6 Measurement and Instrumentation

As establisher earlier, this research aimed to investigate the relationship between the different leadership styles and how they are related with commitment to service quality amongst the public hospitals` medical officer of Sindh, Pakistan with the moderating role of role clarity.

In guaranteeing that the instrument captures systemic desired data from the selected respondents, three concerns were noted. First of all, the general design of the questionnaire, secondly, the approval of pre-testing and finally, the methodologies by which questionnaire were administrated (Hair, Money, Page & Samouel, 2007). The instrument was adopted from different models and researches conducted on the topic previously. For this study, the instrument was used to measure leadership style from the Multifactor Leadership Questionnaire (MLQ 5x-short-form), developed by (Bass, 1995). For dependent variable of measurement scales for (CSQ) were adapted from Clark *et al.,* (2009) which was modified from Mowday, Steers, and Porter (1979). Lastly, role clarity instrument was adapted from (Clark *et al*., 2009) which previously was developed by (Chonko, Howell & Bellenger, 1986).

3.6.1 Multifactor Leadership Questionnaires

Multifactor Leadership Questionnaire (MLQ) is a leadership scale used in operating transformational and transactional leadership theories introduced by Bass (1985a; 1985b). This instrument has been refined and revised several times where initially based on Tejeda, Scandura and Piliai (2001), it incorporated only charismatic and

mundane leadership component. However, in the latest revision, Bass (1985a) refined the theories to include a three order domain which comprises of styles including transformational, transactional and laissez-faire. Besides this, "The Full Range Leadership Model" has been developed in the work of Kirkbride (2006), illustrating the theory based on seven factors which is quite identical to the models of Bass (1998) and Avolio (1999). According to Barnett et al., (2001) and Antonakis *et al.,* (2003), some researchers prefer to measure the scale of transformational leadership by using five simplified factors even though the original scale only has four. Moreover, the idealized influence factor is being theorized into behavior and attributes reflecting the differences in charismatic characteristics. The transactional leadership scales consist of three factors of contingency rewards that are passive and active characteristics (management by exception) and the third concerns with laissez-faire. After the revision by Bass and Avolio (1995), the MLQ 5X has been introduced which contains about 45 questions that identify the full range of leadership model. This instrument has a strong support in the past, but still; according to Yukl (1999), there are criticisms about the scales which are overlapping in some of the contents hence, often result in incurring validity problems. Later, in another study Yukl (2006) found inconsistencies in the support for MLQ and therefore called for more research to support its validity. Similarly, there were also inconsistencies found in the MLQ also whereby only 27 items from the whole were found to be consistent (Tejeda *et al*., 2001).

Consequently, an attempt was made to adapt and modify the measurement of transformational leadership in schools in Hong Kong by Yu and Jantzi (2002). In the

views of Leithwood and Jantzi‟s (1999), the model depicted three broad clusters of leadership practices where they were divided into eight main dimensions based on a 42 item scale of six-point Likert scales. Yu and Jantzi (2002) have outlined that the three clusters set directions (sharing of vision; consensus, objectives, preferences, goals, and priorities and creating high performance expectations", developing people (providing individualized support; intellectual stimulation and modeling values and practices) and redesigning the organization (collaborative culture; sharing knowledge for establishing responsive structures for decision making and establishing networks in collaboration with parents and people from local communities). In the study carried by Yu and Jantzi (2002), factor analysis using principal component extraction along with deploying varimax rotation to analyze every single individual item of the scale and the results obtained indicated that most of the items demonstrated moderate strengths of 0.68 to 0.89. Besides, the eight dimensions found in the transformational leadership used in this study were highly correlated. However, even though Yu and Jantzi (2002) had carried out a valid and reliable study, the scale is yet to be tested empirically in different settings or perspectives.

Furthermore, a later study by Antonakis *et al*., (2003) fully supported the contemporary version of MLQ 5X which comprised of nine (9) full-range factors. They found that, the instruments are valid and reliable whereby they believed other researchers who obtained inconsistencies in the validity of the instruments were possibly because of the differences in homogenous of their samples and research settings. Therefore, in order to obtain significant results, future studies are recommended to use more homogenous samples.

Another study conducted by Walumbwa, Wang, Lawler, and Shi (2004) focused more on analyzing as to how transformational leadership and organizational commitment can influence job satisfaction in the financial sector, particularly in the banking sector. The study suggested that the uni-dimensional constructs for transformational leadership styles. In accordance to this, they argued that the coefficient results indicated a strong correlation (coefficient alpha = 0.92) another study using single dimension same result strong correlation for transformational alpha= 0.91 and for transactional = 0.866 which reflecting "high-order constructs of transformational and transactional leadership". Previous study (Walumba *et al*., 2005) also found consistent results with the application of uni-dimensional construct in their later study that`s why this study followed single dimensional leadership style.

In conclusion, from the previous researches regarding leadership styles, the present study adapted uni-dimensional scale for transformational and transactional leadership style factor as suggested by Walumbwa *et al*. (2004, 2005) and it was found that the scale for transactional leadership to be following the same theory. Besides, this uni-dimensional scale has been adapted by numerous studies in the past for empirical investigation in different occupational settings. For instance, Nguni, Sleegers, and Denessen (2006), in the food and banking services by Emery and Baker (2007) and also in research and development environment by Berson and Linton (2005; Alharbi & Yusoff, 2012). Researchers like Hair, Money, Page, and Samouel (2007) have added that these can absolutely help in satisfying the principle of parsimony of a good research where the simplest application of approach is preferred than to a

multifaceted. Ahmad, Majid and Zin (2015) also use uni-demension transactional leadership style and transformational leadership style and received good results. Furthermore recently research conducted in education sector while using leadership style`s uni-dimensional scale; the researcher retrieved best results (Hashim & Mahmood, 2012, 2011) instrument of transformational 0.916= transactional =0.886 and recommended this instrument in health sectors to further investigate. Alharbi and Yusoff, (2012) also used uni-dimension MLQ Short form and recommended to use this instrument in hospitals. Henceforth, based on the critical literature review, the current study adapted uni-dimensional factor for three (transformational, transactional and laissez-faire) leadership styles (MLQ).

3.6.2 Measurement of Leadership Styles

Studies by Bass and Avolio (1990; 1994) have defined transformational leadership with charisma, compelling apparent vision and inspiring; mobilizing commitment of employees and having ability to bring changes at the institutional level. On the contrary, transactional leadership is characterized as the ones that are focused on employees' expectations of recognition and rewards through which they push employees to meet organizational aims (Boehnke *et al*., 2003).

For this study, the researcher adapted the latest version of (MLQ) instrument which is commonly used currently. It‟s popularly known as MLQ 5X- short-form, which is credibly known as the best to investigate leadership styles. A total of 36 thirty six (36) items were included for data collection.” The third meta category of "non-

transactional" of Antonakis *et al*., (2003) leadership style" of Boehnke *et al*., (2003) of the Full Range Leadership Model was included.

Different authors have described transformational leadership differently. According to Avolio, Bass, and Jung (1999) that transformational leadership is flawless influence an inspirational motivation, a charismatic behavior, a charismatic intellect. Measurement of transformational leadership`s factors were different, (5 measuring factors transformational leaders) as this research adopted a uni-dimensional construct for examining transformational leadership which is in agreement with the empirical studies of Walumbwa et al., (2004; 2005) and Alharbi and Yusoff (2012).

Measurement of transactional leadership comprised of examining management by expectation (active), and management by exception (passive) and contingency rewards (Avolio *et al*., 1999). The respondents were asked about their perception on their hospital leader‟s contractual rewards and disciplinary processes that could impact their commitment to service quality. Out of 36 questions, 20 represent transformational leadership and 12 questions represented transactional leadership and reaming 4 questions represent laissez-faire leadership style and focused on investigating the perceptions about the leadership style. The respondents were required to answer to the questions through using 5 point likert scale. The study decided to use uni-dimension scale which several other studies have also used in the past (Berson & Linton, 2005; Nguni et al., 2006, Emery & Barker‟s 2007; Hashim & Mahmmod, 2012; Alharbi & Yusoff, 2012). This scale adapted from (MLQ).

Table 3.1

Transformational Leadership Style

Construct	Item code	Survey Items
	TSL	Instills pride in me for being associated with her/him
	TSL	Goes beyond self-interest for the good of staff
	TSL	Have my respect
	TSL	Displays sense of power and confidence in me
	TSL	Talks only on most important values and beliefs
	TSL	Specific importance of having a strong sense of purpose
	TSL	Considers moral & ethical consequences of decisions
	TSL	Emphasizes important of group‟s mission
	TSL	Talks optimistically about future
Transformational	TSL	Is excited about what needs to be accomplished
	TSL	Articulates a compelling vision
	TSL	Expresses confidence on goal achievement
	TSL	Raises critical assumption to question whether they appreciate or not
	TSL	Seeking deferent perspective in problem solving
	TSL	Allows me look at problems different angles
	TSL	Suggests new ways to completing my work
	TSL	Spends time on training and caching
	TSL	Treats me as individual rather than member of group
	TSL	Considers me as having different needs/ abilities / aspiration
	TSL	Helps me to develop my strength.

Note. Transformational leadership style has 20 items

Table 3.2

Transactional leadership style

Constructs	Items Code	Items survey
Transactional	TS	Provides with assistants an exchange for my effort
	TS	Discusses with specific terms who is responsible for achieving performance targets
	TS	Clarifies my expectation when meeting perform expectation goal
	TS	Expresses satisfaction when meeting performance
	TS	Focuses attention on irregularities /mistake deviation from standards
	TS	Gives all attention in dealing with mistake/ complains/ failure
	TS	Keeps track of all mistakes
	TS	Directs my attention towards failures to meet standards
	TS	Do not fail interfere until the problem is serious
	TS	Wait for things go to wrong before taking action
	TS	hospital believes in not making changes unless necessary
	TS	Takes action only when problem become serious

Note: *Transactional leadership style has 12 items*

Table 3.3

Laissez-faire Leadership Style

Construct	Items Code	Survey items
Laissez-faire	LFLS	Avoids getting involved when important issues arise.
	LFLS	Is absent when needed.
	LFLS	Avoids making decisions.
	LFLS	Delays responding to urgent questions.

Note. Laissez-faire leadership style has 4 items

3.6.3 Measurement of Commitment to Service Quality

A total of nine (9) items were deployed to measure commitment to service quality. These items were adapted from the past studies on the topic pertaining to quality management and organizational commitment by Mowday *et al*, (1979). Notably, Clark *et al*., (2009) has forwarded the modified version of it. This study used the revised version with minor changes in order to match it with the context of the study. This adapts commitment to service quality from Clark *et al*., (2009). Other studies use this instrument.

Hashim and Mahmood, (2012) in their research on commitment to service quality amongst university (staff) teachers reported .841 Chronbach Alpha. On general grounds 0.70 value of Chronbach Alpha is accepted (Nunnally, 1978; Nunnally & Berstein, 1994); Robinson, Shaver, and Wrightsman, (1991); Sekaran and Bougie

(2010) have all referred to this cutoff point of 0.70. Respondents were required to answer by using the 5 point likert scale whereby 1 referred to strongly disagree and 5 as strongly agree.

Furthermore, Hashim and Mahmood (2011) use the questionnaire of commitment to service quality in education sector with 5 five points likert scale reported the reliability 0.841 which was highly acceptable. Study conducted by the Asgari (2014) with strongly agrees to strongly disagree with 5 points likert scale in banking sector and reliability reported 0.90 which was again highly acceptable. All above studies indicated that commitment to service quality questionnaire is highly reliable in the different research areas.

Table 3.4

Commitment to Service Quality

Construct	Items Code	Survey items
Commitment to Service Quality	CSQ	I feel strongly that about improving the quality of my hospital‟s services
	CSQ	I enjoy discussing services quality-related issues with people in my hospital
	CSQ	I gain a sense of personal accomplishment in providing high quality services to my customers
	CSQ	I completely understand the importance of providing high quality service to our customers
	CSQ	I often discuss quality-related issues with people outside of my hospital
	CSQ	I strongly feel that provision of high quality services to our customers should be the number one priority of my hospital
	CSQ	I am willing to put more effort beyond that normal in order to deliver service quality my hospital.
	CSQ	The way I feel about services is very similar to the way my hospital feels about delivery of high quality services
	CSQ	I really care about the quality of my hospital‟s services

Note: *commitment to service quality has 9 items*

3.6.4 Measurement of Moderating Variable Role Clarity

To measure role clarity, 17 questions in total were adapted. This instrument was originally drawn by Chonko, Howell, and Bellenger (1986) whereas, Clark *et al*., (2009) recently modified it with slight changes. The revised version suited the context of the current study more hence, it was chosen in this regard.

Table 3.5

Role Clarity

Construct	Items Code	Survey Items
Role clarity	RC	I am well aware of how to best serve the customer s
	RC	I get adequate time to spend on various aspects of my job
	RC	I am able to resolve customer complaints.
	RC	I get to fill out required paper work
	RC	I plan and organize my daily work activities
	RC	I can handle unusual problems and situations
	RC	I know where to get assistance in doing my job
	RC	I am satisfied with extent to which I can bend the rules to satisfy the customers
	RC	I am satisfied with extent to which I can make decision without my supervisors‟ approval.
	RC	I am well aware of hospital`s rules and regulations
	RC	I am aware of how my supervisor evaluates my performance
	RC	Your supervisor is satisfied with my performance
	RC	Receive adequate work related training
	RC	I am aware of the factors that determine my promotion and advancement
	RC	I am aware of how my supervisor expects me to allocate my time
	RC	I am aware of how satisfied my customers are with my performance
	RC	I am aware of what my customers expect from

Note, Role clarity has 17 items

3.7 Five-point Likert Scale

Five-point Likert scale was used in the present study. The scale has been extensively used in prior studies concerning to leadership styles and commitment to service quality (Nawaz & Bodla, 2010; Hashim & Mahmood, 2012; Pahi & Hamid, 2015; Madlock, 2008). Similarly, Clark (2009) also used five point scale whilst examining

role clarity and termed it appropriate in this regard . More recently Govender and Ramroop (2013) also used the same scale on leadership styles and role clarity. Colman et al., (1997) have highly recommended using scales applied by past studies on the topic

According to Losby and Wetmore (2012) have expressed that not giving a neutral point in the scale (just like 3 in 1 to 5 scale); indirectly forces the respondents to go on the extreme sides hence, they also fail to outline about something that they are not very sure. Additionally, it becomes quite easy for respondents to report their respective perceptions through five pints likert scale (Dawes, 2008). Accordingly, Frary (1996) mentioned that seven or more points on a scale require more time and effort hence, it could confuse respondents.

3.8 Demographic Variables

The questionnaire also contained questions pertaining to demographics of the respondents such as gender, age, job experience, and education. Gender was coded using dummy variables with value "1" for male and "2" for female. Similarly, marital status was also coded as "1" for Single and "2" for Married. The participants were asked to indicate their educational qualification and were also coded using dummy variables with "1" Specialist (PhD holders) "2" FCPS "3" MBBS "4" Other educational degrees. Age was denoted using dummy variables with "1" = 20-30 years, "2" = 31-40 years, "3" = 40-50 years, and "4" = 50-60. Similarly for

experience “1” for Less than one year, “2” for 1 to 5 years, “3” for 5 to 10 years, “4” for 10 to 15 years, “5” for More than 15 years.

3.9 Population of Study

The population is considered most vital element in research, population focus on individual or objects with related characteristics. There are two types of population in research and they are known as target population and accessible population (Castillo, 2009). Target population represents individuals and objects where the research can be done to generalize the results (another name is theoretical population). Furthermore, the accessible population researcher can be approached for conducting survey. In this study target population was 43 public hospitals of Sindh. Please refer to Pakistan hospital names (in Appendix E). First reason for selecting hospitals of Sindh province was that these hospitals are the biggest serving hospitals of the Sindh province. Secondly, these hospitals were facing the problem of delivering services to customers as forwarded by Nisar and Amjad (2007), and Ahmed and Samreen (2011). In addition to this, it was also noted that Sindh is the second biggest and densely populated province Pakistan with total population of 30,439,893 (www.Sindh.gov.pk, 2014) and facing many challenges of health care problems in reign. Important to note that since there were time and financial limitations because of which it was not feasible for the researcher to conduct primary data collection from the entire country. Lastly, the researcher also outlined that the condition of hospitals in Sindh was very poor particularly in terms of service. Medical officers (doctors) were the prime target population of this study, serving in the public sector hospitals of Sindh province. As per the (Pakistan Medical and Dental Council)

report, there are 70594 registered medical officers (doctors) serving in 43 public hospitals across the Sindh province (PMDC, 2015).

3.9.1 Sample of Study

Krejcie and Morgan (1970) have provided a reasonably good, sample size formula and comprehensive Table to calculate sample given in the population. This study hence has used Krejcie and Morgan Table in this regard.

As stated earlier that the total population for this study was 70,594, whereas, referring to the Krejcie and Morgan (1970) the total number of respondents for a population of 50,000 should be 381 and 382 for population of 75,000. Hence a total number of 382 respondents were required. There is a severe paucity of research on hospital management and on its services in the Pakistan region, especially in the Sindh province. Therefore, finding a specific responsive rate is very hard.

For responsive and sufficient data collection, researcher added 50% in the original sample size as suggested by Bartlet and Kotrilik (2001), and Hair, Black, Babin and Anderson, (2010), sample size 10 times the numbers of studying variables. Based on suggestion, for this study sample is multiplied by two and size of simple 382 equaled 764. Hence 764 questionnaires were responsively circulated amongst the medical officers of public hospitals in Sindh province.

3.9.2 Sampling Technique

In quantitative research, the representativeness of a wider population is important in order to enhance the generalization of findings (Bryman, 1988). In general, sampling can be broadly categorized into two (i.e Probability sampling and non-probability sampling).

Interesting feature of probability sampling is that it suggests all the member of the target population to have an equal chance of being selected. It has further types to do which are known as probability sampling techniques such as simple random, cluster, stratified and systematic sampling. When simple random sampling is done, the researcher takes random selections from the entire population which provides everyone an equal chance to be selected for the study. Accordingly, in stratified random sampling, the researcher takes the entire population and divides it further into different strata from where independent samples are selected on a random basis from each stratum. While in cluster sampling, the target population is distributed into groups based on clusters and areas. Similarly, systematic sampling is called provides a justifiable approximate simple random samples that comprise of cases from an available list of the target population at defined internals.

Talking about non-probability sampling, there are no equal chances available for every target audience to be selected for the study. This includes approaches known as purposive sampling, quota sampling and convenience sampling. In convenience sampling, the respondents from the target population are selected based their availability and willingness to participate. Quota sampling simple assigns quota to

every strata and allows the non-random selection from them. Lastly, purposive sampling gives the researcher the opportunity to pick and choose specific respondents that could potentially be of need or relate to the study.

The current study has strived to responsively cover all the public hospitals operating in the Sindh Province. Researcher requested the complete lists of medical officers serving in the 43 public hospitals for conducting surveys. Notably, the researcher tried utmost to get data from the Ministry of Health, Pakistan and Sindh Health Department but failed. In fact, the list was not available for two reasons. Firstly, the document was not updated, thus it could have provided inappropriate information about the number of doctors in each hospital of Sindh. This was also because the hospitals do not frequently notify these departments with any updates concerning to the list of serving doctors. Therefore, the usage of simple random sampling was not the right approach for this study as every element of the population may not get an equal chance of being included in the sample.

As discussed earlier that in cluster sampling, the population is divided into group‟s population and then selecting cluster or grouping rather than individuals in the sample (Kothari, 2004). Cluster sampling frame is list of clusters Saunders, *et al.,* (2011). Furthermore, some researchers use more than one sampling technique at the same time (Robert, Floyd, Mick, Lepkwisi, Roger, 2009). In the views of Zikmund (2003) that core aim of using cluster sampling is getting an economic sample whilst retaining the characteristics of probability sample at the time when cluster samples are selected.

Thus, even though the present study has chosen the cluster sampling, the randomness of the sample exists, which, according to Anderson (2004) is more appropriate for quantitative data. Further development of cluster sampling in Multi-stage or multi-stage cluster sampling Therefore, for the current study the researcher used multiple stage cluster sampling whereby the target population was divided into geographical segments, cities and towns followed by simple random selection (Kothari, 2004; Allen *et al*., 2002). In multi- stage cluster sampling, random sampling is logically feasible, furthermore researcher described that cluster sampling avoid bias and produce effective sampling (Greener, 2008). Replication of systematic sample use as unbiased or a ratio estimator as outlined.

In multi cluster sampling, the researcher firstly selected whole Pakistan and in the second phase the sample was divided based on four provinces known as Punjab, Sindh, NWF and Baluchistan. Lastly, from the four provinces, Sindh was selected and divided into four clusters based on its larger districts. They are Karachi, Hyderabad, Larkana and Sukkur. These clusters were identified on the basis of location (area) of the public hospitals in Sindh, Pakistan. The probability method used to select in order to perform selection with equal probability or with probability proportional (pps) (Allen *et al*., 2002). Further explanations could be retrieved from Table 3.6 and Figure 3.2

Table 3.6

Proportional sample

Four clusters of Sindh	Number of hospitals	Required	Required sample from each cluster
KARACHI	26	60%	458
HYDERABAD	8	19%	145
LARKANA	6	14%	107
SUKKUR	3	7%	54
Total	43	100%	764

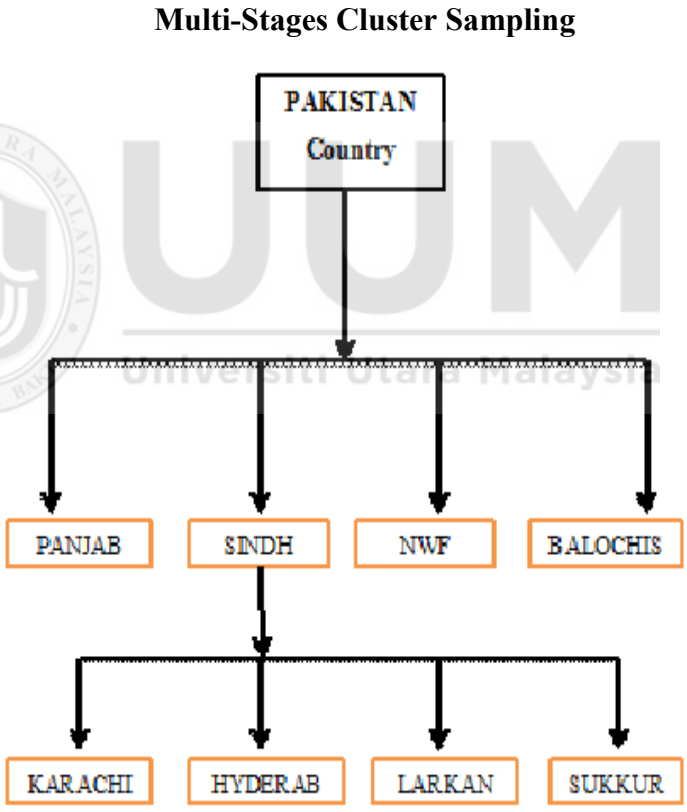

Figure 3.2 Multi Stages Cluster Sampling

The Figure 3.2 shows as how the researcher whilst using multi stage cluster sampling considered the entire country Pakistan from where the entire sample was divided into

four clusters based on the total number of provinces. From there, the Sindh province was selected and the population was further clustered for data collection from the four cities.

3.9.3 Unit of Analysis

According to Creswell (2004) the population sampling is a process whereby a representative group of respondents is selected from the population to study and conduct further statistical analysis. The sample was collected from a targeted population to get the representation of the whole target population. Research sample is apparently a fraction of clear subject whole targeted population of researcher interest area. The sampling offers deep information, that information comprised small units of numbers (Sekaran & Bougie, 2010). Del Brío, Fernandez and Junquera (2007) stated that the researchers need to focus on a single set of respondents rather than multiple respondents; single set of respondent is able to provide needed information and is more responsive compared to multiple sets. For the present study unit analysis was medical officer (doctor).

3.10 Pretesting of the instrument

Before conducting the actual survey, an initial draft of the questionnaire was pre-tested by asking experts to go through and outline if there are any ambiguities. Firstly, four persons, including one staff member; a Professor; a doctor, and one from the management of hospital from the public hospital of Jamshoro, public hospital Hyderabad of Sindh were selected. Moreover, research experts from the Universiti

Utara Malaysia and IBA Sukkur Sindh, Pakistan were also taken to assess the quality of the survey instrument in terms of its face validity (wording, format, clarity, simplicity and ambiguity of the questionnaire) (Dillman, 1991; Yaghmale, 2009). Based on these evaluation criteria, corrections and improvements were suggested, which were later included in the survey instrument. Thus, all corrections and suggestions for improvement were noted and reflected in the survey instrument before it was administered to the respondents.

Secondly, 23 questionnaires were distributed in order for responsive feedbacks and comments from the respondents on the length, structure and wording of the questionnaire. While carrying out pretest of the Instrument, some fundamental issues in the questionnaire were raised by the respondents. These issues raised were recorded in a diary. On the basis of issues identified during the pretest, some changes were made in the questionnaire before administering to the main survey sample. For example, the term organization was changed with hospital and complex words such as critical were altered with important. Additionally, question regarding salary was deleted as per suggestions.

3.11 Pilot Study

The study also deployed pilot study in order to ensure the validity and reliability of the chosen measures of the study (Flynn, Sakakibara, Schroeder, Bates, & Flynn, 1990). This is considered necessary because the original scales that have been adapted in the present study were developed and tested mainly in the developed

countries (Elmadağ, Ellinger & Franke, 2008; Clark, Hartline, & Jones, 2009; Ashill, Carruthers, & Krisjanous, 2006; Long, & Thean, 2011; Emery, & Barker, 2007; Cemaloğlu, Sezgin, & Kılınç, 2012; Yammarino, & Bass, 1990; Bass, 1985a, Bass, 1985b, Bass 1998; Rowold, & Heinitz, 2007). Following the Diamantopoulos and Siguaw‟s (2012) guidelines, a total of 60 questionnaires were sent out for the pilot survey; however, only 42 medical officers from various hospitals located in the Sindh completed the questionnaires which resulted in the response rate of 70%. It should also be noted that these 42 questionnaires from medical officers were not considered in the actual study. PLS path modelling (Wold, 1974, 1985) using Smart PLS 2.0 M3 software (Ringle, Wende & Will, 2005) was employed to ascertain the internal consistency reliability and discriminant validity of the constructs used in the pilot study. In particular, PLS Algorithm (Geladi & Kowalski, 1986) was calculated to obtain the average variance extracted and the composite reliability coefficients. Bagozzi and Yi (1988) as well as Hair et al., (2011) suggested that the composite reliability coefficient should be at the conduct of pilot test are very important as it helps in avoiding any ambiguities for respondents in filling up questionnaires. Hence the pilot tests were conducted before data collection. The views of Fornell and Larcker (1981) have forwarded that AVE (Average Variance Extracted) must be 0.5 or above and composite reliability must be 0.70 or above. They have further stated that to achieve adequate discriminant validity, the square root of the AVE should be greater than the correlations among latent constructs. Table 3.7 presents the average variance extracted and composite reliability coefficients of the five latent constructs.

Table 3.7

Reliability and Validity of Constructs (n=42)

Latent variables	No: indicators	Average variance extracted	Composite reliability
Transformational leadership	20	0.610448	0.967046
Transactional leadership	12	0.587661	0.919068
Laissez-faire leadership style	4	0.640146	0.814952
Role clarity	17	0.720112	0.967681
Commitment to service quality	9	0.800917	0.972992

As Table 3.7 pictures above that the coefficients of composite reliability of all the latent constructs have ranged within .81 to .97 thus exceeding the minimum acceptability levels (.70). This also gives confidence on the internal consistency and reliability of the deployed measures of the study (Hair *et al*., 2011; Bagozzi & Yi, 1988). Accordingly, the Table also outlines that AVE values have ranged between .58 and .80, which are acceptable as well. Table 3.8 shows comparisons of the correlations amongst the latent variables with their square roots.

Table 3.8

Latent Variable Correlations

Latent Variable Correlations	1	2	3	4	5
Commitment to service quality	**0.89494**				
Laissez-faire leadership style	0.578766	**0.800091**			
Role clarity	-0.281	-0.22189	**0.848594**		
Transformational leadership	0.702414	0.514872	-0.17939	**0.781312**	
Transactional leadership	0.764266	0.715393	-0.32624	0.678215	**0.766591**

***Note*,** Figures mentioned in **Bold** underline the square root values of the AVE of whereas the remaining values represent values with other correlations.

The Table 3.8 highlights that the correlations between the latent constructs were matched and equated with the square root of the AVE values (Bold). The Table also outlines that the square root of the AVE of all the latent constructs was greater than the constructs it is cross examined with (Fornell & Larcker, 1981).

3.12 Data Collection Procedure

In the present study, the actual data collection started a month after the proposal defense and went on for nearly four months (i.e., between December, 2014 and March, 2015). The data was collected through using self-administered questionnaire. An official letter was collected from the School of Business Management (SBM) to facilitate the researcher in collecting the data. The letter outlined the core purpose behind the research study along with basic introduction about the student and nature of studies.

In the second stage of data collection, a survey package was sent to the executive members of hospital management who assisted in administering the questionnaires. The survey package was in a fullscap size envelope along with a cover letter, questionnaire and a pen with UUM logo to motivate the participants. The cover letter clearly highlighted the background and purpose of the study. The cover letter also provided instructions on how to answer and return the questionnaire. To further increase the willingness of the participants to take part in the survey, their anonymity and confidentiality were confirmed in the cover letter. The questionnaires were then mailed to management with stamped self-addressed envelopes for the convenient return of the questionnaires. Management distributed questionnaire to medical

officers (doctors). A brief introduction clarifying the purpose of the study, telephone number and email of the researcher and supervisor was mentioned in the questionnaire. The participant of the study was assured of the complete anonymity of their responses.

Nearly 30 days after sending out the survey package, 241 completed and usable questionnaires were received. These 241 completed questionnaires were labeled as early responses and were further used in conducting non-response bias on the main study variables. Despite the encouraging responses, a follow-up phone calls and Short Message Service (SMS) were also sent to remind those participants who were yet to complete their questionnaires. However, since the participants were given assurance of their responses` confidentiality, it was difficult to track them. Therefore, management helped in sending gentle reminders via group emails that participant who was not returned their questionnaires. Hence, this effort yielded additional 74 questionnaires, which were labeled as late responses, which were used for testing non-response bias. Overall, within a period of data collection, out of 764 questionnaires distributed to the target participants, 391 questionnaires were returned. Of these 391 questionnaires, 71 were excluded because a significant part of these questionnaires was noted to be incomplete; and the remaining 320 useable questionnaires were utilized for further analysis. This accounted for a response rate of 51%.

It is practically impossible to collect data without encountering some problems. One of the major problems encountered during the course of data collection was related to

geographical location of the participated hospitals as many of them were sparsely distributed in remote areas of the states.

Another problem encountered during the data collection was related to the time taken before collecting back the completed questionnaires. Initially, it is predicted that the data collection exercise would not exceed as the respondents gave assurance that they will return completed questionnaire within two weeks‟ time. Hence, the use of text messages, phone calls and frequent visits to the participated hospitals facilitated the data collection exercise.

3.13 Data Analysis

The present study employed PLS path modelling (Wold, 1974, 1985) using Smart PLS 2.0 M3 software (Ringle *et al*., 2005) to test the theoretical model. The PLS path modeling is considered as the most suitable technique in this study for several reasons: First, even though PLS path modeling is similar to conventional regression technique, it has the advantage of estimating the relationships between constructs (structural model) and relationships between indicators and their corresponding latent constructs (measurement model) simultaneously (Chin, Marcolin, & Newsted, 2003; Duarte & Raposo, 2010; Gerlach, Kowalski, & Wold, 1979; Lohmöller, 1989).

Secondly, as mentioned at the outset of this study, despite the extant research regarding the transformational, transactional, laissez-fare leadership style and commitment to service quality and role clarity has not yet been explored. Further, the goal of the present study was how leadership can influence on medical officers`

commitment to service quality and how role clarity of staff can increase the efficiency of the staff and change behavior as towards the commitment to service quality and supporting with theories cognitive dissonance and role clarity. This requires a path modeling approach to be employed because it has been suggested that if research is prediction-oriented or an extension of an existing theory, PLS path modeling should be employed (Hair *et al*., 2011; Henseler, Ringle, & Sinkovics, 2009; Hulland, 1999). Fourthly, compared to other path modeling software (e.g., AMOS; Analysis of Moment Structures), the Smart PLS 2.0 M3 software was selected as a tool of analysis because of its friendly graphical user interface, which help users create a moderating effect for path models with interaction effects (Temme, Kreis & Hildebrandt, 2006, 2010).

Several steps were followed in the data analysis. Firstly, the data collected was screen using SPSS to ensure that it is suitable for the PLS analysis. Secondly, for the purpose of ascertaining measurement model, individual item reliabilities, internal consistency reliabilities, convergent validity and discriminant validity were calculated using Smart PLS 2.0 M3 software (Hair *et al*., 2011; Henseler *et al*., 2009).

Thirdly, standardized bootstrapping was also executed whereby the sample was bootstrapped with 5000 samples and 315 cases in order to assess the structural model (Hair *et al*., 2011; Henseler *et al*., 2009; Hair, Sarstedt, Ringle & Mena 2012).

Importantly, as per the recommendations of Hair, Hult, Ringle and Sarstedt (2014) the model was examined to assess path coefficients, predictive relevance, and level of the *r*-square values. Furthermore, a supplementary PLS-SEM analysis (i.e., moderator analysis) was conducted after the assessment of direct effects. Lastly, following the recommendations of Henseler and Chin‟s (2010b) and Henseler and Fassott‟s (2010a) the strength of the moderating effects using Cohen‟s (1988) effect size formula was examined.

Apart from this, the study also performed initial data assessment and cleaning procedures such as identification of missing data, common variance and outliers as per the explanations of Hair *et al.,* (2010).

Hair *et al*., (2010) have also explained outliers which refer to the observations that has a unique mixture of features or characteristics that can be specifically outlined as distinct from other observations. It is important to examine outliers with precision as they affect data results (Sekaran & Bougie, 2010). Therefore, the method of Mahalanobis distance was applied to clean the data.

3.14 Chapter Summary

This chapter has described the methodology comprising the research framework, underpinning theory, development of hypothesis hypotheses, operational definitions, and research design of the variables, measurement, population, sampling, data collection procedures and techniques of data analysis. The present study also adopts cross-sectional research design in which data collected was analyzed and interpreted

statistically. The unit of analysis in this study was individual medical officers working in the selected public hospitals of Sindh whilst using the multi-cluster sampling approach. Measurement scales from the previous studies were adapted to measure four constructs: transformational, transactional, laissez-faire leadership style, commitment to service quality and role clarity. The next chapter presents results of the final data analyses.

CHAPTER FOUR

DATA ANALYSIS AND FINDINGS

4.1 Introduction

This chapter provides the results of the current study through using PLS path modeling. The chapter starts with laying detailing concerning to data screening, preliminary analysis followed by result of all exogenous and indigenous variables. Afterwards, the chapter discusses data results in two parts; the first part puts light on the measurement model of the study whereby loadings for item reliability, internal consistency reliability, discriminant validity and convergent validity are mentioned. The later part discusses the structural model, outlining coefficient significance of the variables and effect size, predictive relevance of the researched model, and r-square. The chapter ends with explaining the moderating effects of role clarity on commitment to service quality.

4.2 Response Rate

A total of 764 questionnaires were distributed amongst the medical officer of 43 public hospitals of Sindh, Pakistan. Please refer to Appendix (E) for further details in this regard. Follow up calls and emails were sent to the concerned individuals in order to boost the response rate followed by information posting over the notice boards (Traina, MacLean, Park & Kahn, 2005; Salim Silva, & Smith 2002; Sekaran,

2003). Out of the total 764 distributed 391 questionnaires were received back, making the response rate of 51%. Moreover, 71 questionnaires out of the 391 retuned were improperly filled or were not completed and thus were discarded. This left 320 for further analysis for the present study. According to Sekaran and Bougie (2010), 30% response rate is sufficient and acceptable for data analysis and on the premise of this, the response rate of this current study after discarding incomplete questionnaires has reached 41% (see Table 4.1) for further details.

Table 4.1

Response Rate of the Questionnaires

Response	**Frequency/Rate**
No. of distributed questionnaires	764
Returned questionnaires	391
Returned and excluded questionnaires.	71
Returned and usable questionnaires	320
Questionnaires not returned	373
Actual response rate	41%

The data collection process was completed in total of four months, starting from December 2014 to March 2015. Once the data collection was completed, SPSS version 22 was used for the purpose of preliminary data cleaning after which, the data was imported to SmartPLS 2.0 M3 (Ringle *et al*., 2005) for further analysis.

4.3 Data Coding

The following codes were used for every construct to easily identify while performing data analysis.

Table 4.2

Variable coding

Variables	Code
Commitment to service quality	CSQ
Transformational leadership	TSL
Transactional leadership	TS
Laissez-faire leadership	LFLS
Role clarity	RC

4.4 Data Screening and Preliminary Analysis

While doing multivariate analysis, it is necessary to perform data screening as it facilitates in outlining violations concerning assumptions related to the application of multivariate technique of data (Hair *et al*., 2007). A total of 320 usable questionnaires were coded and allotted with an ID number, each starting from 1 to 320 in SPSS. (1) missing value analysis (2) assessment of outliers (3) normality test and, (4) multicollinearity tests (Hair, Black, Babin, & Anderson, 2010; Tabachnick & Fidell, 2007) were conducted.

4.4.1 Missing Value Analysis

Treatment of missing values is a critical step in data analysis. In order to deal with the missing values, the descriptive analysis was done through using SPSS. A total of 17 values were found missing as the result of it on a random pattern. Result of 17 missing values, 3 was in commitment to quality; 7 in transformational leadership 3 in transactional, and 4 in role-clarity construct. However, the descriptive analysis did not outline any missing values in laissez-faire leadership. Generally, 5% of missing values or less are accepted and hence does not affect much. This study got less than 5%. Yet there is still not any mutual agreement on the level or percentage of missing values in the research literatures (Tabachnick & Fidell, 2007; Schafer, 1999). Research scholars have proposed several reliable ways to deal with the missing values (Raymond, 1986; Little & Rubin, 2014; Tabachnick & Fidell, 2007). According to Acuna and Rodriguez (2004) when the extent of missing values in a data-set is less than 15% then it becomes convenient to resolve or no matter it will be resolved. This study concluded with less than 5% missing values. This study therefore, employed mean-replacement approach to treat the missing values (Tabachnick & Fidell, 2007). Table 4.3 presents the detailed overview about the missing values in this study (see Appendix B for SPSS outputs).

Table 4.3

Missing Values

Latent Variables	Number of Missing Values
Commitment to service quality	3
Transformational leadership style	7
Transactional leadership style	3
Laissez-faire leadership style	0
Role clarity	4
Total	17 out of 21760 data points

4.4.2 Assessment of Outliers

Outlier assessment defined by Barnett and Lewis (1994), "as observer or subsets of observations that appear to be inconsistent with the remainder of the data" (p. 7). The presence of outliers in the data can severely affect the regression results hence resulting in making the data unreliable (Verardi & Croux, 2008). Therefore, to highlight the observations appearing outside the normal data dispersions, frequency Tables were generated through using SPSS for all the variables using minimum and maximum statistics.

The frequency Tables underlined NO values outside of the given range. Additionally, the data was also examined for univariate outliers via using standardized values with a cut off of ±3.29 ($p < .001$) (Tabachnick &Fidell, 2007). Based on this criterion, none of the cases were highlighted as outliers. Furthermore, multivariate outliers were also outlined in the data through following Mahalanobis distance (D2).

According to Tabachnick and Fidell (2007) Mahalanobis distance (D2) is defined as "the distance of a case from the centroid of the remaining cases where the centroid is the point created at the intersection of the means of all the variables" (p. 74). The recommended chi-square threshold is 102.166 (p=0.001) based on which, 62 observations, that exceeded this threshold, were deleted from the data. There cases were found outlier 53,152,197,269, from 320. After deleting these cases from the data, the total sample for the present study was 315.

4.4.3 Normality Test

Numerous scholars (Reinartz, Haenlein, & Henseler, 2009; Cassel, Hackl, & Westlund, 1999; Wetzels, Odekerken-Schroder, & Van Oppen, 2009) have underlined the significance and robust performance of PLS-SEM in generating exact estimations in situations with non-normal data. According to Hair, Sarstedt, Ringle, and Mena (2012) that normality test is critical for every data set as kurtotic and skewed can inflate the bootstrapped error estimations (Chernick, 2008). Therefore, we conducted normality test in graphical method (Tabachnick & Fidell, 2007) for this study which turns out underestimated results of path coefficients significance (Ringle, Sarstedt, & Straub, 2012a; Dijkstra, 1983). In the views of Field (2009) that when sample size is 200 or more then it is better to apply graphical test rather than checking value of kurtosis and skewness statistics. In addition to this, Field also defined that large samples decrease the standard error, which in turn, inflates the value of the skewness and kurtosis statistics. Based on this suggestion, normality test was examined through histogram in order to ensure that the normality assumptions

were not violated. Figure 4.1 shows that data set of this study is on normal pattern with normal curve hence, the study has not violated the normality guidelines.

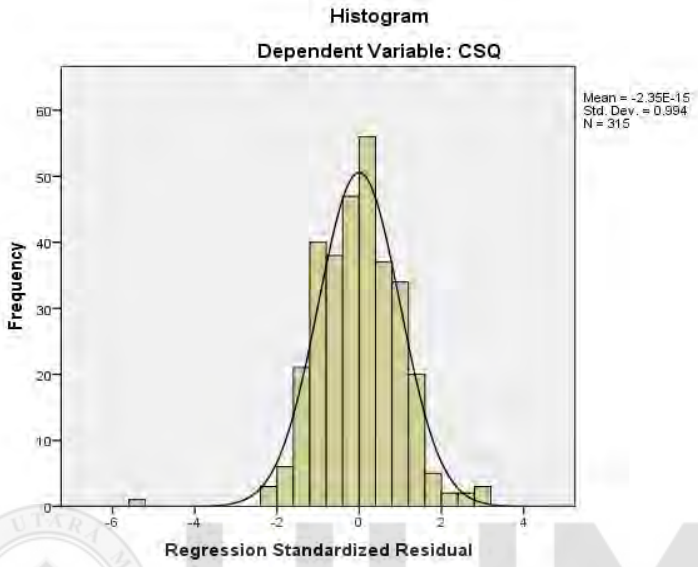

Figure 4.1. Histogram and normal probability plots

4.4.4 Multicollinearity Test

Multicollinearity test amongst the exogenous variables refers to constructs that are highly correlated or vice versa. In general, multicollinearity increases standard error of coefficients, which results in negative impacts on coefficients (Tabachnick & Fidell, 2007). Multicollinearity amongst the exogenous latent constructs can be misrepresenting the estimations of regression coefficient and other bad impacts on statistical significance tests (Hair, Black, Babin, Anderson, & Tatham, 2006; Chatterjee & Yilmaz, 1992; Peng & Lai, 2012). To find the multicollinearity, the present study had used two methods. The first test employed was correlation matrix. Hair *et al*., (2010) suggests that if correlation coefficients are at the value of 0.9 or

above then the multicollinearity in data exists among the exogenous latent constructs. Table 4.4 shows the correlation matrix of all exogenous latent constructs.

Table 4.4

Correlation Matrix of the Exogenous Latent Constructs

No.	***Latent Constructs***	***1***	***2***	***3***	***4***
1.	Transformational	1			
2.	Transactional	.621**	1		
3.	Laissez-faire	.850**	.625**	1	
4.	Role Clarity	.087	.028	.101*	1

Note: ** Correlation is significant at the 0.01 level (1-tailed).
*. Correlation is significant at the 0.05 level (1-tailed).

Results of the Table 4.4 outline that correlation amongst the exogenous latent constructs does not exist as the values are below the 0.90 mark. Based on this test, multicollinearity is not an issue for the present study.

Moving further to the next test to acquire further confirmation on multicollinearity is through tolerance value, variance inflated factor (VIF) and condition index. According to Hair *et al*., (2011) the tolerance values must be more than .50 and VIF less than 5 and index less than 30 to ensure no multicollinearity among the exogenous latent constructs. Table 4.5 provides the details in this regard.

Table 4.5

Tolerance and Variance Inflation Factors (VIF)

Latent Constructs	Collinearity Statistics		Condition Index
	Tolerance	VIF	
Transactional	.609	1.643	1.000
Laissez-faire	.603	1.659	8.719
Role clarity	.988	1.012	15.552

Table 4.5 shows that there exists no multicollinearity amongst the exogenous latent constructs as the tolerance values are above .2, VIF is less than 5 and condition index is also less than 30. Hence this data is free from multicollinearity issues based on the recommendations on (Hair *et al*., 2010 and Hair *et al*., 2011).

4.4.5 Tests for Non-Response Bias

Test of non-response bias can be avoided in the research however, believes that "the difference in the answers between non-respondents and the respondents" (Lambert & Harrington, 1990; p.5) may affect the final results. The present study has used independent t-test analysis to examine the mean and standard deviation. Armstrong and Overton (1977) have recommended the comparison of answers of early respondents with the ones who have responded lately. According to the authors, the late respondents are somehow the same like the non-respondents. In the views of Lindner and Wingenbach (2002) that at least 50% of response rate should be achieved from the target respondents in the early given time. The present study applied the recommendation by Armstrong and Overton (1977) and divided the respondents divided into two groups first group representing the ones who responded within thirty (30) days, were marked as early respondents while all the rest were noted as

late respondents (c.f., Vink & Boomsma, 2008). For present study, out of the sample of 315, (76%) responses were received with 30 days and remaining 24% after the allotted time respectively. in addition to this, independent sample t-test was also applied to identify bias and no-bias respondents. Table 4.6 explains further details in this regard.

Table 4.6

Results of Independent-Samples T-test for Non-Response Bias

Variables	**Group**					**Levene's Test for Equality of Variances**	
Period		**N**	**Mean**	**Std. Deviation**	**Std. Error Mean**	**F**	**Sig.**
CSQ	Early Response	241	3.7603	0.63189	0.0407	2.377	.124
	Late Response	74	3.6111	0.65805	0.0765		
TLS	Early Response	241	3.8122	0.52377	0.03374	1.247	.265
	Late Response	74	3.5358	0.53202	0.06185		
TS	Early Response	241	3.8213	0.76185	0.04908	.088	.767
	Late Response	74	3.2613	0.71558	0.08318		
LFLS	Early Response	241	3.8494	0.69525	0.04479	3.551	.060
	Late Response	74	3.4764	0.75644	0.08793		
RC	Early Response	241	1.7859	0.41639	0.02682	.168	.682
	Late Response	74	1.8172	0.39736	0.04619		

Results in Table 4.6 explain that the values of non-response bias test should be greater than 0.05. For this purpose Pallant (2010) and Field (2009) have recommended Levene`s Test.

4.4.6 Common Method Variance Test

Common method variance (CMV) which is also known as mono-method bias which refers to "variance that is attributable to the measurement method rather than to the construct of interest" (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003, p. 879). Numerous researchers believe that CMV is critical issue when it comes to the usage of self-report surveys (Podsakoff *et al*., 2003; Lindell & Whitney, 2001; Spector, 2006). According to Conway and Lance (2010) that common method bias (CMB) inflates the association between exogenous and indigenous variables measured by self-report.

Meta-analysis of 55 studies on dispositional and attitudinal predictors of organization citizen behavior using the self-report survey reported high correlation due to CMV (Organ & Ryan, 1995). The present study has applied numerous remedies to decrease the effects of common method variance as suggested by (Viswanathan & Kayande, 2012; Podsakoff *et al*., 2003; Podsakoff, MacKenzie, & Podsakoff, 2012; MacKenzie & Podsakoff, 2012; Podsakoff & Organ, 1986). At the first, all the respondents were educated that there is no right or wrong answer to any of the posed question and that the responses will be kept confidential as so there participation in the research study. Secondly, the study conducted pre-test in order to exclude vague ideas and jargons to reduce bias and confusions. Moreover, the questionnaire was developed using simple, easy to understand language to maximize the possibility of getting better answers. Importantly, the present study also applied Harman single test (Podsakoff and Organ, 1986) in order to observe the CMV. This method examines to outline variance in exogenous latent variables. Following the Podsakoff and Organ (1986),

the present study conducted components factor analysis of all items; the total variance was 34.83% which is less than 50% (c.f., Kumar, 2012) which means that the data is acceptable. Additionally, the report has indicated that no single factor has high level covariance amongst the variables and criterion (Podsakoff *et al*., 2012). This implies that common method bias is not an issue for the present study.

4.5 Demographic Profile of the Respondents

Demographic characteristics section contends with gender, age, qualification, status, service/experience (see Table 4.7).

Table 4.7

Demographic Characters of the Respondents

	Frequency	Percentage (%)
Gender		
Male	170	54.0
Female	145	46.0
Age (years old)		
20-30	193	61.3
30-40	92	29.2
40-50	26	8.3
50-60	4	1.3
Qualification		
MBBS	197	62.5
FCPS	23	7.3
PhD (Specialist)	10	3.2
Others	85	27.0
Status		
Single	155	49.2
Married	160	50.8
Service/ experience (years)		
Less than 1year	91	28.9
1-5	130	41.3
6-10	73	23.2
11-15	17	5.4
above 15	4	1.3

The demographics Table outlines that as more than 170 (54%) of the respondents were male and 145 (46. %) were female. This may be due to the fact that majority of doctors in Sindh Pakistan are male. In terms of the age group, 193 (61.3%) respondents marked themselves to the category of 20 to 30 years; 92 (29.2%); 26 (8.3%) to 40 to 50 to 26 and 4 (1.3%) to 50 to 60. Out of the total 29% of the respondents belonged to the age group of 40 to 60 years compared to 2. To 30 years category with highest number of respondents which shows that young medical personnel has been the major respondents of this research. Importantly, in terms of education, the Table shows that 197 (62.5%) of the respondents had MBBS; 23 (7.3%) has FCPS; 10 (3.2%) has PhD, and 85 (27%) had other qualifications. With regards to marital status, 155(49.2%) responded to be single and 160 (50.8%) as married medical doctors. In terms of experience, 91 (28.9%) marked themselves; having 1 year to 5 experience; 130 (41.3%) having 1 to years; 75 (23.2%) having 5 to 10 and 17 (5.4%) as having 10 to 15 years. Only 4 (1.3%) marked themselves having more than 15 experience.

4.6 Descriptive Analysis of the Latent Constructs

Descriptive statistics concerning to the latent variables were also examined in this study outlining the total number of items, mean, and standard deviation of all the variables used in the present study were enquired. A 5 point scale was used in the study where 1 referred as strongly disagrees and 5 as strongly agree. Moreover, the five points in the scale were divided into two categories, 1 to 2 were the lowest

values; 3 denoted moderate value and 4 to 5 explained highest value (Sassenberg, Matschke, & Scholl, 2011).

Table 4.8

Descriptive Statistics for latent variables

Latent Constructs	Number of respondents	Mean	Std. Deviation
CSQ	315	3.7252	.64021
TLS	315	3.7473	.53784
TS	315	3.6897	.78691
LFLS	315	3.7618	.72635
RC	315	1.7933	.41159

Table 4.8 shows that individual latent variables ranging from mean of 3.7252 and 1.7933 and standard deviation ranging from .64021 to .41159 thus denoting 3.7 as the highest mean and 1.7 as the lowest; .640 as the highest standard deviation and .411 as the lowest in this regard. It recommends that respondents have more moderate perception for latent variables. Mean of role clarity is low among other respondents which indicating that most of respondents answered as 1 or 2.

4.7 Confirmatory Factors Analysis Results (CFA)

SmartPLS 2.0 M3 offers the latest feature for performing confirmatory factor analysis (Ringle *et al*., 2005).

4.8 Assessment of PLS-SEM Path Model Results

According to Henseler and Sarstedt (2013) proposed that goodness-of-fit (GOF) index is not an appropriate approach for model validation and accordingly, Hair *et al*., (2014) and Hair, Ringle, and Sarstedt (2013) have also supported this statement, using the PLS path model researchers described that (GOF) index is not suitable validation due to it cannot valid model to from invalid ones.

Based on the propositions of Henseler *et al*., (2009), this study has followed two step process to evaluate and generate results which includes assessment of measurement model and second is measurement of structural model (Henseler *et al*., 2009: Hair *et al*., 2012; Hair *et al*., 2014). Figure 4. 2 provide further details in this aspect.

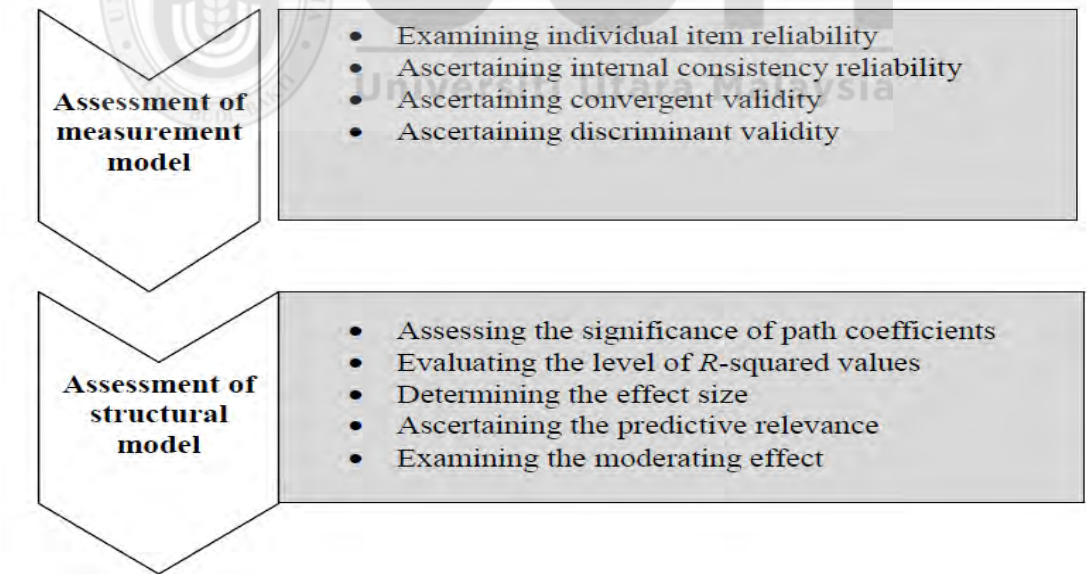

Figure 4.2. A Two-Step Process of PLS Path Model Assessment
Source: (Henseler *et al*., 2009).

4.9 Assessment of Measurement Model

As stated earlier, the first step was the assessment of measurement model in order to ensure that the measurement is reliable and valid. The measurement model comprises of reliability of individual items, content validity, consistency reliability, discriminant validity, convergent validity (Hair *et al*., 2011; Hair *et al*., 2014; Henseler *et al*., 2009).

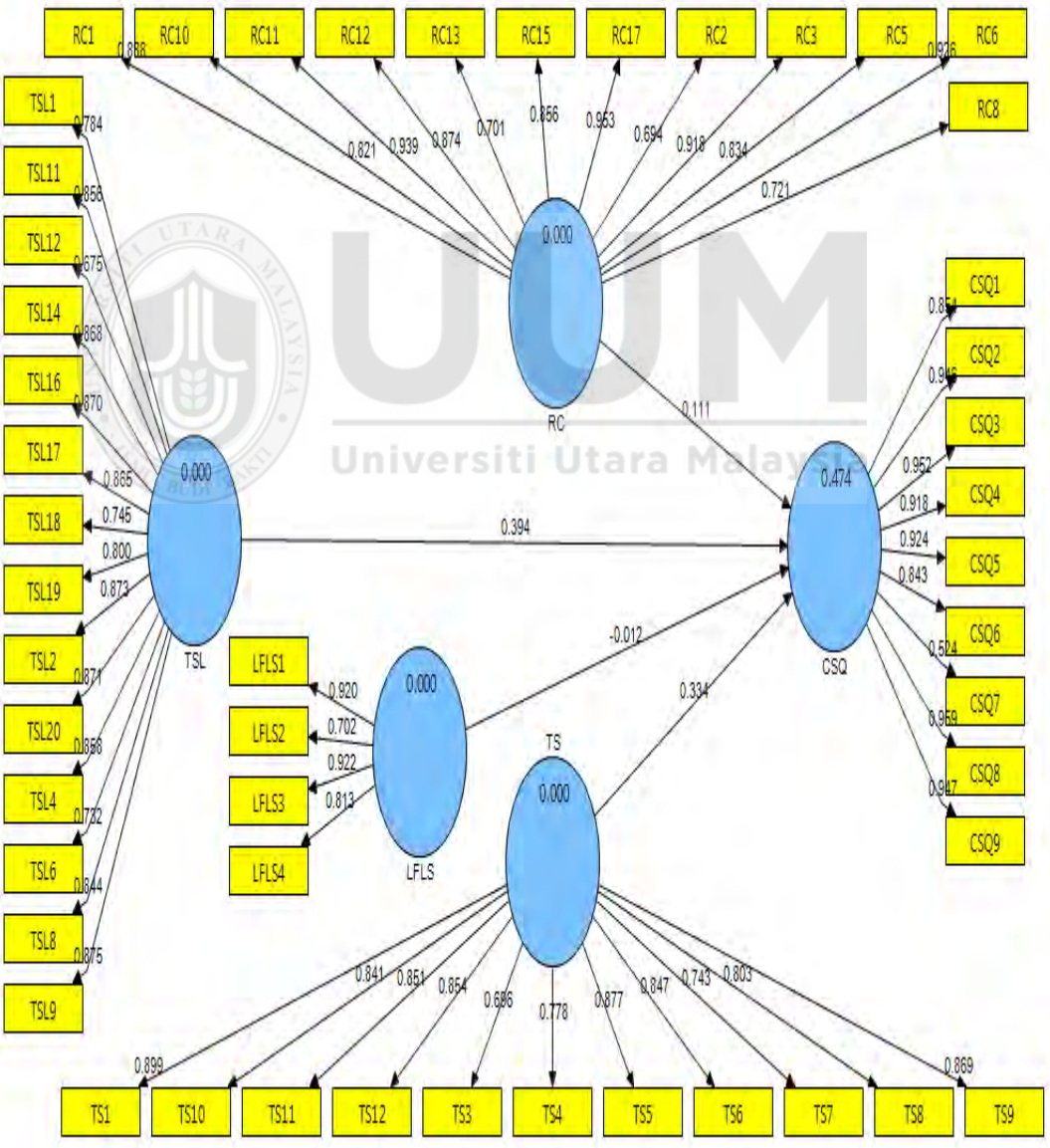

Figure 4.3. Measurement Model

4.9.1 Individual Item Reliability

Measurement of individual item reliability was assessed by outer loadings of constructs` measure (Hair *et al*., 2014; Duarte & Raposo, 2010; Hulland, 1999; Hair *et al*., 2012). Adopting the rule of thumb to retain the items with loading in measurement model is .40 to .50 (Hair, 2014), further, Esposite vinzi *et al*., (2010) have recommended that rule of thumb for outer loading should be at least 0.5 or more. Above recommendation to outer loading consider 0.5 for variance extracted it should be greater than 0.5. Any values below 0.5 were deleted from measurement model, with deleting the lowest values first (Hair *et al*., 2012). This helps to improve data quality in present study model. 62 were marked out of which 12 items were deleted See Figure 4.3 and Table 4.9 (TSL3, TSL5, TSL7, TSL10, TSL13, TSL15, TS12 and RC4, RC7, RC9, RC14, RC16) because of low loading. The study model holds 50 items with loadings between 0.52 to 0.95 see and Table 4.9 and (appendix A) for further understanding and explanation in this regard.

4.9.2 Internal Consistency Reliability

In the views of Sun *et al*., (2007) and Bijttebier *et al*., (2000), internal consistency reliability (ICR) is that all items on specific (sub) scale should measure the same concept. Composite reliability and cronbach`s alpha coefficient to measure the ICR of instruments in social science research studies (McCrae, Kurtz, Yamagata, & Terracciano, 2011; Bacon, Sauer & Young, 1995; Peterson & Kim, 2013). The present study adopted composite reliability coefficient (CR) to determine the ICR of the measurement model. Two justifications can be given for this; first one is that it is

less biased in estimation of reliability compared to cronbach`s alpha coefficient as the cronbach alpha coefficient estimates all the items contributing to its construct without the actual contribution loadings of the individual variables (Gotz, Liehr-Gobbers, & Krafft, 2010; Barclay, Higgins, & Thompson, 1995).

Table 4.9

Loadings, Composite Reliability and Average Variance Extracted

Latent constructs and indicators	**Standardized Loadings**	**Composite Reliability**	**Average Variance Extracted (AVE)**
Commitment to Service Quality		0.969	0.781
CSQ1	0.854		
CSQ2	0.946		
CSQ3	0.952		
CSQ4	0.918		
CSQ5	0.924		
CSQ6	0.843		
CSQ7	0.524		
CSQ8	0.959		
CSQ9	0.947		
Laissez-faire Leadership Style		0.907	0.712
LFLS1	0.920		
LFLS2	0.702		
LFLS3	0.922		
LFLS4	0.813		
Role Clarity		0.968	0.720
RC1	0.888		
RC10	0.821		
RC11	0.939		
RC12	0.874		
RC13	0.701		
RC15	0.856		
RC17	0.953		
RC2	0.694		
RC3	0.918		
RC5	0.834		
RC6	0.926		
RC8	0.721		
Transactional Leadership Style		0.959	0.682
TS1	0.899		
TS10	0.841		
TS11	0.851		
TS12	0.854		
TS3	0.696		

(*table continues*)

Table 4.9. (*continued*)

TS4	0.778		
TS5	0.877		
TS6	0.847		
TS7	0.743		
TS8	0.803		
TS9	0.869		
Transformational Leadership Style		0.967	0.681
TSL1	0.784		
TSL11	0.856		
TSL12	0.675		
TSL14	0.868		
TSL16	0.870		
TSL17	0.865		
TSL18	0.745		
TSL19	0.800		
TSL2	0.873		
TSL20	0.871		
TSL4	0.858		
TSL6	0.732		
TSL8	0.844		
TSL9	0.875		

Another reason behind choosing composite reliability is that Cronbach`s alpha may over or underestimate the scale`s reliability. In order to determine the internal consistency reliability, the past researchers have been deploying composite reliability coefficients and Cronbach`s alpha values. Following the recommendation of Bagozzi and Yi (1988), the present study has reported composite reliability coefficients for which the value should be above 0.70 (see Table 4.9 and Figure 4.3)

Table 4.9 shows that each latent constructs have composite reliability coefficient ranging from .90 to .961 whereby, the minimum acceptance is 0.70 as suggested by (Hair *et al*., 2011; Bagozzi & Yi, 1988).

4.9.3 Convergent Validity

Convergent validity is that items present in the latent construct must correlate with other measures of the similar latent construct (Hair *et al*., 2006). According to Fornell and Larcker (1981) convergent validity was measured by examining the average variance extracted of each. Convergent validity is that items present latent construct and must be correlated with other measures of the similar latent construct (Hair *et al*., 2006). According to Fornell and Larcker (1981), Convergent validity was measured by examining the Average Variance Extracted (AVE) of each latent construct. To achieve satisfactory convergent validity, recommended by Chin (1998) AVE must be .50 or more than. Following by Chin (1998), present study hold the loadings .50 on each constructs which showing convergent validity.

4.9.4 Discriminant Validity

Discriminant validity presents the difference of the constructs different from other constructs (Duarte & Raposo, 2010). This study determined the Discriminant validity by using the average variance extracted recommended, as suggested by Fornell and Larcker (1981). Comparing the correlation between constructs and square roots of AVE to achieved discriminant validity. Furthermore, discriminant validity was also assessed following the recommendation of Chin‟s (1998) criterion through comparing the model indicator loadings with other side reflective indicators in present study cross loading Table. First stage following Fornell and Larcker (1981) using rule of thumb loading having AVE of .50 or more should remain in model to ensure the discriminate validity and further recommended that the square root of the

average variance extracted must be greater than correlations among latent constructs. Table 4.10 shows that AVE ranging between .78 and .68; hence making it acceptable as per the recommendations of Fornell and Larcker (1981). Moreover, Table 4.10 shows that the results of latent construct while comparing with the square root of AVE (in Table 4.10 value in bold face). In this Table square root of AVE is greater than all correlations between the latent construct which indicates acceptable level of discriminant validity (Fornell & Larcker, 1981).

Table 4.10

Latent Variable Correlations and Square Root of Average Variance Extracted

Latent Variable	**1**	**2**	**3**	**4**	**5**
CSQ (1)	**0.883**				
LFLS (2)	0.538	**0.843**			
RC (3)	0.081	-0.043	**0.848**		
TS (4)	0.641	0.812	-0.038	**0.826**	
TSL (5)	0.652	0.720	-0.046	0.817	**0.825**

Note: Entries shown in bold face represents the square root of average variance extracted

As stated above that, the discriminant validity would be determined based on the comparison the indicator loading with cross loadings (Chin, 1998). According to Chin (1998) the indicator loading must be higher than cross loadings in order to get the satisfactory discriminant validity. Results of Table 4.11 suggests that highlights the indicator and reflective loadings and shows that all the cross loadings are less

than indicator loadings thus, referring with no discriminant validity issues in the present study.

Table 4.11

Cross Loadings

	CSQ	LFLS	RC	TS	TSL
CSQ1	**0.854**	0.529	0.051	0.533	0.556
CSQ2	**0.946**	0.476	0.092	0.569	0.559
CSQ3	**0.952**	0.438	0.095	0.559	0.559
CSQ4	**0.918**	0.491	0.118	0.564	0.605
CSQ5	**0.924**	0.432	0.069	0.555	0.548
CSQ6	**0.843**	0.437	0.030	0.496	0.503
CSQ7	**0.524**	0.472	-0.002	0.612	0.618
CSQ8	**0.959**	0.497	0.089	0.567	0.605
CSQ9	**0.947**	0.449	0.087	0.567	0.555
LFLS1	0.529	**0.920**	-0.031	0.765	0.703
LFLS2	0.383	**0.702**	-0.026	0.505	0.424
LFLS3	0.513	**0.922**	-0.044	0.765	0.699
LFLS4	0.358	**0.813**	-0.047	0.682	0.563
RC1	0.036	-0.070	**0.888**	-0.060	-0.073
RC10	0.036	-0.043	**0.821**	-0.039	-0.085
RC11	0.052	-0.028	**0.939**	-0.029	-0.053
RC12	0.092	0.010	**0.874**	0.007	-0.005
RC13	0.001	-0.037	**0.701**	-0.067	-0.050
RC15	0.100	-0.054	**0.856**	-0.044	-0.040
RC17	0.045	-0.073	**0.953**	-0.062	-0.074
RC2	-0.018	-0.036	**0.694**	-0.071	-0.070
RC3	0.053	-0.045	**0.918**	-0.051	-0.043
RC5	-0.016	-0.056	**0.834**	-0.090	-0.102
RC6	0.049	-0.054	**0.926**	-0.058	-0.039
RC8	0.005	-0.043	**0.721**	-0.067	-0.097
TS1	0.520	0.697	-0.059	**0.899**	0.694
TS10	0.660	0.732	-0.020	**0.841**	0.801
TS11	0.518	0.642	-0.055	**0.851**	0.656
TS12	0.505	0.712	-0.036	**0.854**	0.705
TS3	0.402	0.501	-0.010	**0.696**	0.525
TS4	0.451	0.666	-0.006	**0.778**	0.543
TS5	0.517	0.671	-0.049	**0.877**	0.699
TS6	0.677	0.716	0.019	**0.847**	0.801
TS7	0.456	0.618	-0.019	**0.743**	0.519
TS8	0.443	0.622	-0.075	**0.803**	0.613
TS9	0.556	0.748	-0.050	**0.869**	0.735
TSL1	0.608	0.645	-0.043	0.784	**0.784**
TSL11	0.439	0.475	-0.066	0.547	**0.856**
TSL12	0.514	0.564	-0.051	0.676	**0.675**
TSL14	0.447	0.472	-0.063	0.552	**0.868**
TSL16	0.441	0.485	-0.060	0.550	**0.870**

(*table continues*)

Table 4.11. **(continued)**

TSL17	0.672	0.735	0.023	0.820	**0.865**
TSL18	0.549	0.660	-0.044	0.682	**0.745**
TSL19	0.625	0.675	-0.001	0.791	**0.800**
TSL2	0.440	0.484	-0.056	0.552	**0.873**
TSL20	0.448	0.497	-0.054	0.562	**0.871**
TSL4	0.684	0.735	0.003	0.830	**0.858**
TSL6	0.544	0.642	-0.056	0.666	**0.732**
TSL8	0.416	0.477	-0.066	0.537	**0.844**
TSL9	0.440	0.482	-0.059	0.553	**0.875**

4.10 Assessment of Significance of the Structural Model

The nest step in PLS path modeling is the assessment of structural model of the study. Analysis of the structural model was done through running standard bootstrapping procedure whereby 5000 bootstrapping samples were assessed for the significance of the path coefficients (Henseler *et al*., 2009; Hair *et al*., 2011; Hair *et al*., 2014; Hair *et al*., 2012) of 315 cases. Figure 4.4 indicates the structural model with moderator.

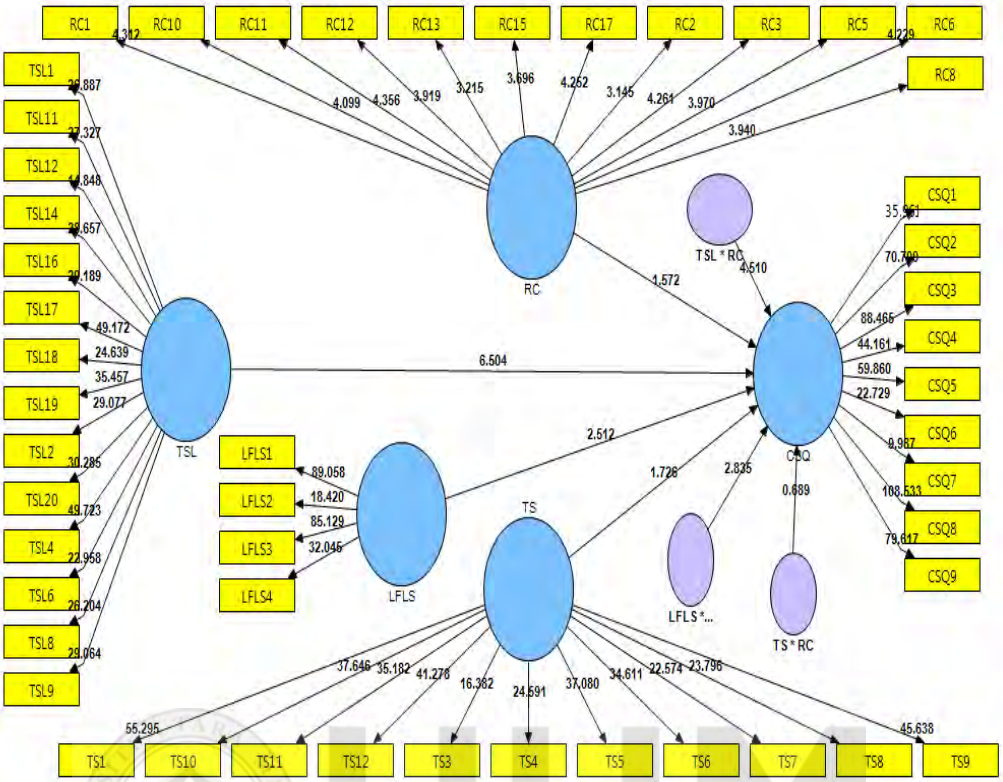

Figure 4.4. Structural model with moderator (Full Model)

Table 4.12

Structural Model Assessment with Moderator (Full Model)

Hypotheses	Relationship	Beta	SE	T-value	Findings
H1	TSL -> CSQ	1.102907	0.16957	6.504156	Supported
H2	TS -> CSQ	0.386495	0.223861	1.726496	Supported
H3	LFLS -> CSQ	0.39968	0.159109	2.51198	Supported
H4	TSL * RC -> CSQ	1.166868	0.258707	4.510387	Supported
H5	TS * RC -> CSQ	-0.264561	0.383969	0.689016	Not-supported
H6	LFLS * RC -> CSQ	0.772355	0.272453	2.83482	Supported

Table 4.12 outlines full structural model, identifying independent variables, dependent variable and moderator (Role clarity). As per the propositions of Hypothesis 1, the results suggest that transformational leadership style (TSL) holds positive relationship with commitment to service quality. Figure 4.4 and Table 4.12 shows this relationship (β = 1.102907, t =6.504156, p< 0.00). In connection to hypothesis 2, transactional leadership has positive relationship with commitment to service quality. Results of the structural model (Figure 4.4 and Table 4.12) have underlined that commitment to service quality (β = 0.386495, t = 1.726496), can be positively influenced by transactional leadership. With regards to hypothesis 3 that talks about laissez-faire leadership style and commitment to service quality, the structural model results show a significant relationship (β = 0.39968, t = 2.51198). This conclusively results in the support of initial three hypotheses.

Accordingly, hypothesis pertaining to the moderation of role clarity between transformational leadership and commitment to service quality has also been found moderate on the relationship with (TSL * RC -> CSQ β = 1.166868t = 4.510387) thus, supporting hypothesis 4. Similarly, the bootstrapping approach has concluded insignificant moderation of role clarity between transactional leadership and commitment to service quality hence rejecting hypothesis 5 (TS * RC -> CSQ β = 0.264561t = 0.689016).

Lastly, role clarity has found to significantly moderate the relationship between laissez-faire style of leadership and commitment to service quality (LFLS * RC -> CSQ β = 0.772355t = 2.83482, p > 0.03).

4.10.1 Assessment of Variance Explained in the Endogenous Latent Variables

It is a compulsory requirement in the PLS-SEM structural modeling to check the R-square value. It is also commonly known as coefficient of determination (Henseler *et al*., 2009; Hair *et al*., 2012; Hair *et al*., 2011). The R-square values refers to the dependent variable`s proportion of variation in an independent variables that can be detailed by one or more predictor (Hair *et al*., 2006; Hair *et al*., 2010; Elliott & Woodward, 2007). Importantly, acceptable values of R-square vary and hence depend on nature of research (Hair *et al*., 2010). Falk and Miller (1992) have recommended 0.10 as the minimum acceptable R-square value. According to Chin (1998) R-square values can be plotted down into three categories whereby 0.10 referring to weak, 0.33 referring to moderate and 0.67 and substantial denoting to considerable value of the endogenous variable.

Table 4 13

Variance Explained in the Endogenous Latent Variable

Latent variable	**Variance explained (R^2)**
Commitment to Service Quality	0.526

Table 4.13 underscores that the model 52.6% of the total variance with four exogenous variables including transformation, transactional, laissez-faire and role clarity. Hence, based on the criterion of Falk and Miller (1992) and Chin (1998), the model holds moderate level of R-square.

4.10.2 Assessment of Effect Size (f-squared)

Effect size highlights the relative effect of any specific exogenous latent variable on endogenous latent variable (s) through changes in the R-squared (Chin, 1998). Statistically, it is determined as the increase in the R-squared of a latent variable to which the path is associated and concerns to latent variable‟s proportion of unexplained variance (Chin, 1998). Notable researchers (Callaghan, Wilson, Ringle, & Henseler, 2007; Selya, Rose, Dierker, Hedeker, & Mermelstein, 2012;; Cohen, 1988) have recommended using the following formula in this regard:

$$\text{Effect size: } f^2 = \frac{R^2_{Included} - R^2_{Excluded}}{1 - R^2_{Included}} \quad (4.1)$$

According to Cohen (1988) f^2 values could be categorized also as weak, moderate and strong. According to the author, any values like 0.02 can be termed as weak; 0.15 as moderate, and 0.35 as referring to strong effect size. Table 4.14 outlines specific effect sizes of the latent variables in the structural model. It is important to understand that low effect size does not basically mean that the moderation is insignificant as even the small interaction effect can be of great imparity in extreme moderating conditions. Therefore, if the resulting beta changes are meaningful, then they should be taken into consideration (Chin *et al*., 2003). Table 4.14 demonstrates the strength of the role clarity as moderate in line with the recommendations of Chen

(1988) and Henseler and Fassott‟s (2010b). Table 4.14 provides further detail in this regard.

Table 4.14

Effect Sizes of the Latent Variables on Cohen's (1988) Recommendation

R-square	Include	Exclude	f-squared	Effect size
Transformational leadership style	0.474	0.423	0.097	Small
Transactional leadership style	0.474	0.448	0.049	Small
Laissez-faire leadership style	0.474	0.474	0	Non

Table 4.14 concludes that the effect sizes for transformational, transactional, laissez-faire, and role clarity on commitment to service quality are 0.0970, 0.0494 and 0.000. Therefore, based on Cohen`s (1988) recommendations, these effect sizes can be viewed as small, small, none respectively.

4.10.2.1 Assessment of Predictive Relevance

The current study has also applied Stone-Geisser test in order to test the predictive relevance of the research model (Stone, 1974; Geisser, 1974). This test accounts for following the blindfolding procedure to test the predictive relevance of the model. Blindfolding procedures are undertaken to assess the predictive capacity of the model. Predictive relevance test is used as an addition in order to see the goodness-of-fit in partial least squares structural equation modeling (Duarte & Raposo, 2010). According to Sattler, Völckner, Riediger and Ringle (2010) this test applies only on endogenous latent variable that have a reflective measurement model

operationalization (p. 320). As all the variables were reflective in nature, the blindfolding procedure was applied. The predictive relevance is denoted by Q^2 and as per Hair *et al*., (2014) Q value is obtained by using the blindfolding technique to assess the parameter estimates and also by assessing how values are built around the model. The more the Q value, the higher the predictive relevance will be. Table 4.15 highlights the cross-validated redundancy Q^2 test result.

Table 4.15

Construct cross-Validated Redundancy

Total	**SSO**	**SSE**	**1-SSE/SSO**
CSQ	2835	1877.9272	0.337

According to Hair *et al*., (2014) and Henseler *et al.,* (2009) when Q^2 value is greater than zero (0) the model have predictive relevance for reflective endogenous latent variable. The results of Table 4.15 showing the cross-validation redundancy measure are above zero for all endogenous latent variables following the predictive relevance of the model (Henseler *et al*., 2009; Chen, 1998). Results of Table 4.15 indicate reasonable cross validated redundancy.

4.10.2.2 Testing Moderating Effects

The present study has applied the product indicator approach by using Smart PLS2.0 M3 (Ringle *et al*., 2005) and to calculate and detect the strength of moderating effect such as role clarity on the relationship of transformational, transactional, laissez-faire leadership with commitment to service quality (Henseler & Chin, 2010; Chin at el.,

2003; Helm, Eggerp, & Garnefeld, 2010). The product indicator approach is thought to be suitable for present study because the moderating variable is continues in nature (Rigdon, Schunacker, & Wothke, 1998).

In order to apply the product indicator approach, a three-way interaction terms are required to be created between the indicating latent independent variables and indicating moderating variable in structural model (Hair, *et al.,* 2011). Moreover, to determine the strength of moderating effects, the current study used (Cohens, 1988) guidelines for identifying the effects size. Hence estimates after applied product indicator investigate the moderating effects of role clarity on relationship of exogenous and endogenous latent variables.

As mentioned earlier that hypothesis 4 pertaining to the moderation of role clarity in the relationship between transformational leadership and commitment to service quality. The relationship as depicted by Figure 4.4 and Table 4.12 was stronger (positive) which means that role clarity moderated on the relationship. Above hypothesis 4 role clarity moderates relationship on the transformational leadership and commitment to service quality. This relationship is stronger (positive) high role clarity as Figure 4.5 and Table 4.12 indicated that role clarity moderates on relationship of transformational and commitment to service quality with statically (TLS: $\beta = 1.167$ $t = 4.510$).

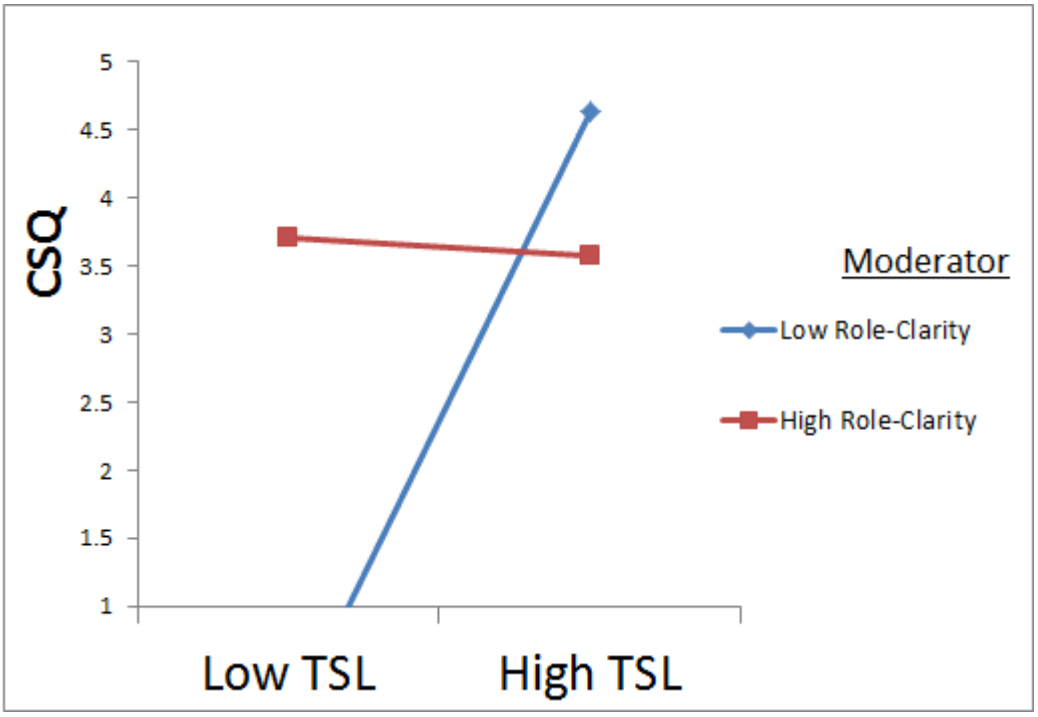

Figure 4.5. Interaction effects of role clarity on the relationship of transformational leadership style and commitment to service quality

According to the Figure 4.5 is supporting the H4 role clarity moderated on the transformational leadership style and commitment to service in public hospitals Sindh, Pakistan. Result suggesting that role clarity is most important for the service employees and clarifications of leaders about workforces and job requirement will highly effected on the commitment of service quality.

Accordingly, hypothesis H6 concerning to the moderation of the relationship between laissez-faire style of leadership and commitment to service quality, Figure 4.6 and Table 4.12 underscore that role clarity significantly moderated ($\beta = 0.772$ $t = 2.834$) showing that role clarity moderates on the relationship of leadership style and commitment to service quality in public hospitals of Sindh Pakistan.

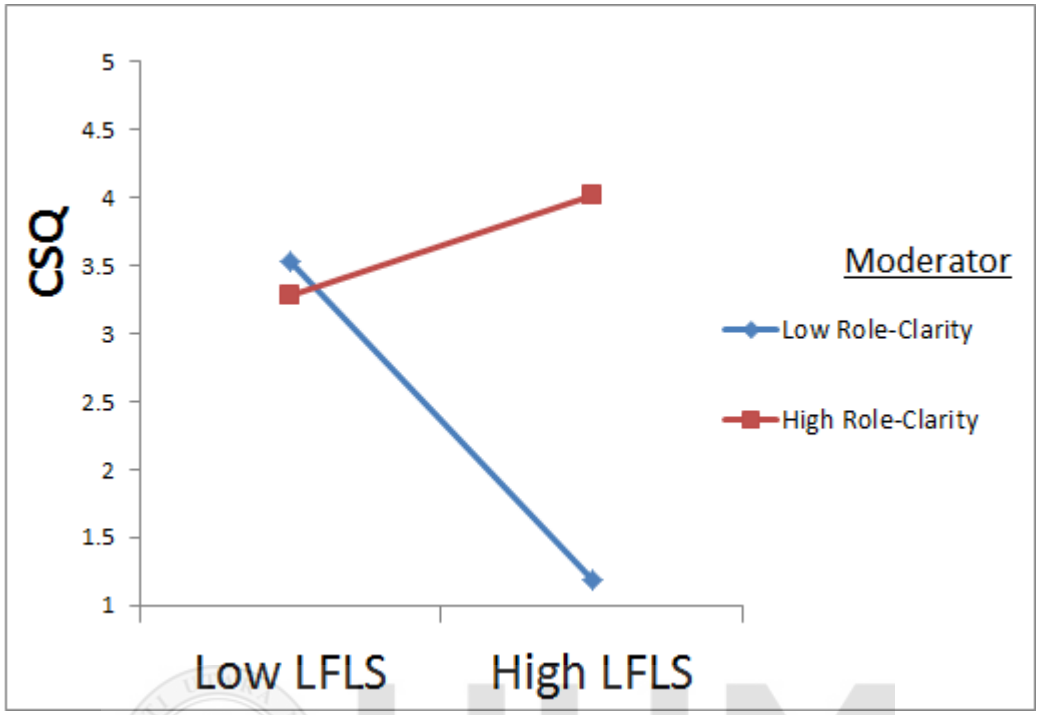

Figure 4.6. Interaction of role clarity on relationship of laissez-faire leadership style and commitment to service quality

According to Figure 4.6 is supporting the hypothesis 6 role clarity moderates on the relationship of laissez-faire leadership style and commitment to service quality. Role clarity will help to increase the commitment of employees at the workplace in emergencies situation. Whenever, employees are providing the service in emergencies situations in hospitals Table 4.12 and chapter 5 provide further detail.

According to hypothesis 5 we are surprised that role clarity does not moderate on the relationship of leadership style in public hospital of Sindh, Pakistan. Table 4.12 showing (beta 0.2647 and t value 0.6890) hypothesis is not supported.

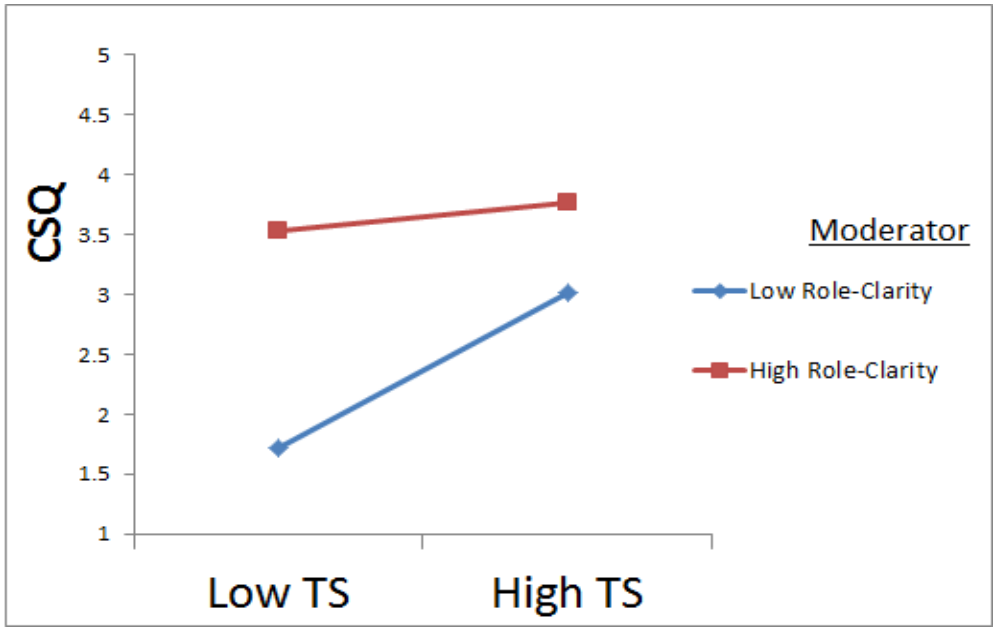

Figure 4.7. Interaction of role clarity on the relationship of transactional leadership and commitment to service quality

Results of the Figure 4.7 also have underlined that role clarity does not moderate on the relationship of transactional and commitment to service quality with regards to hypothesis H5.

4.10.2.3 Determining the Strength of the Moderating Effects

The present study has used the predictor approach to test the moderating effect of role clarity on relationships between transformational, transactional, and laissez-faire leadership styles and commitment to service quality. Cohen`s (1988) effect size was calculated in this regard where terms are created between indicator latent variables and indicator of moderating variable in the structural model (Hair *et al*., 2011). Moreover, the strength of moderating effect is examined by comparing the main effects of the model with R-square value of the complete model including both,

moderating and exogenous latent variables (Wilden, Gudergan, Nielsen, & Lings 2013; Henseler & Fassott, 2010a). The strength of the moderating effects has been tested by using the formula (Cohens, 1988) through using the following formula:

$$\text{Effect size}, f^2 = \frac{(R^2_{\text{moderator included}} - R^2_{\text{moderator excluded}})}{(1 - R^2_{\text{moderator included}})} \quad (4.2)$$

Henseler and Fassott, (2010a) and Cohen, (1988) have explained f^2 values of 0.02, 0.15 and 0.35 as expressing weak, moderate, strong effects respectively. On the other hand, low effects size does not basically mean that moderating effects is insignificant (Even a small interaction effect can be meaningful under extreme moderating conditions, if the resulting beta changes are meaningful, then it is important to take these conditions into account (Chin *et al*., 2003).

Table 4.16 demonstrates the strength of moderating effects role clarity respectively. In line with rule of thumb for determined the strength of moderating effects given by Chen,(1988) and Henseler and Fassott‟s (2010b), Table 4.16 shows that effects size for commitment to service quality 0.1097 proposing the moderating effects was small (Henseler, Wilson, Götz, & Hautvast, 2007 Wilden *et al*., 2013).

Table 4.16

Strength of moderating effects based on Cohen's (1988) and Henseler Fassott's (2010) Guidelines

Endogenous Latent Variables	Included	Excluded	f-squared	Effect size
Commitment to service quality	0.526	0.474	0.1097	Small

4.11 Summary of Findings

Hypotheses	Statements	Findings
H1	There will be positive relationship transformational leadership and commitment to service quality	Supported
H2	There will be positive relationship transactional leadership and commitment to service quality	Supported
H3	There will be positive relationship laissez-faire leadership and commitment to service quality	Supported
H4	Role clarity moderates relationship between transformational leadership and commitment to service quality	Supported
H5	Role clarity moderates relationship between transactional leadership and commitment to service quality	Non-supported
H6	Role clarity moderates relationship between laissez-faire leadership style and commitment to service quality	Supported

4.12 Chapter Summary

The present chapter has explained statistical results after analyzing the primary data through using PLS path modeling. The chapter has outlined key findings along with assessment of path coefficients. Results of path coefficients have forwarded positive relationship between: (1) transformational leadership (2) transactional leadership (3) laissez-faire leadership with commitment to service quality. With regards to moderating effects of role clarity on relationship between transformational

leadership, transaction leadership and laissez-faire leadership style between commitments to service quality. Results of path coefficients have revealed that role clarity moderated the relationship between transformational leadership laissez-faire leadership style and commitment to service quality significantly. However, the finding of path coefficients on the moderation of role clarity on the relationship between transactional leadership and commitment to service quality was found to be insignificant.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter elaborates upon the key findings of the study. Accordingly, the chapter explains the link of current study with previous studies pertaining to commitment to service quality and theoretical understandings respectively. The chapter also presents summary of the findings along with explanation of the study in the light of underpinning theories and prior studies on the topic. The chapter highlights theoretical and practical implications followed by discussion on limitations, and suggestion for future research followed by conclusion to the study as a whole.

5.2 Recapitulation of the Study's Findings

Core aim of this study was to examine the moderating influence of role clarity on the relationship of transformational, transactional, and laissez-faire leadership with commitment to service quality in the public hospitals of Sindh, Pakistan. Over all present study has succeeded in establishing understanding regarding key leadership antecedents of commitment to service quality through answering the following questions:

1. Does transformational leadership influence commitment to service quality?
2. Does transactional leadership influence commitment to service quality?
3. Does laissez-faire leadership influence commitment to service quality?

4. Does role clarity moderate relationship between transformational leadership and commitment to service quality?
5. Does role clarity moderate relationship between transactional leadership and commitment to service quality?
6. Does role clarity moderate relationship between laissez-faire and commitment to service quality?

According to the direct statistical relationships of transformational, transactional and laissez-faire leadership style with commitment to service quality six hypothesis were developed and findings of present study 5 hypothesized were supported. In explanation, results from PLS path modeling regarding transformational leadership was significant and positively and related to commitment to service quality. Transactional leadership was also found significant with commitment to service quality. Similar results were found for laissez-faire leadership`s relationship with commitment to service quality.

Specifically, three hypotheses were proposed pertaining to role clarity as moderator on the relationship between transformational, transactional, and laissez-faire leadership style and commitment to service quality. Findings of study have concluded with two hypothesis receiving significant moderating influence. In explanation, role clarity moderated the relationship of transformational leadership and laissez-faire leadership style with commitment to service quality.

5.3 Discussion

The present study was conducted based on a theoretical framework, developed based on different studies conducted on the topic in past. The questionnaire were accordingly selected in order to understand the importance of commitment to service quality and influence of various leadership styles on the public hospitals of Sindh, Pakistan. Findings can be sketched in detail for each of the investigated relationship by the present study as follows:

5.3.1 The Influence of Transformational leadership style on Commitment to Service Quality

Transformational Leadership (Bass, 1985) outlined that transformational leaders inspire their followers through providing a positive and values-based vision of the future. Transformational leadership is a leadership style that enhances awareness of combined interest among the company's associates and facilitates them to accomplish their collective goals (Bass, 1985; Chen, Tang, Jin, Xie, 2014). Transformational leadership refers to how a leader must evaluate carefully and act upon his or her followers‟ needs (Avolio & Bass, 1995). According to Bass (1985,1990) transformational leaders motivate employees to do more than what is expected out from an employment contract and focuses on the employees‟ higher-order needs. Such leaders act as mentors and pay attention to the individual developmental, learning, and achievement needs of each subordinate. Transformational leadership has been positively concluded to influence numerous employee outcomes such as job satisfaction (e.g., Bass, 1985; Bass & Avolio, 1994; Roueche, Baker, & Rose, 2014;

Hater & Bass, 1988; Seltzer & Bass, 1990; Yammarino & Bass, 1990) and organizational commitment (Podsakoff, MacKenzie, & Bommer, 1996).

In order to examine the relationship between transformational leadership style and commitment to service quality; hypothesis was developed accordingly and statically tested by using the PLS path modeling. Results of path modeling (Figure 4.4 and Table 4.12) have shown significant relationship.

Results of this study have concluded that relationship of transformational leadership style with commitment to service quality is more significant compared to other two variables transactional and laissez-faire leadership style. This result, which concerns with hypotheses one are parallel to the findings of Hashim and Mohmod (2011a; 2012b) whereby, transformational leadership style was studied with commitment to service quality in the education sector and finding that have positive relation between two. Also same results According to Pahi and Hamid (2015b) that it is evident from the findings that transformational leadership has potential to influence the attitudes and behaviors of subordinates which ultimately lead towards becoming committed to quality of service to customers. Pahi and Hamid (2015a) stated that transformational leadership style has positive relationship between commitment to service quality of staff. Commitment to service quality in the views of Clark (2009) is also that transformational leadership style may more influence commitment to service quality. Also Ahmad, Majid and Zin (2015) found the transformational leadership and commitment has positive relationship.

Furthermore, prior studies support the relationship of transformational leadership and commitment to service quality. Commitment of employees is critical to achieve organizational objectives and to link between best service quality and meeting the client‟s anticipation (Suliman, 2001; Wong *et al*., 2002; Malhotra & Mukherjee, 2004). Findings of past studies that transformational leader and subordinates commitment to service quality are positively linked (Barnett et al., 2001; Erkutlu, 2006; Emery & Barker, 2007; Liao & Chuang, 2007). Furthermore, empowering leadership and transformational leadership hold similar characteristics and thus have the ability to influence commitment to service quality (Clark *et al*., 2009). All the above findings have clearly highlighted that transformational leadership holds strong influence on commitment to service quality and the same can be termed from this study‟s results for the medical officer of public hospitals of Sindh, Pakistan.

They have ability to focus on mission, vision, and organization goals and also motivate and engage the medical officer to associations towards commitment to service quality. Result of structural model revealed that leader of public hospital from Sindh Pakistan has significant relationship with medical officer and influence staff toward commitment to service quality. Similarly, Wallace *et al*., (2013) stated that the leaders can encourage employees towards commitment. The argument is also supported by (Mitchell, 2002) that stated that employees are more committed in organizations when the behaviors are reinforced by the top leadership. Hence, it is imperative to study the role of leadership styles to understand and foster employee commitment to service quality. Avolio *et al.,* (2004) conducted a study on staff nurses in a public hospital of Singapore and the study found transformational

leadership, positively influencing organizational commitment. Limsili and Ogunlana (2008) proclaimed that transformational leadership is a better leadership style and works to boost productivity and organizational commitment. Transformational leadership is the highly effective leadership style in determining commitment to service quality.

The relationship of transformational leadership and medical officer has positive association amongst the public staff of Sindh, Pakistan. Transformational leaders to possess some extraordinary cognitive skills would help to reduce issues in directing the medical officers` attitudes and behaviors for the responsive achievement of common goals including commitment towards quality service.

Individuals with this leadership style bring in qualities such as excellent communication skills, helping behavior, and ability to guide the change through motivation and commitment. This is why transformational leadership style has more influence on medical officers` commitment to service quality in public hospital of Sindh, Pakistan. Moreover, the results have also concluded which outlines that this leadership style works well to lead both individuals as well as groups motivate them towards commitment to service quality. Transformational leader has ability to increase the commitment to service quality of medical officer in public hospital of Pakistan.

5.3.2 The Influence of Transactional leadership style on Commitment to Service Quality

Transactional leadership is defined by Burn (1978) as the leader who approaches their subordinates for exchanging one thing to another. According to Ali, Jan, Ali, and Tariq (2014) and Burns (1978) that transactional leadership is based on the exchange process between leaders and subordinates and transactional leaders encourage employees by giving the reward against performance. This in a sense works as a bargain process among the leaders and their subordinates (Hartog, Muijen & Koopman, 1997). Transactional leadership is based on contingency reward ideology whereby, the employees are encouraged to accomplish the organizational goals which poses a positive impact on the employee‟s performance within the organization (Berson & Linton, 2005; Bass, 1997, 1998).

Second hypothesis of the present study was to analyze the relationship between transactional leadership style and commitment to service quality. Figure 4.4 and Table 4.12 have outlined significant direct relationship between transactional leadership and commitment to service quality hence supporting hypotheses H2.

The study has not surprised with its findings on this relationship as some past studies have also reported similar results. Findings of hypotheses 2 are in line with Hashim and Mahmood (2012) study in the education sector whereby, 387 employees from public universities responded. The results of the study outlined transactional leadership influencing commitment to service quality positively. Pahi and Hamid (2015b) have also reported similar results in their study on public hospitals, sampling

the medical officer. The study also found positive and significant relationship between transactional leaders and their ability to influence medical officer commitment to service quality to offers reward. Furthermore, Jamaludin, Hashim and Mahmood (2014) also found that transactional leadership influencing commitment to service quality in the Malaysian service sector. Tyssen, Wald, and Heidenreich, (2014) stated that transactional leadership has strong effects on followers commitment in temporary organization. Ahmad et al., (2015), transactional leadership style influences employee‟s commitment by rewards.

Accordingly, past studies have also praised transaction leadership style to be positively associated with employee outcomes as commitment. For instance McGuire Kennerly (2006) conducted research on health care services and Nguni *et al*., (2006) conducted study in service sector in education Nguni *et al*., (2006). Both the studies reported transactional leadership related to affective commitment. Ali, Jan, Ali, and Tariq (2014) conducted study in education sector to involved 224 from staff and results of study transactional leadership style was strong predicator of the commitment and positive influence over commitment of employees.

Notably, these scholars have argued that transactional leadership fosters more in supportive and bureaucratic cultures particularly in service organizations (Emery & Barker, 2007; Chen, 2004; Bajunid, 2008). Emery & Barker, (2007) the authors have also outlined that transactional leaders can more responsively motivate employees to commitment to service in bureaucratic environment where employees are more closely to supervised by their supervisor. Burn (1987) has stated that

transactional leader approach takes followers to exchange one thing for another. Findings of the present study in the public hospitals of Sindh, Pakistan that expressing transactional leadership style can influence on medical officers` commitment to service quality and Transactional leader can not only support employees in reaching the general organizational goals but can considerably influence them in enhancing their behaviors with regards to their commitment with service quality to reach common goals and provide better services to customer.

Transactional leaders give importance to exchange relationship between followers and leaders whereby leader is fully willing to fulfill the follower‟s needs in exchange for their performance to meet objective of organization and leader motivate medical officer to wards commitment to service quality by rewards. When the exchange the agreement between the leader and subordinates whereby the subordinates already committed to provide the better service and complete the task in specific time. Under the transactional leadership style employee is more committed because staff gets reward against per performance in Pakistan Sindh hospital that‟s why this hypothesis supported.

5.3.3 The Influence of Laissez-faire Leadership Style and Commitment to Service Quality

Apart from transformational and transactional, laissez-faire leadership style is basically based on non-leadership characteristics (Avolio et al., 1999; Northouse, 2010; Spinelli, 2006; Hinkin, & Schriesheim, 2008; Buch, Martinsen, & Kuvaas, 2014; Goodnight, 2004). It‟s a style whereby the leadership qualities are missing in

the person that acts as a leader. The authors have further underlined that this kind of leadership always renounces their obligations, delays decisions, provides no feedback and offers less attention to assist subordinates to fulfill their needs. Similarly, Robbins, Judge, and Sanghi, (2007) and Luthans (2005, p. 562) have proposed similar explanation that laissez-faire style "abdicates responsibilities to avoid making decisions".

Third hypotheses pertaining to the relationship between laissez-faire leadership and commitment to service quality in public hospital Sindh was tested (Figure 4.4 and Table 4.12) showing a positive relationship between laissez-faire and commitment to service quality.

Findings of this study can be seen in line with numerous other studies that accounted for laissez-faire leadership style influencing employee commitment to service quality positively (Sorenson, 2000). Alqudah (2011) has highlighted that although it has a poor relationship with other variables but important connection exists between laissez-faire leadership and commitment. Same results find line with Pahi, Hamid, Umrani and Ahmed (2015) provide the evidences that laissez-faire leadership style also play important role in the service organization and its have influence on the commitment to service quality and they provide the services in emergencies bases. Evidence from previous studies has outlined that laissez-faire leadership and commitment has relationship in different perspective likes. Nyengane"s (2007) correlation results have also indicated important adverse connection between laissez-faire leadership behaviors and effective commitment. Overall results from this

research recommend that laissez-faire behaviors do play an important role in identifying levels of commitment (Garg, & Ramjee, 2013). Laissez-faire leadership style is less effective being practiced in other industry but Ali and Ibrahim (2014) stated that laissez-faire leadership style has also positive effects and outcomes. For Laissez-faire leadership, this style works the belief that employees know their jobs very well and its best so leave them alone to do their jobs effectively (Goodnight, 2004).

This has been fully supported by (Sutermeister, 1969; Williams, 1987) who said that the laissez-faire style may be effective in certain environments such as with a group of scientists or college professors and emergencies bases. Laissez-faire leadership style has relationship between variables as insignificant with various outcomes criteria however in some areas absence of leadership may be important as present of other leadership style Hinkin, and Schriesheim (2008). Further, supporting findings of present study that study conducted in health sector by Ghorbanian, Bahadori, and Nejati (2012) revealed that sometimes, there are many critical situations in medical services or emergencies when service provide to customer. Further Ghorbanian, Bahadori, and Nejati (2012) stated that laissez-faire leadership style is suitable for medical officer those who provide service in emergency wards/departments. This is because such employees need not to ask anything in emergencies situation and have specific outlines provided to follow accordingly. The present study has found that laissez-faire leadership style has relationship with commitment to service quality in public hospital. This relationship is significance because medical officers always

deliver service in emergencies situation and preferred to take the immediately decision to deliver services. They preferred laissez-faire leadership.

This leadership provides the freedom to subordinates to take decision in situations which may not be affective in other areas. Similarly, occupations like teachers, scientists, doctors, etc may also prefer the laissez-faire leadership style. On the basis of this, the present study has found literature supporting that laissez-faire leadership can significantly influence commitment to service quality.

Cognitive dissonance theory is an uncomfortable feeling that arises when an individual holds two opposing views simultaneously (Festinger, 1957). It occurs when a person is faced with conflicting evidence to their personal beliefs or to what they know to be true. This creates an uneasy feeling that makes the individual feel unsettled for the duration of the cognitive dissonance, until the dissonance is reduced or eliminated. The theory of cognitive dissonance suggests that people have a motivational drive or need to reduce dissonance (Festinger, 1957) which can be achieved "by adding consonant cognitions, subtracting dissonant cognitions, reducing the importance of dissonant cognitions, or some combination of these," (Harmon-Jones & Brehm, 1996).

The theory suggested that behavior of person can be change by reducing the dissonance and influence to positive attitude to work. Cognitive dissonance and unresolved internal conflicts, which negatively influence present choices and reactions, can act as a hindrance to anyone, especially to a person who is in a

leadership position and is responsible for managing people and making critical decisions affecting employees‟ attitudes (Vujosevic, 2011). Present study has tested theory of cognitive dissonance, by Festinger (1957) that describe how leadership styles can bring changes in attitudes of medical officer commitment to service quality through leadership in public hospitals of Sindh. These Leadership styles have the potential to build up employee‟s commitment and ensure that they perform better than expectation for organizational success (Bass, 1990; Hashim & Mahmood, 2011). The results of the present study have extended the literature on cognitive dissonance theory by explaining the potential link between transformation, transactional, laissez-faire leadership styles and commitment to service quality. Besides contributing to the cognitive dissonance theory, the study has also notably contributed by investigating multidisciplinary relations through combining organizational behavior and service quality management.

Leaders possess excellent skills in order to overcome the problems and responsively direct staff‟s attitude towards commitment to high service quality. These qualities of leaders not only show the path but it will help in reducing discomfort and dissonance (Hashim & Mohamood, 2012). Similarly leaders encourage, motivate, communicate, and help employees to accomplish common goals and offer rewards, work autonomy to reduce dissonance and bring positivity in staff‟s attitudes towards commitment to service quality of staff (Pahi & Kamal, 2015b). Furthermore, leadership style relationship will develop commitment between the leaders and with their following (1978) and exchange the martial values (William, *et al*., 2007). However leader has

the ability to reduce the dissonance that would inspire the medical officer commitment to service quality.

Theoretical explanations on the basic idea suggest that staff members need to be consistent in their behavior, attitudes as well as beliefs or thought (cognitions). In addition, Arokiasamy, Ismail, Ahmad, and Othman (2007) claimed that professional relationship between leaders and subordinates are developed during working hours and leaders must facilitate employees and try to reduce dissonance and foster their behaviors for enhanced commitment to service quality. Pahi and Hamid (2015a) stated that leader reduce queries of staff and influence toward commitment to service quality. According to Tosi and Mero (2003) and Morris and Maisto (2009), when dissonance or inconsistency occur, individuals try to justify their behavior, thought, or feelings in order resolve or reduce the discomfort situation that they are experiencing. Furthermore, Burnes and James (1995) stated that during dissonance or inconsistencies in attitude badly effects on commitment and working process. Theory suggests that leaders can be reducing the discomfort of staff and influence commitment to service quality. It is most important that alleviated disconfirm related to behavior changes towards positive commitment Woodbine and Amirthalingam (2013).

In accordance with this it is believed that the most convenient way to change their attitude is by reducing the discomfort or dissonance (Morris & Maisto, 2009). The dissonance situation might occur when the staff members encounter leaders, not interested in recognizing their efforts, demanding, or have a distant relationship with

them or even the staffs themselves that have negative attitudes towards their leaders. Therefore, in order to cope with such a situation, sufficient justification should be given by the leaders so that some kind of contingency, rewards, coaching, communication or direction and freedom can be given by leaders to the staffs. Theory recommended this will, for sure, help to reduce staffs‟ dissonance and will potentially change their attitudes to be more positive towards commitment to service quality. Martinie, Milland and Olive (2013) also stated that reduce dissonance by changing the attitude and behavior of staff so that leadership style expected can help in reducing dissonance of medical officer. The leaders as what had been explained by Bass (1990) are known to build employees‟ commitment and loyalty whereby strive hard to perform better than expected. When employees committed themselves than less issues arising in the organization they continue good behavior and efficient way to do work Rubens et al., (2013).

5.3.4 Moderating Effects of Role Clarity

Role clarity refers to the degree to which employees receive and understand information that is needed for them to perform their jobs well (Rogers, Clow, & Kash 1994). Employees need to have role clarity which requires them to be aware of what and how they ought to perform their job roles with effectiveness and efficiency (Bush & Busch, 1981; Teas, Wacker, & Hughes 1979). Employees are provided with adequate information to perform their roles effectively (Rizzo *et al*., 1970). Role clarity is most important for leaders to clear role of the subordinates and to assist them in clarifying their tasks (Newman, *et al*., 2015).

5.3.4.1 Role Clarity Moderates the Relationship between the Transformational Leadership Style and Commitment to Service Quality

5.3.4.2 Role clarity Moderates the Relationship between the Transactional Leadership Style and Commitment to Service Quality

5.3.4.3 Role Clarity Moderates the Relationship between the Laissez-faire Leadership Style and Commitment to Service Quality

The results of present study on role clarity, acting as the moderator between the relationships of transformational, transactional, laissez-faire leadership styles with commitments to service quality were tested through PLS path modeling. Hypotheses H4 and H6 that pertained to the moderation between transformational and laissez-faire leadership were found supported.

This finding can be supported with the statement and recommendation of numerous organisational researcher (Fisher & Gitelson,. 1983; Mukherjee, & Malhotra, 2006 pahi & Hamid, 2015a), suggesting the importance of role clarity as a moderator between leadership styles and commitment to service quality. The findings have concluded that high level of role clarity can dominantly moderate between numbers of different variables (Ivancevich, & Donnelly, 1974). When subordinates perceive higher levels of role clarity, then the relationship between leaders and subordinates gets stronger (Newman, Allen, Miao, 2015). Role clarity is potential to influence the leadership style and commitment to service quality Pahi *et al*., (2015) furthermore When employees has clear goals that will positive influence on the performance of

employees Peralta et al., (2015). Above literature provide evidence that role clarity has potential to influence on leadership style and commitment to service quality.

The findings have underlined that role clarity can significantly help in eliminating role ambiguities to result in enhancing commitment among frontline employees (Boshoff & Mels, 1995; Singh, 2000; Singh, Verbeke, and Rhoads 1996, Hartline & Ferrell 1996). O'Driscoll and Beehr (1994) stated that in situations of high uncertainty, subordinate will generally be looking for their leaders to set goals and help them to solving issues with responsive feedback on performance. This would enhance their potential to handle work stress and enable them to express positive attitudes towards service delivery.

In situations of high role clarity subordinates perceive greater levels of support from their supervisor, with in turn results in subordinates being more conscientious about carrying out their work responsibilities (feeling of being more committed towards work) (Eisenberger *et al*., 1990; Stinglhamber and Vandenberghe, 2004). House (1996) has also supported towards the importance of role clarity for relationship amongst leaders and subordinates behaviors. Based on the findings it can be stated that role clarity has positive influence on exogenous variable and endogenous variables in the service sector.

Furthermore, previous studies also support role clarity as a moderating factor in the relationship of transformational, laissez-faire leadership style and commitment to service quality hypothesizes. Findings of present study hypothesis 4 and 6 are in line

with study (Tracey & Hinkin, 1996), leaders renounce in communication for a clear role in order to influence positively and raise employees` motivation for enhanced behaviors and outcomes. Leadership can be efficient in improving role clarity of employees (Muczyk & Reimann 1987). In the views of Viator and Ralph (2001) stated that leadership has positive relationship with role clarity which impacts on employee affective commitment directly and indirectly on other employee outcomes. Leadership style may improve the role clarity of subordinates and reduce the role ambiguity (MacKenzie *et al*., 2001).

Based on the findings it can also be said that when employees have low level of role clarity then leaders directing and motivating employees to achieved task and resolve role clarity issue (House, 1996). Furthermore, with high role clarity, employee perceives greater support from leaders which helps them to resolve task difficulties of task for responsive achievement of organizational goals (Eisenberger *et al*., 1990; Stinglhamber & Vandenberghe, 2004). High level of role clarity not only impacts on high performance of employees but also enables them to recognize and appropriately use their capabilities to increase the service delivery to customer. This also makes them to perceive leader to be helpful (Bray & Brawley 2002). Role clarity, have been proven to have an effect on employees services efficiency (Singh, Verbeke, & Rhodes 1996; Hartline & Ferrell, 1996). Role clarity has direct and indirect impacts on output key variables as employee‟s behavior (Tracey & Hinkin, 1996).

Based on the findings it can be said that role clarity moderates the relationship as leader has characters to provide the direction, specifically clear role of followers and

motivates to ward commitment to service quality. Leaders provides clear picture to employees to understand the all responsibility in hospital of medical officer to provide best services and also keep trust to take decision at emergencies bases. This has concluded in supporting the two hypotheses fully pertaining to the impact of role clarity as a moderating between transformational leadership and laissez faire leadership style relationship and commitment to service quality.

Surprisingly, results pertaining to fifth (5) hypotheses on the moderation of role clarity in the relationship between transactional leadership and commitment to service quality; the results of structural model have shown that role clarity does not moderate on the relationship of transactional leadership and commitment to service quality.

These findings are in parallel to the empirical conclusions of Clark *et al*., (2009) whereby role clarity did not moderate the relationship on leadership style and commitment to service quality and similarly, another study conducted by Shoemaker, (1999) stated that industrial role clarity has less influence on transactional leadership and subordinate. Role clarity did not exert any influence by supervisory behavior on the sales man (Kohli, 1985). According to Wolverton, Montez and Gmelch (2000) and Heck, Johnasrud and Rosser (2000) that negative impact on commitment of employee by leader is due to role not being clear which may be due to insufficient leadership training. In situations where an employee perceives low levels of role clarity, this is often due to the failure of role guidance and poor feedback from the supervisors (Podsakoff *et al*., 1996). This is evidence to the idea that low role clarity

indicates the unwillingness of leaders or their inability to support their subordinates (Kahn *et al*., 1964). All above previous studies providing the evidence to role clarity does not moderate on the relationship of transactional leadership style and commitment to service quality.

Several other reasons can also be implied with regards to this particular finding of this study that role clarity does not moderate on the transactional leadership and commitment to service quality. For instance, the public hospitals are managed by the government of Sindh, Pakistan whereby, lack of job designing in order to incorporate training, workshop, and seminars on role clarity is not received by individuals with transactional leadership. It may also be due to the vagueness of the role of those leaders themselves. It may be due to the nature of transactional leaders not proving to be a helping hand in clarifying the medical officers` roles and responsibilities in public hospitals of Sindh, Pakistan. In other perspective on basis of demographic results that reveal that 197 were young doctors and MBBS fresh medical officer and they did not fully understand role clarity and had less experience due to new appointment as medical officer members. All above reasons also indicating the role clarity does not moderate on the relationship between transactional and commitment to service quality.

The term path-goal refers to the belief that effective leaders clarify the paths necessary for their subordinates to achieve the subordinates' goals. Leaders can do this in two main ways. First, leaders can engage in behaviors that help subordinates

facilitate goal attainment (e.g., by providing information and other resources necessary to obtain goals). Second, leaders can engage in behaviors that remove obstacles that might hinder subordinates' pursuit of their goals (e.g., by removing workplace factors that reduce the chances of goal attainment and bad effects on commitment (House, 1971). Furthermore path-goal theory entails that a major responsibility of a leader is to enhance subordinates` expectancies, instrumentalities and valences.

Path-goal theory also states that the influence of a leader on subordinate can be moderated by certain situational variables. Beyond facilitating role clarity through the role negotiation process, leadership improves role clarity by increasing the availability of knowledge and other resources because leaders are key sources of role-related information and feedback for employees (Whitaker *et al*., 2007). These resources and knowledge are likely to help employees to develop clear perceptions of their roles because well-defined descriptions of job duties and expectations may be effective means of facilitating role clarity (Eatough *et al*., 2011). If employees have higher-quality relationships with their leader reported significantly higher levels of role clarity Kauppila, (2014).

The findings of present study suggest that role clarity has high influence on the commitment to service quality by leaders. According to Malik, Aziz and Hassan, (2014) leaders should help to subordinates to perform their work efficiently and easily. In situations of high role clarity subordinates perceive greater levels of

support from their supervisor, with this in turn results in subordinates being more careful about carrying out their work responsibilities (feeling of being more committed towards organization and the work) (Eisenberger *et al*., 1990; Stinglhamber and Vandenberghe, 2004). Act of role clarity of leaders influence the commitment of employees Gilbert (2013). This study findings has evidence that role clarity influence and important for service employees who deliver service in emergencies situation.

Path goal theory describes that leaders must clarify their subordinates of job requirement and important information to achieve the goals. Leaders can adopt behaviors that helps subordinate accomplish their objective achievement as providing information and other resources necessary to obtain goals. Leaders must be engaged in a behavior that helps to remove hindrances of subordinates (Clark et al., 2009). Path goal-theory leaders, fulfill the workplace needs by satisfying and rewarding people in their accomplishing of goals. It also suggests that people at work need clear paths so that they could direct their work and skills accordingly. Furthermore, Pahi *et al.,* (2015) stated that leader‟s clear path of employees to enhance employee‟s commitment to service quality.

In the views of House (1971) that path-goal theory has the responsibility to provide necessary information and support to the staff so that they could responsively achieve work goals. For leaders, this theory focuses on leaders and followers in the similar fashion as explained by House and Dressler (1974). According to them, numerous situational factors can moderate the effect of task characteristics and its

relationship between behaviors of leaders and subordinates` expectation, role clarity. Result of the present study provides the evidence that role clarity will help the staff towards commitment to service quality.

Path goals theory has indicated towards the moderating influence of role clarity Greene (1979). The theory has indicated that role clarity and leadership behavior effect on employees` (staff) commitment to service quality. Clack et al., (2009) using the path goal theory and supporting with conceptual models described that role clarity is important for staff to understand job requirements in order to express commitment to service quality importantly, other studies followed path goal theory of leaders that described important factors like role clarity influencing the service level of employees (Donnelly & Ivancevich, 1974; Singh, 1993; Armstrong, 2014). Role clarity has shown structure for employees, employees who received the role clarity from leaders were found to be more satisfied with their jobs (Singh, 1993; De Ruyter *et al*., 2001). Supervisors can also play a vital role in interpreting rules and procedures determined by the organization thus, reducing the levels of role ambiguity (O"driscoll & Beehr, 1994). Empirical findings of De Ruyter *et al*., (2001) have found role clarity to be influencing the employees toward employee"s commitment to service quality. In testing path goal theory, result supported two hypothesis role clarity moderates on the transformational and laissez-faire leadership style in the public hospitals of Sindh, Pakistan. Taken as a whole, this study has added empirical evidence to the body of knowledge in the area of commitment to service quality and lending empirical evidence in support of the theory. Based on the results, it can be concluded role clarity plays important role between

transformational, laissez-faire leadership and commitment to service quality. Therefore, management and leaders exercising any of these two leadership styles need to work on clarifying individual roles in order to help them to further boost their commitment to service quality.

5.4 Contribution to Body of Knowledge

The present study has resulted in notable contributions towards the body of knowledge pertaining to two disciplines of organizational behavior and service marketing management. Results of study have marked major contribution to the theory on leadership style, commitment to service quality, and role clarity. Importantly, the study has also expressed managerial and theoretical and contributions.

5.4.1 Theoretical Implications

This study was conducted based on a conceptual framework that was based on empirical evidence suggesting numerous theoretical gaps in the literature. The framework was established and explained under the arena of two theoretical perspectives; cognitive dissonance (Festinger‟s 1957), and path goal theory (House 1971). The study integrated role clarity as moderating variable understand and clarify the relationship between transformational, transactional, laissez-faire and commitment to service quality. This study was set to find clarity over pervious inconsistent relationship findings in same variables and followed to highlighted recommendation and limitation by previous scholars.

A base on the findings, the study has contributed towards organization behavior and service quality management in hospital as transformational, transactional, laissez-faire leadership and commitment to service quality and moderating with role clarity. Whilst addressing the inconsistent results regarding transformation, transactional, and laissez-faire leadership styles in different service sectors like education, hospitality, the current study has found that leadership styles can play an important role in enhancing commitment to service quality in the service industry like hospitals. Accordingly, role clarity can notably help medical officer of hospitals to enhance their attitudes and behaviors.

The study has also strived to address the lack of studies on the relationships for further establishment and understanding of those connections responsively. Based on the present study findings and discussion, the study has several theoretical contributions in the research on transformational, transactional, laissez-faire leadership style and commitment to service quality and incorporating the moderating role clarity in health settings.

Importantly, transformational, transaction and laissez-faire leadership styles are more important to influence staff for commitment to service quality which is highly essential for sectors like hospitals. Empirical findings of the present study on relationship of leadership styles and commitment to service quality has added towards existing literatures and has also addressed the weak and inconsistent relationships from previous studies. Additionally, the literature on the topic outlined no moderating studies on the relationship of leadership styles and commitment to

service quality and other literature also suggesting role clarity moderator on relationship between variables (Mukherjee & Malhotra, 2006; Pahi and Hamid, 2015). According to Baron and Kenny (1986), “moderator variables are typically introduced when there is an unexpectedly weak or inconsistent relation between a predictor and a criterion variable” (p. 1178). Present study fill the gap by incorporating role clarity as moderate variable on leadership style and commitment to service quality to enhance understanding how influence on relationship between two in the public hospital of Sindh, Pakistan. Findings of the moderator contributed in the literature how role clarity influence on the leadership style and commitment to service quality and extended the literature of organization behavior and service quality management.

Findings of this research has concluded that role clarity can play an important role towards commitment to service quality and leadership styles hence making a significant contribution in the service quality management and organizational behaviors literatures. Empirical findings of this study have also extended the literature in terms of outlining how commitment to service quality of medical officer can be improved. More importantly, how organizational behavior concepts like leadership styles can contribute to service features is a major input of this study. Hence, this study has forwarded a comprehensive framework that outlines the relationship of leadership styles with commitment to service quality along with role clarity as a noteworthy moderator in the public sector hospitals of Sindh, Pakistan.

5.4.2 Practical Implications

In connection to practical contributions, the empirical findings of the present study outline several implications in terms of organizational behavior and management of service in healthcare sector of Sindh, Pakistan settings.

Findings of study have underlined that leadership style is most important to influence on commitment to service quality in public hospital and findings provide the evidence that hospitals leaders can notably influence the medical officer towards commitment to service quality. Leaders can exercise behaviors like direction, communication, motivation, feedback, faire control, team work rewards, role clarity, training and empowerment and freedom which would ultimately lead them to enhance staff`s commitment to service quality. As the study focused on public health sector for observing how transformational, transaction, and laissez-faire style and role clarity brings change to medical officers` behavior toward commitment to service quality; the findings have shown that transformational leadership is a better predicator and thus imparts more influence compared to transactional and laissez-faire leadership style on commitment to service quality. This is since in the public hospitals, transactional leaders are less obliged towards supporting for enhancing commitment to service quality.

The empirical findings can be implemented to public health sector organization in different ways. All three types of leaders must take efforts to spend more time,

communicate, rewards, freedom with the medical officer to foster commitment to service quality. The findings can be responsively applied across the health sector.

Firstly, leaders‟ own the commitment to service quality has direct influence on medical officer and on their understanding of the jobs. Moreover, leaders as an inspiration can directly influence upon an employee‟s role clarity. When leaders are able to communicate their expectancy to concerning employees then it becomes convenient for the staff to serve as per expectation. The findings have outlined that influential role of the leader can notably boost employee outcomes like commitment to service quality.

Secondly, results have indicated through the underpinning path-goal theory that exercising appropriate leadership practices can enhance service quality and enhance commitment to service. Although leaders in Pakistani environment often express limited behaviors in this regard but the findings suggest that leaders and human resources management professionals should work to ensure that sufficient attention is given in this regard. Numerous orientation and training programs may be launched to promote leadership and foster its influence in enhancing commitment to service quality. Accordingly, such programs will also help to understand general background of employees, significance of value service, commitment to service quality and its benefits. In emergencies situation leader give freedom to medical officer to deliver service immediately bases and take own decision. Leaders should take responsibility to clear role of the medical officer in public hospital of Sindh, Pakistan to understand the job requirement and achieve the organization common goals.

Summary of practical implication of present study, findings of present study identify that leadership styles influence on the medical officer and it helps to increase the performance of staff in the organization and role clear by the leaders of public hospitals that will also help to increase the performance of organization. Findings of study encourage the staff by leaders to be commitment to service quality when employees is agree to deliver the high service quality to customer it is also beneficial for the customer who received high quality service from staff and enhanced in the long term and it remains a sustainable image which also can help in attracting customers and an advantageous strategy in customer retention and satisfaction. Moreover increase the competitive edge over the other competitors and contribute to its success in building a market niche. Police makers also get advantages from findings of the study they make polices where leaders make practices to influence on the medical officer to deliver high services and health sector to optimize the allocation of the best facilities and resources in the training and hiring of their future leaders so that it can enhance the quality of service and organization to build up their confidence, especially when their reputation begins to soar. Based on this, the fundamental implication of this study is that leaders that influence medical should develop transfer climate and their commitment to service quality.

5.5 Limitations and Recommendations for Future Research

The main limitation and future direction of this study addressed through three categorization named as causality and generalizability. Besides the fact that the current study has provided evidence and robust result to a number of hypothesized relationship between the exogenous and endogenous variables; the findings still holds considerable limitations.

Firstly, the research design used by this study was survey questionnaire, employed with cross-sectional research strategy, gathered at a particular time period. Due to this, it was difficult to find out the direction of causality because of which, causal relationships between independent and dependent variable could not be concluded. For that reason, it is more suitable to have adequate time lapse in between the time of data collection for independent variables and dependent variable. Future studies mayrali consider targeting wider sample from different occupational settings to unearth the generalizable findings with regards to leadership styles and their contribution towards commitment to service quality followed by the moderation of role clarity.

Secondly, this study was only focused on the public hospitals of Sindh, Pakistan thus leaving the private sector hospitals unattended. Future studies may consider undertaking private hospitals also in order to establish further understanding and generalization of research results.

Thirdly, limitation of this study is that concerns with its geographical region. Since, the present study focused on one geographical region (Sindh) of the country Pakistan hence, further studies may take other provinces into consideration as well.

Fourthly, notably, the respondents were permanent employees of the public hospitals of the Sindh province; the results of the study can be responsively generalized across other departments of the health sector as the nature and organizational set is somehow similar.

Fifth, the present study offers quite limited generalizability as it focused mainly on medical officers from public hospitals located in the Sindh zone Pakistan. Consequently, additional work is needed to include other staff like nursing staff from various hospitals in order to generalize the findings.

Sixth, this study was quantitative in nature and the researcher therefore relied on the questionnaire data for statistical analysis. This leads towards outlining potential for further study on the topic through qualitative means.

Seventh, this study depended on self-reported questionnaire data, hence the probability of common method variance may have prevailed because all the variables were measured employing a single survey instrument. In accordance to Avolio *et al.* (1991) the common method variance is more bothersome in analyzing the relationships between the attitudinal or psychological data obtained from a single respondent at one point in time. With respect to this study, both independent and

dependent variables are based on perceptions data. Due to that reason, future research should include a method that could reduce common method variance, for instance instead of using perceptions data, the objective measures could be employed.

Finally, no significant moderating effect of role clarity on the relationship between transactional and commitment to service quality may potentially be explained through mediation effect (Sharma, Durand, & Gur-Arie, 1981; James, & Brett, 1984; Hayes, 2013). Therefore future studies may consider evaluating the mediation of role clarity between transactional leadership and commitment to service quality which will also underline the strength of other intervening relationships.

5.6 Conclusion

These study findings have revealed that significant direct relationship exists between transformational, transactional and laissez-faire leadership style and commitment to service quality. Role clarity moderated only two variables namely, transformational, and laissez-faire leadership style and did not moderate the transactional leadership style and commitment to service quality relationship in the Public hospitals of Sindh, Pakistan. The study has lent support to key theoretical propositions. In particular, the current study has successfully answered all of the research questions whilst achieving all the noted objectives with robust literature support. More importantly, the present has study addressed the theoretical gaps by incorporating role clarity as significant moderating variable.

Findings to of present study have supported the explanation of cognitive dissonance theory (1957) suggesting that leaders have the ability to influence subordinates. Similarly, the present study also revealed that role clarity is most important to boost (moderate) these relationships between transformational and laissez-faire leadership style as per the assertions of path goal theory (1971). As per path goal theory, when a leader clarifies the role and responsibilities of employees, they result in better outcomes. Under this explanation, the study found moderation of role clarity on the relationship transformational and laissez-faire leadership with commitment to service quality.

In addition, several future research directions were drawn. Findings of research with recommendations made to leaders, employees and policy makers that hospitals leaders need to enhance medical officer‟s commitment to service quality. Similarly, role clarity can influence positively towards commitment to service quality in the public hospitals of Sindh, Pakistan.

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Appendix A
Research Questionnaire

UNIVERSITI UTARA MALAYSIA

SURVEY OF HOSPITALS IN SINDH

Dear Sir/Madam,

My name is Munwar Hussain, a PhD candidate of College of Business, Universiti Utara Malaysia. My research interest is related to the health industry in Sindh. This study is aimed that how much medical officer and leaders are committed to provide services to their customer.

I would be very grateful if you could take some minutes of your time to complete the following questionnaire regarding ***the moderating effect of role clarity on the relationship between leadership style and commitment to service quality among medical officer in public hospital of Pakistan.***

Your answer will be kept anonymous and strictly confidential. Your name and other identity will not be disclosed as part of ethical protocols of Universiti of Utara Malaysia,

The Questionnaire contains 4 sections A, B, C, D, question items examining various statements which will be taking about 15- 20 mints to complete it. Please read each statement carefully ☐ and tick one box answer that corresponds in the best way to your agreement or disagreement.

Should you require any further assistance whilst filling in the questionnaire, please do not hesitate to contact me on mobile phone: 0306-8224402 or alternatively email to:

Munwar
Hussian
Research Student
Othman Yeop Abdullah Graduate School of Business
Universiti Utara Malaysia
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SECTION A:

Commitment to Service Quality (CSQ)

The section consists of statements on Employee commitment to service quality (CSQ). It represents possible to commitment to service quality that you might have. Please tick the appropriate answer using question the scale below to indicate your agreements or disagreement with each statement.

NO:	Statement	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	I feel strongly that about improving the quality of my hospital"s services	1	2	3	4	5
2	I enjoy discussing services quality-related issues with people in my hospital	1	2	3	4	5
3	I gain a sense of personal accomplishment in providing high quality services to my customers	1	2	3	4	5
4	I completely understand the importance of providing high quality service to our customers	1	2	3	4	5
5	I often discuss quality-related issues with people outside of	1	2	3	4	5

	my hospital					
6	I strongly feel that provision of high quality services to our customers should be the number one priority of my hospital	1	2	3	4	5
7	I am willing to put more effort beyond that normal in order to deliver service quality my hospital.	1	2	3	4	5
8	The way I feel about services is very similar to the way my hospital feels about delivery of high quality services	1	2	3	4	5
9	I really care about the quality of my hospital"s services	1	2	3	4	5

SECTION B:

The person you are rating to your leader. This questionnaire to be describes the transformational leadership, Transactional and laissez-faire style of above-mentioned individual as you received.

Thirty six descriptive statements are listed below on following pages. Please answer all items. Judge how frequently each statement fit person you are describing by tick appropriate alternative.

Please use following (5) rating scale

The person I am rating….

Transformational leadership style

NO:	Statement	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	Instills pride in me for being associated with her/him	1	2	3	4	5
2	Goes beyond self-interest for the good of staff	1	2	3	4	5
3	Have my respect	1	2	3	4	5
4	Displays sense of power and confidence in me	1	2	3	4	5
5	Talks only on most important values and beliefs	1	2	3	4	5
6	Specific importance of having a strong sense of purpose	1	2	3	4	5
7	Considers moral & ethical consequences of decisions	1	2	3	4	5
8	Emphasizes important of group‟s mission	1	2	3	4	5
9	Talks optimistically about future	1	2	3	4	5
10	Is excited about what needs to	1	2	3	4	5

	be accomplished					
11	Articulates a compelling vision	1	2	3	4	5
12	Expresses confidence on goal achievement	1	2	3	4	5
13	Raises critical assumption to question whether they appreciate or not	1	2	3	4	5
14	Seeking deferent perspective in problem solving	1	2	3	4	5
15	Allows me look at problems different angles	1	2	3	4	5
16	Suggests new ways to completing my work	1	2	3	4	5
17	Spends time on training and caching	1	2	3	4	5
18	Treats me as individual rather than member of group	1	2	3	4	5
19	Considers me as having different needs/ abilities / aspiration	1	2	3	4	5
20	Helps me to develop my strength.	1	2	3	4	5

Transactional leadership style

21	**Provides with assistants an exchange for my effort**	**1**	**2**	**3**	**4**	**5**
22	Discusses with specific terms who is responsible for achieving performance targets	1	2	3	4	5
23	Clarifies my expectation when meeting perform expectation goal	1	2	3	4	5
24	Expresses satisfaction when meeting performance	1	2	3	4	5
25	Focuses attention on irregularities /mistake deviation from standards	1	2	3	4	5
26	Gives all attention in dealing with mistake/ complains/ failure	1	2	3	4	5
27	Keeps track of all mistakes	1	2	3	4	5
28	Directs my attention towards failures to meet standards	1	2	3	4	5
29	Do not fail interfere until the problem is serious	1	2	3	4	5
30	Wait for things go to wrong before taking action	1	2	3	4	5
31	hospital believes in not making changes unless necessary	1	2	3	4	5
32	Takes action only when problem	1	2	3	4	5

	become serious					

Laissez-faire leadership style

33	Avoids getting involved when important issues arise.	**1**	**2**	**3**	**4**	**5**
34	Is absent when needed.	1	2	3	4	5
35	Avoids making decisions.	1	2	3	4	5
36	Delays responding to urgent questions.	1	2	3	4	5

SECTION C:

Role clarity

This part of the questionnaire is designed to measure the extent to which your role (job) is clear at work. Please indicate the extent of your agreement or disagreement with each statement by ticking (x) in the appropriate block.

NO:	Statement	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	I am well aware of how to best serve the customers	1	2	3	4	5
2	I get adequate time to spend on various aspects of my job	1	2	3	4	5

3	I am able to resolve customer complaints.	1	2	3	4	5
4	. I get to fill out required paper work	1	2	3	4	5
5	I plan and organize my daily work activities	1	2	3	4	5
6	I can handle unusual problems and situations	1	2	3	4	5
7	I know where to get assistance in doing my job	1	2	3	4	5
8	I am satisfied with extent to which I can bend the rules to satisfy the customers	1	2	3	4	5
9	I am satisfied with extent to which I can make decision without my supervisors‟ approval.	1	2	3	4	5
10	I am well aware of hospital`s rules and regulations	1	2	3	4	5

11	I am aware of how my supervisor evaluates my performance	1	2	3	4	5
12	Your supervisor is satisfied with my performance	1	2	3	4	5
13	Receive adequate work related training	1	2	3	4	5
14	I am aware of the factors that determine my promotion and advancement	1	2	3	4	5
15	I am aware of how my supervisor expects me to allocate my time	1	2	3	4	5
16	I am aware of how satisfied my customers are with my performance	1	2	3	4	5
17	I am aware of what my customers expect from	1	2	3	4	5

SECTION D:

Demographic information:
Please response to all the questions that best describe the general information of yourself

Please tick only one

GENDER

Male	
Female	

YOUR AGE

20-30	
30-40	
40-50	
50-60	

YOUR QUALIFICATION

MBS	
FCPS	
PhD (specialist)	
Others	

MARITAL STATUS

Single	
Married	
Others	

LENGTH OF SERVICE

1 year	
1-5 year	
5-10 year	
10-15 year	
Above	

Thank you very much for completing the questionnaire.

Appendix B

Missing value output

Result Variables

	Result Variable	N of Replaced Missing Values	Case Number of Non-Missing Values		N of Valid Cases	Creating Function
			First	Last		
1	CSQ2_1	1	1	30	320	SMEAN(CSQ2)
2	CSQ5_1	1	1	320	320	SMEAN(CSQ5)
3	CSQ6_1	1	1	320	320	SMEAN(CSQ6)
4	TSL2_1	1	1	320	320	SMEAN(TSL2)
5	TSL6_1	1	1	320	320	SMEAN(TSL6)
6	TSL10_1	2	1	320	320	SMEAN(TSL10)
7	TSL15_1	1	1	320	320	SMEAN(TSL15)
8	TSL16_1	1	1	320	320	SMEAN(TSL16)
9	TSL18_1	1	1	320	320	SMEAN(TSL18)
10	TS1_1	1	1	320	320	SMEAN(TS1)
11	TS5_1	1	1	320	320	SMEAN(TS5)
12	TS12_1	1	1	320	320	SMEAN(TS12)
13	RC2_1	1	1	320	320	SMEAN(RC2)
14	RC5_1	1	1	320	320	SMEAN(RC5)
15	RC13_1	1	1	320	320	SMEAN(RC13)
16	RC15_1	1	1	320	320	SMEAN(RC15)

Appendix C

SmartPLS output- measurement model

	AVE	Composite Reliability	R Square	Cronbachs Alpha	Communality
Commitment to service quality	0.781134	0.969143	0.51536	0.961353	0.781134
Laissez-faire leadership	0.712187	0.907267		0.862916	0.712187
Role clarity	0.720396	0.968336		0.96907	0.720398
Transactional leadership	0.681618	0.959065		0.952847	0.681618
transformational	0.68075	0.939911		0.931061	0.58755

Appendix D

Blindfolding Procedure Output

CV Red

CV	Red
	1-SSE/SSO
CSQ	0.330597
LFLS	0.71196
RC	0.693445
TS	0.681624
TSL	0.680763

Indicator Cross validated Redundancy

Indicator Crossvalidated RedundancyTotal	SSO	SSE	1-SSE/SSO
CSQ1	315	214.4199	0.319302
CSQ2	315	203.9309	0.3526
CSQ3	315	205.7388	0.346861
CSQ4	315	193.5764	0.385472
CSQ5	315	210.5245	0.331668
CSQ6	315	230.8319	0.2672
CSQ7	315	218.1605	0.307427
CSQ8	315	195.1253	0.380555
CSQ9	315	205.6191	0.347241
LFLS1	315	48.66591	0.845505
LFLS2	315	160.3803	0.490856
LFLS3	315	47.35444	0.849668
LFLS4	315	106.5209	0.661839
RC1	315	81.85529	0.740142

RC10	315	110.2164	0.650107
RC11	315	50.27637	0.840392
RC12	315	78.25439	0.751573
RC13	315	167.2924	0.468913
RC15	315	87.31886	0.722797
RC17	315	36.55609	0.883949
RC2	315	168.1469	0.4662
RC3	315	62.9056	0.8003
RC5	315	101.4645	0.677891
RC6	315	51.81308	0.835514
RC8	315	167.7648	0.467413
TS1	315	60.09346	0.809227
TS10	315	92.378	0.706737
TS11	315	86.99415	0.723828
TS12	315	84.90359	0.730465
TS3	315	162.3965	0.484456
TS4	315	124.0661	0.606139
TS5	315	72.84887	0.768734
TS6	315	89.35411	0.716336
TS7	315	141.0027	0.552372
TS8	315	111.7365	0.645281
TS9	315	77.39726	0.754294
TSL1	315	121.8506	0.613173
TSL11	315	83.68725	0.734326
TSL12	315	171.4251	0.455793
TSL14	315	77.60219	0.753644
TSL16	315	76.35925	0.75759
TSL17	315	79.38621	0.74798
TSL18	315	140.2435	0.554783
TSL19	315	113.3294	0.640224
TSL2	315	74.4172	0.763755
TSL20	315	75.75295	0.759514

TSL4	315	83.27727	0.735628
TSL6	315	146.2801	0.535619
TSL8	315	90.37182	0.713105
TSL9	315	73.67946	0.766097

CV Com.

CV Com.	1-SSE/SSO
CSQ	
LFLS	0.711967
RC	0.692099
TS	0.681624
TSL	0.680802

Construct Cross validated Communality

Total	SSO	SSE	1-SSE/SSO
CSQ	2835	2835	
LFLS	1260	362.9215	0.711967
RC	3780	1163.865	0.692099
TS	3465	1103.171	0.681624
TSL	4410	1407.662	0.680802

Indicator Cross validated Communality

Indicator Crossvalidated CommunalityTotal	SSO	SSE	1-SSE/SSO
CSQ1	315	315	0
CSQ2	315	315	
CSQ3	315	315	
CSQ4	315	315	
CSQ5	315	315	0
CSQ6	315	315	0
CSQ7	315	315	
CSQ8	315	315	
CSQ9	315	315	
LFLS1	315	48.66591	0.845505
LFLS2	315	160.3803	0.490856
LFLS3	315	47.35444	0.849668
LFLS4	315	106.5209	0.661839

RC1	315	81.85529	0.740142
RC10	315	110.2164	0.650107
RC11	315	50.27637	0.840392
RC12	315	78.25439	0.751573
RC13	315	167.2924	0.468913
RC15	315	87.31886	0.722797
RC17	315	36.55609	0.883949
RC2	315	168.1469	0.4662
RC3	315	62.9056	0.8003
RC5	315	101.4645	0.677891
RC6	315	51.81308	0.835514
RC8	315	167.7648	0.467413
TS1	315	60.09346	0.809227
TS10	315	92.378	0.706737
TS11	315	86.99415	0.723828
TS12	315	84.90359	0.730465
TS3	315	162.3965	0.484456
TS4	315	124.0661	0.606139
TS5	315	72.84887	0.768734
TS6	315	89.35411	0.716336
TS7	315	141.0027	0.552372
TS8	315	111.7365	0.645281
TS9	315	77.39726	0.754294
TSL1	315	121.8506	0.613173
TSL11	315	83.68725	0.734326
TSL12	315	171.4251	0.455793
TSL14	315	77.60219	0.753644
TSL16	315	76.35925	0.75759
TSL17	315	79.38621	0.74798
TSL18	315	140.2435	0.554783
TSL19	315	113.3294	0.640224
TSL2	315	74.4172	0.763755
TSL20	315	75.75295	0.759514
TSL4	315	83.27727	0.735628
TSL6	315	146.2801	0.535619
TSL8	315	90.37182	0.713105
TSL9	315	73.67946	0.766097

Appendix E

List of Public Hospital in Pakistan

Karachi	Hyderabad	Larkana	Sukkhur
Civil hospital Karachi	Liquat university health since, Hyderabad	Shaikh Zayed Women Hospital, Larkana.	Civil hospital, Sukkur
Abaasi shsheed hospital Karachi	Sir Cowasjee Jehangir institute of psychiatry Hyderabad.	Civil Hospital, Larkana.	GMMC Teaching Hospital, Sukkur.
Civil hospital burn center Karachi	Civil hospital Hyderabad	Chandka Medical College Hospital, Larkana	Govt. Anwar Piracha Teaching Hospital, Station Road, Sukkur.
Jinah post graduates medical center Karachi	Eye hospital Hyderabad	Zaid-bin-Sultan Al-Nayan Women & Choldren Hospital.	
Karachi institute of heart diseases, Karachi	Civil hospital Kotri	Shaik Zayed Hospital	
Lady dufferin hospital Karachi,	Liaquat University Hospital, Jamshoro hyderabad	Shaikh Zayed Women Hospital	
Leprosy hospital, karachi	CMH Hospital		
Layari general hospital Karachi	taluka hospital qasimabad Hyderabad		
National institution/ hospital of Cardiovascular Diseases, Karachi			
National institute/ hospital of child health Karachi			

	PNS Sifa, Karachi hospital			
	Sindh government Qutar hospital, Karachi			
	Sindh police hospital, Karachi			
	Sindh government hospital new Karachi, Karachi			
	Sindh institute/ hospital of skin disease, Karachi			
	Sindh institute/ hospital of urology and transportation, Karachi			
	Sindh institute/ hospital of Skin Diseases, Karachi			
	Sobhraj Maternity Home, Karachi			
	Spencer eye Hoapital			
	Ghazderabad General Hospital			
	Sindh Govt Hospital Ibrahim Haideri, Karachi			
	Serfaraz Rafiqui Shaheed Employees Hospital			
	Sindh Govt. Children Hospital North Nazimabad			
	Cardiac Emergency Centre Landhi/ hospital			
	Cardiac Emergency Centre Shah Faisal/ hospital			
	50 Beded Hospital Lal Market New Karachi			
	Homeopathic Hospital Nazimabad karachi			
Total	26	8	6	3

Sources:

(1) http://lazer-eyecenter.blogspot.com/2009/07/list-of-hospitals-in-pakistansindh.html

(2) http://www.pmdc.org.pk/AboutUs/ListofHospitals/tabid/111/Default.aspx

(3) http://pakmed.net/college/forum/?p=11802.

(4) LIST OF MAJOR HOSPITALS OF CITY DISTRICT GOVERNMENT KARACHI