

**Testing the relationship between staff satisfaction and patient  
satisfaction in the Palestinian health care services as a way of  
exploring the management culture**

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Studies, School of Nursing and Midwifery in partial fulfillment of  
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By

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## Dedication

**This thesis is dedicated to my children, without them there is no meaning for my life. I also dedicated this work to my mother, brothers and sisters.**

## Declaration

**No portion of the work referred to in this study has been submitted in support of an application for any other degree or qualification to this or any other university or other institution of learning.**

**Asma Imam**

**2002**

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## Abstract

This study is designed to examine the relationship between health professionals' leadership behavior, job satisfaction of the staff (nurses and physicians) and patient satisfaction in the hospital sector of the Palestinian health care system as a way of exploring management culture. Within this general framework, the study aimed at:

1. exploring the relationship between the staff's perceived leadership behavior and their job satisfaction.
2. describing the relationship between the personal characteristics of staff and their job satisfaction.
3. determining the relationship between environmental factors such as socioeconomic, political and cultural conditions and staff's job satisfaction.
4. examining the relationship between staff's job satisfaction and the satisfaction of their patients.
5. determining the relationship between the staff's perception of leadership behavior, their job satisfaction and satisfaction of their patients.

The data for the research were gathered using a self-administered job satisfaction questionnaire and Multifactor Leadership Questionnaire (MLQ-5x) distributed by the researcher to 230 health care professionals (physicians & nurses). Questionnaires with envelopes were distributed to health care professionals working in 11 adult-patient units in two general hospitals in the West Bank. One hundred fifty-three job satisfaction and 153 MLQ-5x of the returned questionnaires were usable (66.6% response rate). A semi structured exit interview with 207 patients who agreed to participate in the study was conducted at the same time as the collection of data from health professionals. Patients were selected from the same 11 adult-patients units.

Statistical analyses were performed using the Statistical Package for Social Science (SPSS) version 8. Descriptive statistics, Pearson Correlation Coefficient and multiple regressions were used to analyze the data. The major findings of the study included the followings:

- 1- A positive significant correlation between transformational leadership and job satisfaction.
- 2- Leadership behavior accounted for 37.3% of the variance in job satisfaction.
- 3- Personal and demographic characteristics of health professionals accounted for 17.2% of the variance in job satisfaction. The two variables that significantly predict job satisfaction were work motivation and positive affectivity.
- 4- There was positive and significant correlation between environmental factors (socioeconomic, political and cultural factors) and job satisfaction.

- Environmental factors accounted for 34% of the variances in job satisfaction.
- 5- The result of the stepwise multiple regressions showed that transformational leadership, socioeconomic and political factors and work motivation accounted for 57.6% of the variance in job satisfaction.
  - 6- There was positive and significant correlation between job satisfaction and patient satisfaction. Job satisfaction accounted for 77.5% of the variance in patient satisfaction.
  - 7- The results of the regression analysis showed that job satisfaction, transformational and transactional leadership accounted for 81.4% of the variance in patient satisfaction. However, job satisfaction accounted for 77.5% of the variance in patient satisfaction.

A comparison of the major findings with other research findings of relevant research is presented. Finally, suggestions and recommendations for future research studies are included. All suggestions are aimed at enhancing the knowledge of Palestinian managers in particular, and managers in the Arab world as well as managers in other countries in general. In the conclusion both theoretical and policy implications of the findings are discussed.



## Abbreviations

AAUG	Association of Arab-American University Graduates Press.
ANOVA	One Way Analysis of Variance.
CD	Computer Diskette
CNE	Chief Nurse Executive.
FAFO	Center for International Studies at the Institute for Applied Social Science.
GNP	Gross National Product
IWS	Index of Work Satisfaction.
JCAH	Joint Commission on Accreditation of Health Care Organization.
LEAD	Leadership Effectiveness and Adaptability Descriptive Instrument.
LISREL	A computer program used to perform several statistical procedures among which multiple regression and factor analysis.
LPC	Least Preferred Co-worker.
M	Mean.
MAS	Palestinian Economic Policy Research Institute.
MBEA	Management by Exception Active.
MBEP	Management by Exception Passive.
MLQ	Multifactor Leadership Questionnaire.
MNM	Middle Nurse Manager.

MoH	Ministry of Health
MS	Mean Square.
NCES	National Center for Economic Studies.
NGOs	Nongovernmental Organizations.
NSHP	National Strategic Health Plan.
PA	Palestinian Authority.
PASSIA	Palestinian Academic Society for Study of International Affairs.
PC	Personal Computer.
PCBS	Palestinian Central Bureau of Statistic.
PCH	Palestine Council of Health.
PLO	Palestine Liberation Organization.
PNA	Palestinian National Authority.
RNs	Registered Nurses.
SAS	Statistical Analytical Software.
SD	Standard Deviation.
SPSS	Statistical Package for Social Science.
SS	Sum of Squares
TA	Transactional Leadership.
TF	Transformational Leadership.
UNRWA	United Nation Relief and Work Agency.
USA	United State of America.

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## **Chapter One**

### **Introduction**

This study examines the relationship between perceived leadership behavior, staff's job satisfaction and patient satisfaction in the hospital sector of the Palestinian health care system. The literature review reveals that there is no one theory that explains the relationship between leadership behavior, job satisfaction and patient satisfaction. A conceptual framework therefore has been developed and tested.

This study is important to managers in Palestine as well as to managers in other contexts. It will also contribute to organizational behavior and management science in general.

The following is an overview of the social structure, economy and cultural values of the Palestinians. This will help in understanding Palestinian society as the environment in which the study was conducted.

#### **1.1 Background to Palestinian society**

##### **Sociopolitical Background**

Since the Peace Agreement in 1993 between Palestine Liberation Organisation (PLO) and the Government of Israel, the Palestinian National Authority (PNA) is officially responsible in some areas in West Bank and Gaza Strip. The Palestinian system is clearly authoritarian and power centred (Said, 1995). Thus, democracy as a concept and practice is not incorporated into the framework of leaders and decision-makers. To a high extent, politics interfere in most professional issues, such as recruitment, promotion and rewards (Massoud, 1995). However, this situation could be seen as affecting not only the mode of working in the Palestinian institutions but also all life aspects of the population. The political instability, the uncertainty of the Palestinian situation and the way of making decisions adversely affect the Palestinian organisations including health care organisations (Massoud, 1995; World Bank, 1998). Most decisions



therefore are arbitrary, with a high degree of political orientation and a minimum level of involvement of professionals (Massoud, 1995). However, in some sectors like health, the development of its strategic plan included a participatory process involving all stakeholders (Ministry of Health, MoH, 1999).

Currently, the peace process failed to meet people's expectation at the social, political and economic level. Therefore, people developed a level of disappointment and frustration that have great influence on people both at the personal level as well as at the organizational and community levels. This situation influenced the people who have become sensitive, impulsive, insecure and who place high value on safety, security and interpersonal relationships. The social structure of the Palestinian society consists of three classes: upper, middle and lower class (Nakhleh, & Elia, 1980; & Nakhleh, 1990). Traditionally, powerful clans formed the majority of the upper class where, as a consequence, some of them have become political and social leaders. Others own businesses, large areas of land, or work as merchants or exporters. Academicians, physicians, small factory owners, traders and private craftsmen with mainly family businesses constitute the middle class. The lower class includes laborers mainly working in Israel, and farmers who form the majority of the Palestinian society (Nakhleh, & Elia, 1980).

The social structure of the Palestinian society includes the nuclear family, the extended family, and *Al-Hamula*. The smallest unit is the nuclear family, a two-generation household comprising the married couple and their children. The nuclear family is increasingly common today, mainly in cities. The second unit is the extended family which consists of three generations in one household, usually comprising the male family head, his wife, their unmarried children and their married sons with their own families. They often make a social and economic community. The third and the largest unit is *Al-Hamula* which is a "clan" of extended families related through a common ancestor and carrying the same family name ( Nakhleh, & Elia, 1980; Nakhleh, 1991; & Muslih 1993).

The family in the Palestinian society plays an essential role in the way one thinks, behaves and makes decisions. It is well recognized that the individual

does not operate in isolation but is dependent on the support and contributions of his or her family (Center for International Studies at the Institute for Applied Social Studies, FAFO, 1993). It is important to know that one's family comes second after God and the prophets. In Palestine, as in any other Arab country, the family plays a primary role in the formation of one's social identity.

Traditionally, *Al-Hamula* shared common land and mutual responsibilities. Although *Al-Hamula* nowadays has lost much of its traditional power, it still plays a major role in the Palestinian society (Muslih, 1993). *Al-Hamula* is considered as a whole unit and, if conflict arises among its members, it has to be tackled and solved internally. However, when one of *Al-Hamula* members is exposed to external threats, *Al-Hamula* will represent a power base for him/her in the society. This individual will use the power and the reputation of *Al-Hamula* to obtain what he/she needs or wants regardless of his or her capabilities. It is similar to the concept of a person who fights in the battle with another's sword.

Moreover, in most instances *Al-Hamula* has an influence on one's way of thinking, the decision making process, behavior and practice. It is imperative to clarify here that the Palestinian context is influenced by a tribal, Arabic and Islamic culture, which values the community interest for the individual interest (Hamad, 2001). This affects the mode of management of the Palestinian health institutions and services.

### **Economic Status in Palestine**

Political instability in Palestine is one of the factors that has influenced the economic situation. During the period from 1967 to 1993, Israeli forces have occupied the West Bank and the Gaza Strip. Palestinian reaction to Israeli occupation was exemplified by a strategy of rejection and non-cooperation (Association of Arab American University Graduates Studies, AAUG, 1989). Occupation enhanced the establishment of several political factions and organizations. These factions have had an influence on many areas of life besides their role in resisting occupation.

Throughout the Israeli occupation period, Israel was not concerned with



improving the economy of the West Bank and the Gaza strip. On the contrary, constraints have been imposed through several decisions and actions taken by the Israeli authority. Among these are the 1) annexation of Jerusalem, therefore changing the structural relationships in the economy of the West Bank and the Gaza strip, 2) adopting the so called open bridges policy to Jordan to ensure a market outlet for the Occupied Territories' agricultural products, therefore protecting similar Israeli products from competition, and 3) using a selective opening strategy of the borders between Israel and the West Bank and Gaza Strip to ensure a flow of goods and services beneficial to the Israeli economy (Nakhleh & Elia, 1980). Moreover, Israel's policy has involved control of water resources, expropriation of land, closure of banks that existed prior to occupation, and restrictions on quantities of crops which can be grown (Shaban, 1996).

The West Bank and Gaza Strip have faced a situation in which economic development had ceased with complete Palestinian dependence on Israel's economy. The West Bank and Gaza Strip became new markets for Israeli goods and services and a source of cheap labor for Israel's economy (FAFO, 1993). This situation has forced thousands of Palestinians to emigrate and to seek employment in the Arab World or the West.

During the Palestinian popular uprising (Intifada) in the period between 1987 and 1993, shopkeepers and traders in West Bank and the Gaza Strip suffered from having to close their shops. Many Palestinians found themselves without any form of income for many weeks. To overcome this situation, a wide range of popular small-scale projects were initiated, including industry, agriculture, crafts and services. The main aim of popular economy was to decrease dependency on Israel.

Since the Oslo Agreement (1994) donor countries have played a major role in providing a financial foundation for the reconstruction and development of the Palestinian economy. Unfortunately, the donor countries have not completely fulfilled their commitment to the Palestinian authority. Only 44.4 % of committed financial aid has been received in the period 1993 to 1997 (National Center for Economic Studies, NCES, 1997).

The closure that was imposed by Israel on the West Bank and Gaza Strip post-Oslo agreement had other major new effects on the Palestinian economy. The closure meant the loss of millions of dollars and thousands of jobs (Palestinian Academic Society for the Study of International Affairs, MAS, 1997). Also, the closure led to disruption of organizational operations because employees could not reach their work sites. In the long run, the aim of the closure has been to increase political, economic, and social pressure on Palestinians (Mass, 1997). This situation makes health care professionals as other Palestinians highly concerned about their safety and security.

The economic situation has continued to deteriorate. A sharp increase in unemployment, a decline in household income and general broadening of poverty pose serious challenges for economic sustainability (MAS, 1997). However positive developments have occurred since 1994, with the transfer of some areas of authority to the Palestinians and the setting up of a functioning civil service that has managed to collect taxes and deliver services in various fields such as health, education and public utilities (MAS, 1997). As a result of the removal of regulatory restrictions, the banking system has managed to grow rapidly and to attract a substantial amount of deposits within a few years (MAS, 1995; & MAS, 1997).

In general, there are several factors acting to depress the Palestinian economy among which are: (1) the under-developed physical infrastructure, (2) the uncertainty related to the continuing conflict with Israel over land and sovereignty, (3) inflation in public sector employment, (4) control by Israel of trade, security and foreign relations, and (5) territorial fragmentation which has led to the break up of an already small domestic market into even smaller units (MAS, 1997; MoH, 1999).

It is worth noting that it is difficult to trace the exact transformations of the economy because data about macroeconomics are not available for the period 1995-1999. The Palestinian Central Bureau of Statistics has been working on collecting data that will enable economists to reflect in a more informed manner on the economic status in Palestine.



According to the World Bank (1997), the per capita GNP in Palestine is 1710 US dollars and unemployment is estimated at 30% (World Bank, 1997). These financial constraints could badly affect health care professionals' satisfaction, both in terms of salaries and working conditions. Moreover, it might have an effect on employment which could be a contributing factor to increasing the workload of health care professionals'.

In 2000, prior to the Al-Aqsa intifada, numerous economic and development projects were established but economy was still dependant on support from outside. However, the Palestinian economy was drastically affected since Al-Aqsa *Intifada*. The current crisis has entirely offset the gains of the past years. Economic instability and political turbulence make management of health care institutions a challenging process that necessitates the commitment of both employees and leaders.

### **Palestinian culture**

Culture has a great influence on how people think, behave and manage their lives. Culture has a crucial effect on how managers run businesses and organizations. Management in Palestine, as in other aspects of life, is deeply influenced by Islamic and Arab cultural values and beliefs (Hammad, 1989). The Palestinian identity is largely affected by religion (about 96% of Palestinians are Muslims while the rest are Christians) and by nationality as Arabs. This is evident in daily behaviors, sense of belonging, life style, and most aspects of life such as marriage, divorce, family structure and conflict resolution.

Some of the cultural themes that are prominent in Palestine and which will be discussed in the following paragraphs include: honor, consultation, fatalism, firmness and mercy, team work, planning, and hospitality.

Honor is related to respect, dignity, good reputation, bravery, good conduct and chastity in woman. Because purity and loyalty of a woman to her family and husband outweighs the needs of the woman herself, most women are deterred from working outside the household. Women account for only 14.5% of the Palestinian labor force (PCBS, 1996b).

Consultation (*Al-Shura*) is a very important Islamic principle governing the management of public interest. In consultation, the manager consults with all powerful and important figures and then takes a decision and executes it. However, only 39% of Saudi Arabian managers surveyed by Ali & Swieercz (1986) reported using this style.

Fatalism is believing that whatever happens to a person is due to interference from a divine power (God). It is one of the main themes in the Arab society. God orders people to do their best and then to depend on him. Fatalism as a concept has been misunderstood by some Arab people as well as by some Palestinians. Fatalism to some means spontaneity, and impulsive behaviors. Misinterpreted, Fatalism can lead the individual or group to accept everything in life as part of God's will, that cannot be changed, planned for or controlled (Hammed, 1989). However, not all Palestinians are the same because one can see that amongst Palestinians there are those who appreciate advancement in technology and knowledge, and they devote themselves to education (Abu-Znaid, 1990).

Abu-Znaid (1990) found that West Bank managers have a high appreciation of time and that they stress communication and good relationships with employees. Yet the findings of his study indicate that West Bank managers are not in favor of planning and forecasting.

Firmness and mercy are other themes that are important in the Arab culture. Firmness is seen as very crucial in carrying out responsibilities and executing instructions (task orientation). On the other hand, mercy reflects being compassionate and understanding of others needs (people orientation) (Abu-Znaid, 1990).

In an Arab organization, where the management is traditional, one can observe a manager who has some or all of the following characteristics (1) dual loyalty, (2) authoritarian, (3) dominant (4) devalue women's work, (5) insecure and unconfident, and (6) defensive. These characteristics reflect the culture in which these managers grew up and matured. However, in the Arab Conference on Administrative Development in the Arab World in 1981, it was concluded that



an administrative manager should be qualified, courageous, show initiative, be committed and patient. Moreover, the administrative manager should be able to make decisions that might contradict his political affiliation.

With regards to team work, Islamic teachings urge believers to work and act in unity and cooperation, and to avoid disagreement. At the same time, believers are instructed not to interfere in matters that are not their concern (Abu-Znaid, 1990).

As for planning, Islam urges people to plan for everything they do and then put their trust in God. However, it seems difficult for Palestinian leaders to plan systematically and strategically. Israeli political control over Palestine has prevented systematic planning for the future (FAFO, 1993)

Hospitality and respect are other themes in the Palestinian society. Hospitality is related to honor and is reflected in unselfishness and increased prestige. It is clearly observable that Arab managers demonstrate their hospitality and respect by offering foods and drinks during meetings, and by shaking hands with their clients and customers (Abu-Znaid, 1990). Additionally, Palestinian managers seldomly terminate a conversation or dismisses a client no matter how busy they are. They use a lot of phrases and compliments especially with some one with high prestige or an expatriate (Abu- Znaid, 1999).

Hammad (1989) concluded that ineffectiveness and inefficiency in the management of the Palestinian health services are closely related to the political, economic, social, traditional and cultural aspects of the Palestinian society and, in particular, to the lack of good management practices. Cultural values in Palestine that could affect management practices are respect for people, politeness, generosity, affection, intimate relationship and kindness (Hammad, 1989). The Palestinian society has its own cultural values and beliefs that either positively or negatively influence management practices and behaviors.

## **1.2 Significance of the study**

The issue of quality improvement of health care in Palestine is one of the major concerns for both health care professionals and the public. Many

complaints and discontent by customers can be heard through the media and through social gatherings (Palestine Council of Health, PCH, 1994).

Palestinian professionals and the general public feel that a lot should be done to improve the quality of health care. Moreover, it is worth noting that patient satisfaction studies have received very little attention, if any, in governmental and non-governmental health care settings in Palestine. At the same time consumers have had little choice in their selection of providers {public, United Nations Work and Relief Agency (UNRWA), non-governmental organizations (NGOs), and private organizations} based on their needs and expectations (Massoud, 1995).

In the literature on effectiveness and quality health care, the focus is on patient outcomes captured by patients' perceptions of quality of care or indicators of compliance, morbidity, or mortality (Reed et. al, 1998). In the Palestinian situation it is important to understand the various factors that influence the quality of care as perceived by patients. For this study, leadership behavior, and socioeconomic, political, and cultural factors are explored. An analysis of the relationship between job satisfaction and patient satisfaction is in the context of their value. Understanding the factors that influence the quality of care may lead to improved quality of care, if integration, collaboration and accountability are emphasized.

In addition Palestinians invest a significant portion of their national income on health care services. Several reports about the health costs revealed that Palestinian national expenditures on health care appear to be very high in relation to the national product (The World Bank, 1993 & PCH, 1994). In 1996 the total health expenditure was approximately 9% of the gross domestic product as estimated by the World Bank. The total health expenditures from all sources (Ministry of Health, United Nations Relief and Work Agency, donors, non-governmental organizations and private expenditures) rose from 276 million dollars in 1995 to 278 million dollars in 1996 (MoH, 1999). It is expected that the Palestinian Ministry of Health's expenditures will rise from 100 million dollars in 1997 to 163.8 millions in 2002 (World Bank, 1997).



The Palestinian Ministry of Health will face more changes and challenges in the near future such as increased financial resource constraints, increased financial expenditures, and intense competition from neighboring countries, especially Jordanian and Israeli health care organizations ( Massoud, 1995). Consequently, to survive, it is crucial to enhance the Palestinian health care management and performance to a level at which it can compete with others and also contain costs. The health care services in Palestine need attention and the focus should be on improving the quality of services through changing the processes in the health care institutions.

This study is a baseline study designed to investigate several areas related to quality in two hospitals, one public and one private non-profit. Investigated areas are: socioeconomic, political, and cultural factors, perceived leadership behavior, staff's satisfaction and patient satisfaction.

The concepts of job satisfaction and patient satisfaction have been studied intensively and reported in the literature (Kangas et.al, 1999; Anderson, et.al 1998; McNeese-Smith, 1997; Morrison, et.al, 1997; Arnetz, 1997; Acron, et.al, 1997; Rickard, 1996; Medley & LaRochelle, 1995; Goodell & Coeling, 1994; Agho, et.al 1993; Weisman & Nathanson, 1985; Linn, et.al, 1985). However, relatively few studies have been conducted on job satisfaction in Palestine, the only two being Abu Ajamieh (1991), Hashish (1993) and Abu-Hammd (2001). To date studies have not tackled in detail the relationship between job satisfaction and leadership behavior and the relationship between job satisfaction and patient satisfaction. One can argue, how can patients receive proper care, unless employees are satisfied in their jobs?

### **1.3 Aims of the investigation**

The following were the aims of the study:

1. To explore the relationship between perceived leadership behavior and job satisfaction.
2. To describe the relationship between the personal characteristics of staff and job satisfaction.

3. To determine the relationship between environmental factors such as socioeconomic, political and cultural factors and job satisfaction.
4. To examine the relationship between staff's job satisfaction and patient satisfaction.
5. To determine the relationship between perceived leadership behavior, staff's job satisfaction and patient satisfaction.

#### **1.4 The formulated hypotheses:**

A hypothesis is "a declarative statement about the relationship between two or more variables that predicts an expected outcome" (Lobinodo-Wood & Haber, 1994, p. 189). Burns and Groves (1997) stated that "some correlational studies include a purpose and specific questions or hypothesis" (p.48). In order to achieve the aims of the study the following tentative hypotheses were formulated:

1. There is a relationship between health professionals' perceptions of leadership behavior of their leaders and their own job satisfaction.
2. There is a relationship between personal and demographic characteristics of health professionals and job satisfaction.
3. There is a relationship between environmental factors and health professionals' job satisfaction.
4. There is a relationship between health professionals' job satisfaction and patient satisfaction with care.
5. There is a relationship between the perceived leadership behavior, staff's job satisfaction and patient satisfaction.

#### **1.5 Feasibility and cost:**

Extensive discussion took place with hospitals' administration at the Ministry of Health, and with the managers of the hospitals involved in the study. The ethical approval committee at Al-Quds University was approached and the subject of the study was discussed intensively. All parties showed their interest and approval to facilitate and support the study.

**Summary:**

This chapter covered an introduction to the study and an overview of the background of Palestinian society. Social, economic and cultural issues that might influence leadership behavior were discussed. The aims of the study and formulated hypotheses have been included.

Review of relevant literature pertinent to the study will be presented in the following chapter. The review includes job and patient satisfaction models and studies and leadership behavior and management styles. Theoretical background and the conceptual framework will also be discussed.



## **Chapter Two**

### **Review of literature**

#### **Introduction**

The aims of this study were to examine the relationship between leadership behavior, job satisfaction and patient satisfaction in the hospital sector of the Palestinian health care system. This chapter includes a review of the relevant literature. A theoretical background and conceptual framework of the study are also included. The literature review includes theories and models that relate to the concepts under study: job satisfaction, patient satisfaction and leadership behavior.

The purpose of the literature review is to gain background knowledge about the topic under study. This background information about previous studies enabled the investigator to develop the conceptual framework and to specify the study aims, questions and hypothesis. A review of the literature helped in selecting and developing definitions of major variables and in choosing instruments for data collection (job satisfaction, patient satisfaction and management practice questionnaires).

Literature review continued throughout all stages of the study. It included a review of relevant theories and studies from journals and books as well as published and unpublished master's theses and doctoral dissertations. Internet and CD Roms were used to obtain abstracts and bibliographies related to the study topic. Sources were selected for inclusion in the literature review according to their quality, significance, and relationship to the aims of the study.

The most current articles and studies about job satisfaction and leadership behavior and patient satisfaction were included. Theoretical literature includes theories and models related to job satisfaction, motivation, patient satisfaction and leadership behavior and management styles.



## **2.1 Job satisfaction**

### **Theories and models of job satisfaction**

In order to explain and describe the nature of job satisfaction, several theoretical models have been identified from the literature. They have been classified as either content or process theories of motivation. Content theories are those that identify the factors that energize, direct, sustain or stop behaviors. The process theories are those which describe how behavior is directed, energized, sustained or stopped (Daft, 1994).

Content theories include Maslow's hierarchy of need (1970) and Herzberg's two-factor theory (1960s). Vroom's expectancy model of motivation (1967) is an example of a process approach, which offers some useful insight about job satisfaction. The causal model of Price and Mueller (1986) and the Revised Causal Model of Agho, Mueller, and Price (1993) are other models of job satisfaction that will be discussed later.

Maslow suggested that human beings are motivated to act so as to fulfill their needs and that people's needs are arranged in a hierarchy. In Maslow's view, only needs not yet satisfied influence behavior, and a satisfied need is no longer a motivator. Maslow suggested that if people attain lower-level needs they tend to keep them and then they move to attain higher-level needs.

From the lowest to highest order, the five categories of needs identified by Maslow begin with basic physiological needs, safety and security needs, social needs, ego needs and then self-actualization needs (Appendix A). Although Maslow's hierarchy of human needs was not conceived as a theory of satisfaction, it has been used in job satisfaction studies (Goodell & Coeling, 1994).

Fredrick Herzberg (1966) started with questions of what makes people satisfied or dissatisfied in their work. He investigated 200 engineers and accountants and found that job satisfaction consisted of two separate and independent dimensions. These dimensions are: (1) job satisfiers or motivators which include achievement, recognition, work itself, responsibility, advancement and growth, and (2) job dissatisfiers or hygiene factors which include

organizational policy, supervision, relationship with supervisors, working conditions, salary, relationship with peers, personal life, relationship with subordinates, status and security (Appendix B) (Daft, 1994).

Herzberg (1987) noted that hygienic factors (maintenance) are necessary to maintain a reasonable level of satisfaction and if these factors are absent or eliminated, job dissatisfaction will occur. However, if motivational factors (satisfiers) are present in work they tend to build high levels of motivation and job satisfaction (Daft, 1994). According to Herzberg, managers must enhance or control hygiene factors to minimize dissatisfaction, while achieving satisfaction depends equally on improving the motivating factors.

The two-factor theory suggests that motivators are typically intrinsic reward factors, while hygiene factors are extrinsic reward factors. This theory suggests that two well-identified series exist; one affects dissatisfaction and the other satisfaction. The opposite of satisfaction is no satisfaction, and the opposite of dissatisfaction is no dissatisfaction. The two-factor theory made a major contribution to understanding the dynamics of job satisfaction and provided a conceptual framework for job enrichment (Dessler, 1995).

Vroom (1964) argued that not only are people motivated to satisfy their needs, but they make choices about what they will and will not do to fulfill their needs. The choices are based on three conditions: (1) an individual must believe that effort to perform at a particular level will achieve the desired level of performance (first-order outcome), (2) the desired performance must lead to some expected outcome (second-order outcome), and (3) the outcomes should be valued by the individual. Job satisfaction is enhanced if work sites provide employees with a variety of rewards such as pay, promotional opportunities, consideration from supervisors, close interaction with co-workers, an opportunity to influence decisions which have effects on them and control over their own work (Matus & Frazer, 1996). So if an individual believes that better performance will be rewarded, the level of performance will be high. Conversely, if someone believes that improved performance will not be rewarded, performance will be low (Sullivan & Decker, 1992).



The Price-Mueller Model (1986) is a model with nine exogenous variables which are routinization, centralization, instrumental communication, integration, pay, distributive justice, promotional opportunity, role overload and professionalism. This model provides a comprehensive framework for analyzing and understanding employees job satisfaction (Agho, et.al, 1993). Three of the variables; routinization, centralization, and role overload will negatively affect job satisfaction. On the other hand, six variables will positively affect job satisfaction; instrumental communication, integration, pay, distributive justice, promotional opportunity and professionalism. This model has been criticized by Agho, et.al (1993). First, it leaves out various vital job characteristics that have been supported by previous research. Second, it disregards environmental determinants of job satisfaction. Third, it does not consider personal characteristics and their effect on job satisfaction. Fourth, it does not take into account interaction effects that the literature has identified as important (Agho, et.al, 1993). Agho, Mueller and Price (1993), who proposed a “Revised Causal Model” of jobs satisfaction, have addressed these four criticisms.

In this revised model nine variables were retained. However, the first modification was with four terms in the Price Mueller model: instrumental communication, promotional opportunity, centralization, and professionalism being changed to role ambiguity, internal labor market, and autonomy and work motivation. The second area of revision dealt with the inclusion of five variables that have been identified in the literature as having influence on job satisfaction. These variables are the work conditions, role conflict, supervisory support, task significance, and positive and negative affectivity.

The third revision involved the examination of interaction effects of job - related stress and social support on job satisfaction. It is suggested that job-related stress will not negatively affect job satisfaction as long as employees receive adequate support from supervisors, co-workers, or family members. Moreover, demographic variables have been excluded from the revised model. As a result of these modifications and revisions, the Revised Causal Model includes fifteen independent variables; opportunity, autonomy, role ambiguity,



role conflict, role overload, distributive justice, supervisory support, internal labor market, task significance, integration, pay, routinization, work motivation, positive affectivity, negative affectivity and one dependent variable, job satisfaction.

### **Job Satisfaction studies**

Job satisfaction is a complex phenomenon that has been studied in relation to causes and outcomes. Job satisfaction has been one of the mainly studied concepts in organizational research (Agho, et.al, 1993).

In reviewing the literature it appears that there is no consensus on the definition of job satisfaction. Locke (1983, cited in Cavanagh, 1992) defined job satisfaction as "a pleasurable or positive emotional status resulting from the appraisal of one's job or job experience" (p. 704). Bushy and Banik (1991) defined job satisfaction as "the gratification and self-fulfillment received in the work environment" (p. 35). McNeese-Smith (1997) defined job satisfaction as "the feelings an employee has about the job in general, it is a global construct, including such aspects as satisfaction with work, supervision, conditions, pay, opportunities, and practices in the organization" (p. 47). In these definitions (McNeese Smith, 1997; Bushy & Banik, 1991; Lock, 1983) explain satisfaction as an emotional state or feeling, others looked at work context and content to explain what job satisfaction stood for (McNeese-Smith, 1997; Agho, et.al. 1993).

Job satisfaction has been related to many factors such as leadership style, organizational commitment, stress, communication, autonomy, recognition, fairness, personal characteristics and many others (Acron, et.al, 1997; Arnetz, 1997, McNeese-Smith, 1997; Morrison, et.al, 1997; Rickard, 1996; Medley & LaRachelle, 1995; Adams, et.al, 1988; Brooke, et.al, 1988). Analysis of pervious studies showed that no simple factor stands out as a major explanatory variable (Belgen, 1993). Goodell and Coeling (1994) acknowledged that the quality and direction of the relationship between job satisfaction and other contributing factors remains unclear.

Belgen (1993) conducted a meta-analysis of 48 studies of nurses' job satisfaction. The purpose of this analysis was to determine the factors most important to job satisfaction and to examine the strength and consistency of relationships between job satisfaction and the variables associated with it in previous studies. Belgen found that job satisfaction positively correlated to a varying degree with organizational commitment (.526), communication with supervisors (.446), autonomy (.419), and communication with peers (.358), fairness (.295), recognition (.415), professionalism (.06), age (.133) and years of experience (.086). Belgen also found a negative correlation between job satisfaction and routinization (-. 412), personal locus of control (-. 283), stress (-. 609), and education (-. 070). The results indicated that job satisfaction for nurses is most strongly and positively associated with commitment, and stress (negatively). Autonomy, communication with peers, communication with supervisor, and recognition were moderately related to job satisfaction. Fairness in reward distribution and locus of control were related to job satisfaction though these correlations were low.

Belgen and Mueller (1987) used a longitudinal analysis technique in their study. A multivariate causal model of nurses' job satisfaction was tested. Analysis of thirteen causal determinants and five correlates at time 1, and job satisfaction measured at time 2 was conducted. The 13 theoretical determinants included: opportunity for alternative jobs, routinized work, autonomy in job-related decisions, job related communication, social integration in the unit, pay, fairness in distribution of pay and fringe benefits, opportunity for promotions, workload, motivation to produce high levels of job performance, level of general training, level of kinship, responsibility, and unit size. Five correlates of job satisfaction were added during analysis to check for model comprehensiveness. The correlates included age, years of services, full-time work, day of shift assignment, and rank in the hospital hierarchy. Data in this study were collected in two waves, eight months apart, from five short-term, acute care hospitals in the Rocky Mountain area. The sample included 370 females, with males excluded, as they constituted too small a group to analyze separately. Nurses were contacted



by mail at their home address and asked to complete the questionnaires and return them anonymously on both occasions. Data were analyzed by using the LISREL program to estimate the path coefficients (Joreskog & Sorbom, 1984). The results of the study showed that for the determinants, higher level of satisfaction related significantly to: lower opportunity for jobs outside the hospital (-0.196) lower routinization (-. 338), higher autonomy (.367), more job communication (.205), more social integration (.167), more fairness in distribution of pay (.317), more promotional opportunity (.359), higher pay (.127), workloads just right (.130), less general training (.098), and higher kinship responsibility (.130). Moreover, for the correlates, higher levels of satisfaction are associated with older age (.204), more tenure (.138), day shift assignment (.216), and higher position in the hospital hierarchy (.113). The results showed that correlation between job satisfaction and the variables in the study was low for both the positive and negative correlation.

Agho, Mueller & Price (1993) tested the revised Price-Mueller causal model. Job satisfaction was estimated with a sample of 405 (49% response rate) white-collar and blue-collar employees of a Veterans Administration Medical Center. Full-time and part-time employees were included in the sample. Two-wave longitudinal data were collected by means of two questionnaires distributed in September and December 1988. The first-wave questionnaire contained measures of the independent variables and initial satisfaction. The second-wave questionnaire contained measure of satisfaction and questions to identify respondents who had experienced changes in their work situation between September and December 1988. In the data analysis four different models representing refinements of the proposal model were estimated using LISREL maximum likelihood methods (Joreskog & Sorbom, 1984).

Agho et.al (1993) found that the degree to which employees like their job is influenced by a combination of characteristics of the environment (opportunity -.106 at  $P < .5$ ), the job itself (routinization .541 at  $P < .01$ ), distributive justice (.520 at  $p < 0.1$ ), personality variables (positive affectivity .442 at  $p < 0.1$ ), and work motivation (.354 at  $p < 0.05$ ). Although, the results of the study indicated almost



high positive correlation, the generalizability of the results is questionable because response rate is low.

Acron et.al (1997) conducted a study to test a theoretical model of job satisfaction. The variables included in the model were decentralization, professional autonomy, job satisfaction, and organizational commitment. Data were collected through a comprehensive survey of 200 first-line nurse managers in acute care hospitals with more than 100 beds, in British Columbia, Canada. Decentralization was measured with two scales of the index of centralization (Hage and Aiken, 1967). Autonomy was measured with the Autonomy sub scale of the Job Characteristics Inventory (Sims, Szilagyi & Keller, 1976). Organizational commitment was measured with a 15-items questionnaire (Mowday, Steers & Porter, 1979). Job satisfaction was measured by the 31-item McCloskey/Mueller satisfaction scale (Mueller & McCloskey, 1990). To test the model, it was hypothesized that (1) decentralization would directly influence autonomy, job satisfaction, and organizational commitment; and (2) autonomy would directly influence a job satisfaction, which in-turn, influences organizational commitment. Path analysis (Duncan, 1985) was used to determine the direct and indirect influence of decentralization and selected personal characteristics of the nurse managers on autonomy, job satisfaction, and organizational commitment. The findings of the study revealed that job satisfaction was an important predictor of organizational commitment ( $\alpha = 0.52$  at  $p < 0.001$ ). Decentralization, however was the most important because it affected organizational commitment directly ( $\alpha = 0.30$  at  $p < 0.001$ ), as well as indirectly, through professional autonomy ( $\alpha = 0.641$  at  $p < 0.001$ ) and job satisfaction ( $\alpha = 0.503$  at  $p < .001$ ). The findings of the study revealed that job satisfaction has a strong influence on organization commitment and autonomy of first-line nurse managers.

Yamashita (1995) investigated job satisfaction among nurses in Japan. Self-reported questionnaires were filled by 87.5% of nurses practicing in large acute-care hospitals. The questionnaire was based on the work of Stamp et., al (1978)



(Measurement of work satisfaction). Items, however, were analyzed and reworded and some were eliminated so as to fit the Japanese context. The internal consistency of the instrument was evaluated as adequate with Cronbach's alpha of 0.87, with sub-scale reliability coefficients ranging from 0.59 – 0.85 (Ozaki. & Tadamasa, 1988). Data were analyzed using SPSSPC computer programs based on 436 usable responses. The results of the study showed correlation scores for autonomy ( $r = 0.69$ ), administration ( $r = 0.62$ ), interaction ( $r = 0.65$ ), doctor-nurse relationship ( $r = 0.60$ ), commitment ( $r = 0.62$ ), opportunity for promotion ( $r = 0.50$ ), and security ( $r = 0.45$ ). Extrinsic factors such as having little opportunity for promotion or less favorable working condition appeared to negatively influence job satisfaction. The findings of the study supported the two-factor theory of Herzberg and also Maslow's hierarchy theory. Autonomy and doctor-nurse relationship had the highest correlational score while security and opportunity for promotion had the lowest score.

Cavanagh (1992) conducted a study to explore a model of the theoretical relationship between selected variables and job satisfaction using structural modeling techniques. The following variables were utilized in this study: salary, kinship, communication, social integration, justice, promotion, participation, education, opportunity and routine. A convenience sample of 221 female nurses working full-time in the greater Los Angeles area agreed to participate in the study. Data were collected using a questionnaire delivered with monthly salary cheques. The questionnaire that used was designed by Price and Mueller (1981) to assess respondent's characteristics on the selected variables. Completed questionnaires were returned via conveniently placed boxes at the subjects' place of work. A Pearson correlation, covariance matrix and path coefficients were used in data analysis (Bentler, 1990). The results suggested that staff participating in the study were found to be predominantly satisfied with their job.

The model had many statistically significant path coefficients including (in order of size) benefits ( $\alpha = 0.215$ ), participation in decision making ( $\alpha = 0.202$ ), education ( $\alpha = -0.153$ ), routine ( $\alpha = 0.153$ ), promotion ( $\alpha = 0.148$ ), and opportunity for advancement outside their institution ( $\alpha = -0.128$ ). The level of



salary was not found to be a statistically significant factor in determining job satisfaction ( $\alpha = 0.013$ ). Generalizability of the study findings is limited because of the characteristics and size of the sample.

McNeese-Smith (1997) used a semi-structured interview to ask nurses about their perceptions of the factors, including manager behavior that influenced their satisfaction, productivity, and commitment to the organization. Thirty nurses from a university-based Los Angeles hospital were invited to participate in the study. They were selected from participants in an earlier study that examined nurse manager characteristics and behaviors, and their effect on nurses' satisfaction, productivity and commitment to the organization (McNeese-Smith, 1995). The participants were recruited from the three units with the highest combined job satisfaction and organizational commitment scores and the three with the lowest, whose managers remained the same. Demographic data were analyzed using Statistical Analytical Software (SAS Institute, Cary, North Carolina). Interviews were transcribed and coded using Ethnograph v4.0 (Qualis Research Associate, Amherst, Massachusetts).

Nurses in this study attributed their feelings of satisfaction to the following manager's behaviors: providing recognition and thanks (43%), meeting their personal needs (27%), helping or guiding the nurse (23%), using leadership skills (23%), meeting unit needs (20%), and supporting the team (20%). Nurses described providing recognition and/or thanks (30%) and creating a positive climate (17%) as the major factors that improve productivity. Commitment was influenced mainly by the ability of managers in using leadership skills (47%). In the study, generalizability of the results are limited by the setting, in one University-based Los Angeles Hospital, and by the relatively small sample size.

Bushy and Banik (1991) focused on self-reported work satisfaction among rural nurses in eight South Dakota hospitals. The tool used in this study consisted of four parts: 1) selected demographic questions; 2) 15 paired questions relating to work satisfaction; 3) a list of Stamps and Piedmont's (1986) six-related factors that respondents ranked in the order of importance; and 4) 44 statements, rated on a Likert scale from one to seven, that indicated the respondent's feelings about



their work situation. In addition, an open-ended question was included which asked respondents to write one suggestion for improvement in the work place situation. The questionnaire was mailed to 100 RNs ( Registered nurses) working in nonprofit hospitals, having 50 or fewer beds. There was a 69% response rate. Data were analyzed with descriptive statistics, Chi square, and a stepwise linear regression. The open-ended question was analyzed using content analysis techniques. The main findings revealed that of the six work-related factors, the respondents rated them in importance as follows: 1) pay; 2) professional status; 3) interactions with physicians; 4) autonomy; 5) task requirements; and 6) organizational policies. The analysis also revealed decreased satisfaction associated with longevity, and with the on-call schedule. The themes that were generated from the content analysis centered around 1) the need for improving communication between nurses and administrators, physicians, and governing boards, 2) nurses should control nursing and have impact on improving patient care, and 3) there was a need to increase salary and compensation for nurses. The findings of this study cannot be generalized because the sample was small and consisted only of respondents from one geographic area in North-Central South Dakota. Moreover, the investigators did not include correlational values in the report (because it seems that phi coefficient or Cramer's V were not calculated). Phi coefficient and Cramer's V are used with chi-square to describe the relationships between variables and to determine the location of differences among cells (Bruns & Groves, 1997, p. 456).

There have been several studies conducted to examine the relationship between job satisfaction and leadership behavior in organizations, but the results of these studies are contradictory. Morrison, Jones and Fuller (1997) explored the relationship between leadership style and empowerment and its effect on job satisfaction. A self- reported questionnaire was completed by 275 (64%) of the nursing department staff of a regional medical center. The exact site where the study was conducted is not mentioned. Leadership style was measured using Bass Multifactor Leadership Questionnaire (Bass, 1995), empowerment was



measured with items from Spreitzer's Psychological Empowerment instrument (Spreitzer, 1995), and job satisfaction was measured by Warr, Cook, and Wall's job satisfaction questionnaire (Warr et.al 1979). The result of this study showed that transformational leadership had a powerful influence on job satisfaction both directly, with a correlation of 0.64 at  $p < 0.05$ , and indirectly through its influence on empowerment, with a correlation of 0.26 at  $p < 0.05$ . Although transactional leadership has no effect on empowerment (correlation 0.08), it does have a direct effect on job satisfaction with a correlation of 0.35. Empowerment was positively related to job satisfaction with a correlation coefficient of 0.41 at  $p < 0.05$ .

Nakata and Saylor (1994) studied the relationship between perceived management style and staff nurse satisfaction. A non-experimental, cross-sectional survey designed to collect data from hospital staff nurses was utilized. Perceived and desired management style was measured by the Profile of Organizational Characteristics (from SLM-1978 by Rensis Likert Associates, inc). Job satisfaction was measured by a job satisfaction tool developed by Munson-Heda (1974) based on Maslow's hierarchy of needs. A 398-bed, general, acute care, private, not for profit hospital in California was selected. Data were obtained from 102 nurses (43% response rate). The data were analyzed using means, standard deviations and Pearson product-moment correlation statistics. The results indicated a positive correlation ( $r = .48$  at  $p = .0001$ ) between perceived management style and staff nurse job satisfaction. The authors concluded that the closer the management style was to the participative group management style, the higher the level of staff nurses job satisfaction. Sources of job satisfaction, such as responsibility, autonomy, advancement potential and pleasant work environment can be related to management style. Sources of job dissatisfaction related to management style included poor planning, poor administration and inadequate explanation of decisions affecting the nursing unit. In this study, the response rate was low, thus the results can not be generalized to other health care settings. Also the correlation between sources of job satisfaction and management style is not mentioned in the report.

Moss and Rowles (1997) conducted a correlational study to investigate the



relationship between head nurse management style and staff job satisfaction. Two hundred and fifty staff nurses (40% response rate) in three acute care Midwestern hospitals in Indiana participated in the study. Likert's Profile of Leadership Behavior (Likert & Likert, 1976) and Price and Mueller's Job Satisfaction Sub Scale (Price & Mueller, 1981) were used to collect the data. The mean scores were computed for both leadership behavior and job satisfaction. The mean scores of 1 to 2.99 represented exploitive/authoritative management style, scores of 3 to 4.99 represented benevolent/authoritative management style, and scores of 5 to 6.99 represented consultative management style. The job satisfaction mean scores ranged from 1 to 5; a score of 1 indicated the greatest degree of job satisfaction and 5 indicated the least degree of job satisfaction. The findings indicated that job satisfaction clearly improves as the management style approaches the participative style. The mean score for job satisfaction was 1.97 with participative management style, and the mean score for job satisfaction was 2.62 with exploitive/authoritative management style. The response rate in the study was low which might have influenced the findings, so the study should be replicated to validate the findings.

Gresham and Brown (1997) examined the relationship between middle nurse managers' (MNM) job satisfaction and chief nurse executives' (CNE) leadership style and adaptability in North Carolina acute care hospitals with more than 100 beds. The response rate of CNEs was 50% (22 respondents). The response rate of MNMs was 62% (87 respondents). Data were collected by using Leadership Effectiveness and Adaptability Descriptive Instruments (LEAD) (Hersey & Blanchart, 1977), and Satisfaction with My Supervisor Scale (Scarpello & Vandenberg 1987). LEAD instrument was used to obtain data about a leader's perception of his/her leadership style and to gather data about perceptions from other people who work with the leader.

The findings showed that 44 middle nurse managers agreed with the chief nurse executive on the CNE's dominant leadership style and 43 disagreed. A t-test was used to examine the significance of differences between the two groups' satisfaction with the supervisor. Middle nurse managers who agreed with the



CNE's dominant leadership style recorded higher satisfaction (72.43) than those who disagreed (62.97). This difference was significant at the 99% confidence level ( $p < .01$ ). Thirty-three of MNMs agreed with CNEs' on the CNE's leadership adaptability and 54 disagreed. A t-test was performed for the significance of the difference between the two group's satisfaction with their supervisor. There was no significant difference between the two groups in the level of their satisfaction with their supervisor (score 68.93 and 67.03). The sample size in the study is small, so further research is needed to explain the relationship between satisfaction with supervision and leadership style.

Kangas et. al. (1999) explored relationships and differences among job satisfaction of registered nurses, patient satisfaction with nursing care, nursing care delivery models, organizational structure and organizational culture. Three hospitals with three different nursing care delivery models, including team nursing, case management, and primary nursing were selected. One hospital had a shared governance model and used the case management model of nursing care delivery. The other two hospitals had traditional organizational structures; one of the them practiced team nursing and the other used the case management model of nursing care delivery. Systematic random sampling was used to select the sample from all registered nurses who had been working in adult medical-surgical units, inpatient critical care areas, or critical care step-down units for a minimum of 6 months. Patients were selected from the same units on which the registered nurses worked. Sample size was 102 RNs and 102 patients. Nurses filled out demographic and background data forms, a job satisfaction form developed by Torres (1988), and the Organizational Culture Index by Wallach (1983). Patients filled out a demographic data form, and a Hinshow and Atwood (1981) patient satisfaction with nursing care questionnaire. By using analysis of variance to answer the research questions, it was found that: 1) no significant differences were found in the job satisfaction of nurses practicing with different nursing care models and by the two different organizational structures, and 2) no significant differences were found in patient satisfaction with nursing care in hospitals with different care delivery models and by the different organizational



structures. Since patients in this study were asked to indicate their satisfaction with nursing care only it might be difficult for them to isolate nursing care from the entire hospitalization experience and this might effect the results of the study. Patients were given the satisfaction questionnaire while still hospitalized, which may have affected their responses and the results of the study.

The relationship between job satisfaction and productivity is not well understood and is an issue of continuing debate and controversy (Mullins, 1996 p. 521). Surveys like the one by Gannon and Noon (1971) suggest that a large majority of personnel officers believe happier workers are more productive workers. However, the relationship between job satisfaction and job performance is weak and there is more evidence to suggest that job performance leads to job satisfaction than that job satisfaction leads to job performance. Performing well brings intrinsic rewards to employees, who will be pleased that they have successfully accomplished their jobs (Davis & Newstrom, 1985).

Weisman and Nathanson (1985) examined the relationship between the aggregate job satisfaction level of 344 nursing staff in 77 Maryland family planning clinics and two client outcomes; 1) the aggregate satisfaction level of teenage clients with contraceptive services obtained in the clinic, and 2) the subsequent rate of client compliance with contraceptive prescriptions. Weisman and Nathanson (1985) hypothesized that organizations with more highly satisfied professional staff are likely to produce higher levels of client satisfaction and better client compliance than organizations with less satisfied staff.

Data were obtained in a longitudinal study of the professional staff and clients of all 77 county health department family planning clinics located in 21 counties in Maryland. One county was excluded because of incomplete data. Three hundred and forty-four registered nurses were interviewed, representing a response rate of 86% of all nurses who worked in the family planning clinics during the study period. For clients, the following selection criteria were used: 1) unmarried women; 2) under the age of 20, and 3) who were making their first visit for contraception to one of the 77 clinics during a 10-months period in 1986-87. Base-line interviews were obtained from 2,900 clients at the time of the first



visit, both prior and immediately after interaction with clinic staff. Follow-up data on subsequent contraceptive use were obtained in 6 and 12 month telephone interviews with 76% of the subjects interviewed at baseline. The findings revealed that the mean clinic compliance rate was 79.8%, the average clinic-level satisfaction (client satisfaction) level was high (mean, 4.75) and the average clinic nurses' job satisfaction score was 4.05. Using zero-order Pearson Product-Moment correlation and regression coefficients, it was found that the job satisfaction level of nursing staff is the strongest determinant of the aggregate satisfaction level of clients ( $r = 0.32$  at  $p < 0.05$ ). Client satisfaction level, in-turn predicts the rate of clients' subsequent contraceptive compliance ( $r = 0.24$  at  $p < 0.05$ ). Staff satisfaction had a significant indirect effect on compliance through client satisfaction. Compliance, however, appeared to be more susceptible to variations in clinic structure than to variations in staff satisfaction levels. The results of the study showed that there is a positive correlation between job satisfaction and patient satisfaction and clients' compliance. The study did not test the relationship between job satisfaction and patient satisfaction at individual levels which is very important in detecting the effects of professional satisfaction (Weisman & Nathanson, 1985).

Goodell and Coeling (1994) conducted a pilot study at an urban Midwestern teaching hospital to explore the relationships among nurses' job satisfaction, quality of nursing care, and patient satisfaction with nursing care. The mean quality of nursing care scores were computed for each of nine inpatient units, using the quality monitoring scores of the institution for 10 quarters preceding the study. Using these data, the two highest quality units (group 1) and the two lowest quality units (group 2) were grouped for further study. The Index of Work Satisfaction (IWS) developed by Slavitt et al. (1978) was administered to 130 registered and licensed practical nurses who were randomly selected from the four units. Thirty-seven nurses from group 1 and thirty nurses from group 2 returned the completed questionnaire, representing a 52% response rate. The t-test revealed no significant difference in overall job satisfaction between the two groups ( $t = - 1.35$ ,  $p = 0.183$ ).



A patient Satisfaction Instrument, developed by Risser (1975), and refined by Hinshow and Atwood (1982) was used in that study. A stratified random sample of 33 registered nurses and licensed practical nurses was chosen from those nurses who had previously returned the completed IWS. The patient satisfaction instrument was administered to 4 to 8 patients who received nursing care from each of these nurses (N=168). The Pearson product-moment correlation was used, and no significant correlation was observed between the job satisfaction sub scale and the patient satisfaction instrument sub scale (r range from 0,0084 to -. 2948). The researchers concluded that the inability to demonstrate any significant relationships in the study might be due to the complexity of the concepts. In this study the sample was small and from the same hospital. A larger, more diverse sample from more than one hospital might show correlation among the concepts.

Anderson et. al (1998) conducted a descriptive correlational study to explore the relationship of nurse/patient ratio, provider job satisfaction and provider workload on patient satisfaction. A 250-bed army medical treatment facility located in a south-eastern metropolitan area (Kentucky) was used. General adult patient care units were included in the study. One hundred eighty-eight patients completed the Lamonica-Oberst Patient Satisfaction Scale (1986). The Work Environment Scale (1994) was chosen for measuring provider satisfaction. The workload was documented using the workload system developed by the Army Nurse Corps (1990). The findings of the study showed that there was: 1) a negative correlation between patient satisfaction and average daily bed occupancy rate ( $r = -0.66$ ), 2) a positive correlation between patient satisfaction and registered nurses available ( $r = 0.73$ ), 3) a positive correlation between patient satisfaction and number of nursing care hours ( $r = 0.86$ ), 4) no correlation between the staffs' perceptions of their work environment and patient satisfaction. Relationship dimension accounted for 0.7% of the variance, which leaves 93% of the variance unexplained. In this study the number of nurses who participated in this study and the method of sample selection is not reported.

McNeese-Smith (1995) concluded that managers who used leadership



behaviors in guiding their hospital units have employees who reported significantly higher level of productivity, job satisfaction, and organization commitment than manager who did not. Kouzes and Posner 1988 in McNeese-Smith (1995) identified leadership behaviors which are 1) challenging the process, 2) inspiring a shared vision, 3) enabling others to act, 4) modeling the way, and 5) encouraging the heart. These leadership behaviors were positively correlated with productivity, job satisfaction, and commitment. The leadership behaviors accounted for only 9-15% of the variance for productivity, 11-27% of the variance for job satisfaction, and 16-29% for organizational commitment.

Job satisfaction is of great importance to health professionals for several reasons: 1) for many health care workers job satisfaction is something to be valued in itself especially because of the stress they suffer while taking care of patients, and 2) there is potential impact of staff job satisfaction, especially nurses' job satisfaction, on patient care (Cavanagh, 1992).

Job dissatisfiers and satisfiers were investigated and discussed in the literature. Commonly cited dissatisfiers include unsafe practice; poor leadership, unresponsive administration and limited patient care (Wandelt, Preece and Widdowson, 1981, and Weismen 1982).

Stevens et. al (1992) studied the reaction of physicians to their work situation in 13 medical departments in Dutch University hospitals. One hundred and seventy one physicians were included in the study. In the first part of the study 40% of the sample interviewed about the structure and functioning of the departments. Then a questionnaire about professional attitudes, work preferences and job satisfaction was filled out by 121 physicians (71% response rate). Pearson product-moment correlation of all variables was used in the analysis. Multiple regression analysis was run between the hypothesized antecedents and dimensions of job satisfaction.

The study indicated that formal structuring of work activities is a positive predictor of work environment satisfaction ( $r = 0.24$  at  $p < 0.05$ ), whereas the size of the department is a negative predictor ( $r = -0.10$  at  $p < 0.05$ ). Professional attitude such as service orientation is as a strong predictor of satisfaction with

patient demand ( $r = 0.38$  at  $p < 0.05$ ). The study also indicated that certification (being a medical specialist) positively related to work load satisfaction ( $r = 0.36$  at  $p < .05$ ). This study only looked at physicians in university hospitals and this might affect the result of the study, so it is important to replicate the study in other settings.

Arnetz (1997) studied physicians' view of their work environment and organization. Four hundred and fifty eight physicians at a major regional academic hospital in Sweden were included in the study. The response rate was 78%. A self-administered structured questionnaire was distributed with pre-stamped envelopes. The questionnaire included 346 questions concerning physicians' work, organization and professional development. Data were analyzed by using means, standard deviation and linear regression. The results showed that even though physicians overall were very satisfied with their work, only 25% stated that the overall work load was well balanced, and only 1 in 3 observed that their influence on their work and working conditions was satisfactory, with 51% wanting more influence on their work. 60% of the respondents were aware of the overall mission statement for their hospitals and were more satisfied with and informed about department goals. Leadership qualities and organizational efficiency played a significant role in global work satisfaction.

## **2.2 Patient satisfaction**

### **Patient satisfaction models**

In reviewing the literature on patient satisfaction, it was found that most of the work has concentrated on the development of models explaining the results of patient satisfaction studies.

Most theories which have been proposed to explain patient satisfaction come from or are based on motivation theories which have been developed and mostly used in the workplace (Merkouris et.al, 1999). Bond and Thomas (1992), applied Herzberg's two-factor theory to explain patient satisfaction with nursing care. Herzberg (1987) suggested that there are two groups of factors which



influence worker's attitude towards their job. The first group of factors is called hygiene or dissatisfaction factors, which refers to external factors. The second group of factors is called motivation or satisfaction factors and refers to internal factors which if met, lead to satisfaction.

According to Herzberg (1987) the two groups of factors are completely different and unrelated. This means that to meet the dissatisfaction factors may not lead to satisfaction, but may just eliminate dissatisfaction. Similarly, not satisfying the motivation factors may not create dissatisfaction, but simply may not bring about job satisfaction.

Bond and Thomas (1992) explained that patients are satisfied when internal needs are met, such as the need for recognition, interpersonal relations and participation in decision making. Patients also become dissatisfied when the physical attractiveness of the setting and environmental factors are not as expected. Patients expect to stay in a quiet and pleasant place.

Linder-Pelz's (1982) value expectancy model is based on the attitude theory framework of Fishbein and Ajzen (1975). According to Linder-Pelz, patient satisfaction is a positive attitude toward an object or an event and is influenced by the information given to him/her. A patient's positive attitude is related to both his/her beliefs that the care possesses certain attributes and his/her evaluations of those attributes (Pascoe, 1983, & Williams, 1994). The attributes in this model are distinct dimensions of health care such as access, efficacy, cost, and convenience (Linder Pelz, 1982 a). Thus, satisfaction is based on two pieces of information: belief strength and evaluation of dimensions of care of those attributes.

Fitzpatrick (1984) identified three independent models of satisfaction. The first model is the need for the familiar. This model argues that socially formed expectations are the key determinant of the degree of satisfaction (Sitza & Wood, 1997). The second model is the goals of help seeking. It proposed that most patients expect some resolution to their health problems and not satisfaction. Thus patients evaluate a health professional or a treatment simply by whether it helps them achieve goals in relations to their health problems. (Sitz & Wood,

1997). The third model is the importance of emotional needs. This model stressed that most patients experience emotional changes when having medical problems. This is somewhat due to uncertainty and the anxiety that goes along with many medical problems. Patient's perception therefore is influenced by observing effective behavior and communication skills of health professionals (Sitz & Wood, 1997).

According to Ware, et. al (1983), patient satisfaction is a multidimensional construct. They proposed eight dimensions that correspond to the major characteristics of providers and services. These dimensions are interpersonal manner, technical quality of care, accessibility/convenience, finances, efficacy/outcomes, continuity of care, physical environment and availability of medical care resources. Ware et. al, reported that satisfaction rating is both a measure of care and a reflection of the respondents. They also argue that satisfaction ratings reflect three variables: the personal preferences of the patient, the patient's expectation, and the realities of care received.

### **Patient satisfaction studies**

Patient satisfaction and clinical outcomes along with cost effectiveness are among the indicators of health care quality or organizational performance and organizational progress. Jones (1994) defined quality as "meeting customers' needs and expectations" (p. 97), while Messner and Lewis (1996) defined patient satisfaction as "the degree of congruency between a patients expectations of ideal care and their perception of actual care received" (p.2).

Ford, et. al (1997) defined client satisfaction as "a judgment by the client on aspects of quality that the client is particularly capable of appreciating" (p.75). Donabedian (1980) stated that: "Client satisfaction is of fundamental importance as a measure of quality of care because it gives information on the provider's success at meeting those client values and expectations which are matters on which the client is the ultimate authority. The measurement of satisfaction is, therefore, an important tool for research, administration, and planning" (p.250).

Patient satisfaction has been adopted as one of the indicators of health care



quality by provider institutions. Auditing process includes not only monitoring and evaluating performance but it also incorporates patient views (Sitz & Wood, 1997). Patient satisfaction is integrated into hospital quality improvement programs (Joint Commission on Accreditation of Health Care Organizations, JCAH,1994).

Ware (1987) in Davis & Adams-Greenly (1994) stated that patient satisfaction is "a determinant of the choice of health care provider or system" (p.28). Patient satisfaction must be a major objective for any health organization.

Martin (1989) identified four basic needs of customers, 1) the need to feel important, 2) the need to feel welcomed, 3) the need to be understood, and 4) the need for comfort. Patients in general are more satisfied if health care providers treat them with respect, trust, sensitivity, and communicate with them effectively (Davis & Adams-Greenly, 1994).

Patient satisfaction studies are regarded as the most important tool for evaluation of health care institutions. Abed Alkareem, et.al (1996) used a self-administered survey of patients receiving care in two major government outpatient health care facilities, Hamed General hospital and Khalifa Town Health Center in the State of Qatar. The purpose of the study was to provide data to improve service delivery and quality of primary care provided in the state of Qatar. A proportionate stratified sample of 1,028 patients (563 citizen residents and 465 non-citizen residents) was drawn from patient logs for the period September 15 to October 31, 1991. Out of 1,028 patients, 444 responded (43%). The questionnaire utilized in their study was based on a standardized Likert-scale of patient satisfaction developed by Ware et.al (1983). The questionnaire contained the following components: general satisfaction, availability of services, convenience of services, facilities, humanness of doctors, quality of care, and continuing of care. The internal consistency of the total score and the major sub dimensions of satisfaction were examined using Cronbach's alpha. The coefficient alpha was 0.88 for the total scale. The findings indicated that respondents were more satisfied overall with the services provided through Hamad General Hospital (mean satisfaction score in 3.09) than through Khalifa



Town Health Center (mean satisfaction score is 2.78). The study pointed to a number of deficiencies in the availability and delivery of services in government health facilities in the State of Qatar. These deficiencies were inaccessibility and incompleteness in the patient record system, patients' scheduling arrangement, inadequate number of staff, and lack of communication and counseling skills. The response rate in this study was low and this might affect the findings. The findings signal the importance of doing patient satisfaction studies.

Andrzejewski & Laguna (1997) surveyed health care providers using a customer satisfaction questionnaire. The purpose of the survey was 1) to determine the quality of service provided by the staff of a regulatory agency; 2) to collect information on provider needs and expectations, and 3) to identify perceived and potential problems that need improvement. The questionnaire contained twenty declarative statements that fell into six quality domains: proficiency, judgment, responsiveness, accommodation, communication, and relevance. A five-point Likert scale procedure was used. Content validity of the instrument was established using a group of provider advisors and a research consultant. Reliability was assessed by computing Cronbach's alpha coefficient for internal consistency. A coefficient of 0.959 was obtained. The survey was mailed to 324 hospitals, nursing homes, home care agencies, hospices, ambulatory care centers, and health maintenance organizations. The results showed that fifty-six percent of provider agencies responded. The three highest levels of customer satisfaction were in courtesy of staff (90%), efficient use of waiting time (84%), and respect for provider employees (83%). The three lowest levels of satisfaction were in judgment domains. Only 44% felt that there was consistency among staff in the interpretations of regulations, 45% felt that interpretations of regulations were flexible and reasonable; and 49% felt that regulations were applied objectively. Of the 20 quality indicators surveyed, nine did not meet the acceptable performance standard. In this study respondents' characteristic, frequency of contacts and experience with the regulatory office staff might have influenced the results.

A limited number of studies have looked at staff satisfaction and patient



satisfaction in an in-depth and comprehensive way (Nathanson, 1985 and Linn, et.al 1985). Linn et.al (1985) compared patient satisfaction scores with job satisfaction scores of physicians providing their care in 16 general internal medicine teaching hospital group practices across the United States of America. They formulated the following research questions 1) to what extent if at all are the expressed satisfactions of patients and their providers congruent with each others, and 2) how do patient and physician satisfaction scores relate to selected organizational and environmental features of the health care settings.

Data on job satisfaction were obtained from faculty and house staff in April and May 1982 by means of a self-administered questionnaire. The faculty sample included all department of medicine faculty who provided patient care and/or supervised medical house staff in the internal medicine group practices at least one help day per week during the 1981-82 academic year. The house staff sample included all interns and residents who saw patients in the group practice one half day or more per week during the 1981-82 academic year. Completed questionnaires were returned by 94% of the faculty sample and by 88% of house staff sample. Data on patient satisfaction with their ambulatory medical care were obtained from a random sample of 100 patients who were scheduled for a visit in each of the 16 group practices.

Data were obtained either by mailed questionnaire or by a self-administered questionnaire for those who showed up for their visit. The overall response rate was 77%. Measuring work satisfaction was done by two questionnaires. The house staff scale was a satisfaction scale consisting of seven items measuring satisfaction. Some items were taken from Stamps and Piedmont, 1978 work satisfaction questionnaire and others developed by Linn et.al 1985. Cronbach's alpha reliability coefficient for the house staff satisfaction was 0.72. The faculty scale was a seven-item satisfaction scale that directly measured satisfaction with the organizational and administrative arrangements in the group practice. The alpha reliability coefficient for this scale was 0.76.

Measurement of patient satisfaction was done by a four-item general satisfaction scale. The alpha reliability coefficient for this scale was 0.72. The



questionnaire items were rated on a five-point continuum from strongly agree to strongly disagree.

Twenty one organizational characteristics of the group practices at teaching hospitals were measured: Age, continuity, house staff case presentation, faculty time, house staff time, faculty time supervising, faculty time doing research, faculty time in patient care, size, new patient volume, continuing patient volume, no-show rate, physician efficiency, ancillary staff efficiency, patient waiting time, patients seen by faculty, pleasantness and power to change. Data were analyzed using averages and frequency distributions for all variables. Pearson correlation coefficients were calculated between pairs of continuous variables. Findings showed that group practice sites with more satisfied patients were also more likely to have more satisfied house staff and faculty physicians. The Pearson correlation coefficient between faculty and patient satisfaction was 0.42 ( $p < 0.056$ ). The Pearson correlation coefficient between house staff and patient satisfaction was 0.61 ( $p < 0.007$ ). The Pearson correlation coefficient between faculty and house staff satisfaction was 0.49 ( $p < 0.02$ ). Higher satisfaction scores for both physician groups and patients were consistently associated with a greater percentage of patients experiencing continuity of care, lower patient no-show rates, more efficient use of ancillary staff in providing direct patient care, and more reasonable charges for a routine follow-up visit.

The results from this study cannot be considered conclusive or generalizable because the study was confined to 16 general internal medicine teaching hospital group practices, thus there is a need to replicate it in other practice environments and with more than 16 practice settings.

In conclusion, review of the research literature revealed that few studies looked at satisfaction of health care professionals (physicians & nurses) and its relationship to patient satisfaction and leadership behavior. Weisman and Nathanson (1985) found that the job satisfaction level of nursing staff is the strongest determinant of the aggregate satisfaction level of clients in a sample of 344 registered nurses employed in 77 Maryland family planning clinics. Goodell and Coeling (1994) concluded that there was no significant correlation between



work satisfaction and patient satisfaction in a randomly selected group of 130 registered and licensed practical nurses from four units at an urban Midwestern USA teaching hospital. Linn et.al (1985) compared patient satisfaction scores with job satisfaction scores of physicians in a sample of faculty and house staff in 16 general internal medicine teaching hospitals. Linn found that correlation between house staff and patient satisfaction was higher than correlation between faculty staff and patient satisfaction (table 3).

Morrison et. al (1997) found that transformational leadership had a powerful influence on job satisfaction, both directly and indirectly, through its influence on empowerment in a sample of nursing department staff in a regional medical center (Table 3). Medley and LaRoche (1995) found that a transformational leadership style positively effect nurses' job satisfaction levels in a sample of 122 staff nurses employed throughout acute care community hospitals in many patient care areas.

The nature and direction of the relationship between job satisfaction and patient satisfaction, and leadership behaviors remain unclear. Further study is required to clarify these relationships. There is also a need to understand the relationship between job satisfaction of health care providers (nurses and physicians) and patient satisfaction, and leadership behavior.

**Table (2.1) Major studies reviewed, parameters and findings**

No.	Study	Main Purpose	Measured Used	Procedure for sample allocation	Data analysis	Findings	Major Weaknesses
1.	Mc Neese-Smith (1997)	To identify what nurses perceive to be the factors contributing to job satisfaction, productivity, and commitment	Semi-structured interview	Thirty nurses were selected from participants in an earlier study. The participants were recruited from the three units with the highest combined job satisfaction and organizational commitment scores and the three with the lowest and whose managers remained the same (Mc Neese-Smith, 1995)	Demographic data analyzed using Statistical Analytical Software. Interviews were transcribed and coded using Ethnograph V4.0	Nurses attributed their feelings of satisfaction to the following manager's behavior: providing recognition and thanks, meeting their personal needs, helping or guiding the nurse, using leadership skills, meeting unit needs, and supporting the team. Nurses described providing recognition and/or thanks and creating a positive climate as the major factors that improve productivity. Commitment was influenced mainly by the ability of managers in using leadership skills.	Generalizability of the results is limited in one University-based Los Angeles hospital and by the relatively small sample size.
2.	Morrison et. al (1997)	To explore the relationship between leadership style and empowerment and its effect on job satisfaction	- Bass Multifactor (1995) Leadership Questionnaire (1995). - Spreitzer's Psychological Empowerment Instrument (1995). - Warr, et.al Job Satisfaction Questionnaire (1979)	Nursing department staff of a regional medical center.	Analysis of variance correlation	Transformational leadership had a powerful influence on job satisfaction both directly and indirectly through its influence on empowerment. Transactional leadership has no effect on empowerment but it does have a direct effect on job satisfaction. Empowerment was positively related to job satisfaction.	The site where the study was conducted is not mentioned in the study report.
3.	Moss & Rowles	To investigate	- Likert's profile	Two hundred fifty staff	Mean	The findings indicated that	Response rate is



	(1997)	relationship between nurse management style and staff job satisfaction	of Leadership Behavior (1976) - Price & Mueller's Job Satisfaction Sub Scale (1981)	nurses in three acute care hospitals in Indiana.		job satisfaction clearly improves as management style approaches the participative style.	low.
4.	Weisman & Nathanson (1985)	To examine the relationship between the aggregate job satisfaction level and two client outcome (1) the aggregate satisfaction level of teenage clients with contraceptive services obtained in the clinic, and (2) the subsequent rate of client compliance with contraceptive prescriptions	- Base line. interviews - Follow-up data were obtained in 6 and 12 month telephone interviews	-344 nursing staff in 77 Maryland family planning clinics. - 2,900 clients were interviewed to obtain baseline data. - 2,204 clients were interviewed twice 6 months apart to collect data on contraceptive use.	Zero - order Pearson Product Moment correlation and regression analysis	It was found that the job satisfaction level of nursing staff is the strongest determinant of the aggregate satisfaction level of clients; client satisfaction level, in turn predicts the rate of clients' subsequent contraceptive compliance. Staff satisfaction had a significant indirect effect on compliance through client satisfaction.	Correlation is relatively low.
5.	Gresham & Brown (1997)	To examine the relationship between middle nurse managers job satisfaction & chief nurse executives' leadership style and adaptability.	- Leadership Effectiveness and Adaptability Descriptive Instruments Hersy & Blanchard (1977). - Satisfaction with My Supervisor Scale (scarpello & vandenbergh, 1987).	- Middle nurse managers & chief nurse executives in North Carolina acute care hospitals with a census greater than 100	T-test was used to examine the significance of differences between the two group's satisfaction with supervisor. Those who agreed with CNE's dominant leadership style & those who	There was no significant difference between the two groups in the level of their satisfaction with supervisor.	The sample size is small.

6.	Goodell & Coeling (1994)	To explore the relationships among nurses' job satisfaction, quality nursing care, and patient satisfaction with nursing care	- The Index of Work Satisfaction (Slavitt, 1978) - Patient Satisfaction Instrument (Risser, 1975, & Hinshaw & Atwood, 1982).	- Randomly selected 130 registered & licensed practical nurses from four units. - The four units were selected using the quality monitoring scores of the institution for 10 quarters preceding the study. (The two highest qualities & the two lowest quality units selected).	disagreed. Pearson Product - Moment correlation	There was no significant correlation between the Index of Work Satisfaction sub scales and patient satisfaction Instrument sub scale.	Sample size is small and from the same hospital.
7.	Linn et. al (1985)	To compare patient satisfaction scores with job satisfaction scores of physicians. - To identify how patient & physician satisfaction scores relate to selected organizational & environment features of the health care settings.	Self-administered questionnaire	- Both faculty & house staff in 16 general internal medicine teaching hospital group practices across the United States of America. - Random sample of 100 patients who were scheduled for a visit in each of the 16 group practices.	Averages, frequencies & Pearson correlation coefficients	- Higher satisfaction scores for both physician groups and patient were consistently associated with greater percentage of patient experiencing continuity of care, lower patient no-show rates, more efficient use of ancillary staff in providing patient care, and more reasonable changes for a routine follow-up visit. - Pearson correlation coefficient between house staff and patient satisfaction was higher than correlation between faculty staff and patient satisfaction.	The study was confined to 16 general internal medicine teaching hospital group practices.
8.	Medley & LaRochelle (1995).	To investigate relationship between head nurse leadership style and staff nurse job	- Multifactor Leadership Questionnaire. - Index of Work Satisfaction.	122 randomly selected staff nurses employed throughout acute care community hospitals in many patient care areas.	Descriptive statistics, (mean & standard deviation) correlation	Correlation showed a significant positive relationship between those head nurses exhibiting a transformational leadership	Sample size is small and limited to acute care community hospitals.



9.	Kangas et. al (1999)	To explore relationships and differences among job satisfaction of registered nurses, patient satisfaction with nursing care, nursing care delivery models, organizational structure and organizational culture.	<p>-Job Satisfaction form developed by Torres (1988).</p> <p>-Organizational Culture Index by Wallach (1983).</p> <p>-Patient Satisfaction with Nursing Care by Hinshaw and Atwood (1981).</p>	102 RNs selected using systematic random sampling technique. RNs were selected from adult medical - surgical units, inpatient critical care areas, or critical care step-down units, who work for a minimum of 6 months. The sample was selected from three hospitals with three different nursing care delivery models. One hospital had a shared governance model while; the other two hospitals had traditional organizational structure.	Analysis of variance was used to answer the research questions.	style and the job satisfaction of their staff nurses.	<p>-No significant differences were found in the job satisfaction of nurses practicing with different nursing care models and by the two different organizational structures.</p> <p>-No significant differences were found in patient satisfaction with nursing care in hospitals with different care models and by the different organizational structure.</p>	<p>-Patients were given the satisfaction questionnaire while still hospitalized, which may have affected their responses and the results of the study.</p> <p>-Patients were also, asked to indicate their satisfaction with nursing care only and it might be difficult for them to isolate nursing care from the entire hospitalization experience.</p>
10.	Anderson et.al (1998)	To explore the relationship of nurse patient ratio, provider satisfaction, and provider workload on patient satisfaction.	<p>-Lamonica-Obrest patient satisfaction scale (1986).</p> <p>-The Work Environment scale (1994).</p> <p>- Workload system developed by Army Nurse Corps (1990).</p>	<p>- One hundred eight-eight patients from general adult patient care units.</p> <p>- Nurses from general adult patient units.</p>	Correlation coefficient and multiple regression were used to test the hypotheses.	<p>-A negative correlation between patient satisfaction and average daily census.</p> <p>-A positive correlation between patient satisfaction and registered nurses available.</p> <p>-A positive correlation between patient satisfaction and number of nursing care hours.</p> <p>-No correlation between staff's perceptions of there work environment and</p>	<p>- The number of nurses who participated in the study and the method of sample selection are not reported.</p>	

patient satisfaction.

It is worth mentioning that all of the studies in table 3 were found lacking in a satisfactory description and evaluation of the psychometric properties of the measurement tools. The results of power analysis were also, not reported or not determined.



### **2.3 Leadership behavior and management styles**

There have been several approaches used throughout the twentieth century to explain leadership behavior. The oldest approach was the trait theory (Marriner, 1996). The trait approach focused on identifying the personal characteristics that differentiate leaders from followers. Behavioral style theories began during World War II as an attempt to develop military leaders (Kinicki & Kreitner, 1992). Behavioral theorist tried to distinguish different kinds of leader behaviors that contributed to higher work group performance (Kinicki & Kreitner, 1992). Situational leadership theories grew out of this as a result of the inconsistency in research findings regarding trait and styles of leaders. Situational theories propose that a leader should be able to demonstrate different leadership styles depending on the situation (Kinicki & Kreitner, 1992). In the following paragraphs three models of leadership behavior will be presented. These theories are the Ohio State Studies, the Likert System of Management Style and Blake and Mouton's Management Grid.

The Ohio State Studies:

Ohio State University research personnel were pioneers in the 1950s and 1960s in studying leadership behavior. The Ohio State researchers concluded that there were only two independent dimensions of leader behavior: consideration structure and initiating structure (Daft, 1992). The consideration structure behaviors refer to friendship behavior, respect, warmth in the interactions and mutual trust between the leaders and members of the group (Yukl, 1989). The initiating structure dimension describes task-oriented behaviors and stresses what group members should be doing to maximize output (Daft, 1992). These two dimensions of leadership behavior intersect at right angles. Four leadership styles were derived from the Ohio State studies: low structure low consideration, low structure high consideration, high structure low consideration and high structure high consideration.

## The Likert system of management styles:

The Likert System of Management Styles consists of four management styles: exploitive-authoritative, benevolent-authoritative, consultative and participative group (Nakata & Saylor, 1994, p. 52).

- The exploitive-authoritative style is autocratic, uses fear and threats, punishment and occasional rewards as motivation. Decisions and goals are made at the top. Communication is downward and control is concentrated at the top.
- The benevolent-authoritative style allows some upward communication and economic rewards are used more than fear and punishment. This style permits staff members to share their ideas and opinions.
- The consultative management style allows staff members' participation in decision making especially those at the operational level. There is a greater use of staff members' ideas and opinions, and communication flows up and down. Motivational rewards are used more frequently in the consultative style.
- Participative group leadership style is a democratic, human relationship oriented style and focuses on building effective work group. The communication style is open and involvement in decision-making and goals setting are enforced (Nakata & Saylor, 1994; Terry & Franklin, 1982). This theory concentrated on the degree to which leaders allow followers to influence their decisions (Longest, 1996).

## Blake and Mouton's leadership Grid:

Blake and Mouton's Leadership Grid is a two dimensional leadership theory. On the vertical axis is concern for people. Concern for production is on the horizontal axis. Each axis on the grid is a 9-point scale, with 1 representing low concern and 9 high concern. Blake and Mouton pointed out that concern for production and concern for people involves attitudes and patterns of thinking, as well as specific behavior (Kinicki & Kreitner, 1992).



Five management styles are demonstrated as a result of the intersection of the two dimensions (Daft, 1992). These are team management, country club, authority-obedience, organization man management and impoverished management (Appendix C).

- Team management (9,9) is the most highly recommended style for managers because organization members work as a team to accomplish tasks. It is often considered the most effective style.
- The Country club style (1,9) occurs when the primary focus is given to people rather than the work outcomes.
- Authority-obedience management (9,1) occurs when efficiency in accomplishments of the tasks is the prevailing orientation. The concern for people is minimum.
- Organization man management (5,5) reflects a balance in the amount of concern for both production and people.
- Impoverished management (1,1) is a style in which the manager puts forth the minimum effort toward both interpersonal relationships and work achievements (Daft, 1992).

In the following paragraphs three contingency approaches will be presented. The contingency theories of leadership are Fielder's Contingency Model, Path-Goal Theory and Hersey and Balanchard's Situational leadership Theory.

Fiedler's Contingency model:

Fiedler's Contingency model proposes that leadership effectiveness is dependent on an appropriate match between the leadership style and the degree to which the leader controls the situation (Kreitner & Kinicki, 1992). Fiedler developed the least preferred co-worker (LPC) scale to identify leadership styles. The LPC scale measures whether a leader has a task-oriented style or a relationship-oriented style. According to this model, leadership styles are relatively stable in all situations because they reflect the individual's basic motivation (Du Brin, 1995).

Situational control refers to the amount of control and influence the leader has in the immediate work environment. The leader with high control and influence on work outcomes will produce predictable results. The leader with low control will not be able to influence work outcomes.

There are three dimensions of situational control (Appendix D). These are:

- Leader-member relationship: Is a measure of how well members of the group and the leader get by. Good leader-member relationship proposes that the leader can depend on the group to attain goals and objectives.
- Task structure: Is a measure of how exactly the procedures, guidelines, goals and evaluation of the job are defined.
- Position power: refers to the degree to which the leader has formal power and authority to hire, fire, discipline and grant rewards. (DuBrin, 1995,; Kreitner & Kinicki, 1992).

To link leadership style and situational control, Fiedler completes the model by plotting on the horizontal axis the eight control situations and on the vertical axis the level of leader effectiveness. In short, Fiedler argues that task-oriented leaders are more effective in intense situations of either high or low control, but relationship-oriented leader tend to be more efficient in middle-of-the-road situations of moderate control (Kreitner & Kinicki, 1992). Fiedler's contingency model is a complex one.

Hersey and Blanchard's Situational leadership theory:

Hersey and Blanchard's situational leadership theory grew out of the Ohio State model. This theory takes into accounts the task and relationship behavior of the leader and the behavior of follower. Task behavior is similar to initiating structure behavior and relationship behavior parallels consideration behavior in the Ohio State model (La Monica, 1994; DuBrin, 1995).

Task behavior focuses on the job and involves a top-bottom communication approach. The leader explains what the follower is to do and how, when and where to do it. In relationship behavior, the communication is two way. The leader listens, encourages, clarifies and facilitates interactions among followers



(La Monica, 1994; Du Brin, 1995; Daft, 1992). The four leadership styles described in Hersey and Blanchard's theory: 1) telling, used when there is high task and low relationship 2) selling, used when there is high task and high relationship 3) participating, used when there is high relationship and low task and 5) delegating, used when there is low task and low relationship. When using the leadership style of telling, the leader provides specific instructions and closely supervises performance. When selling is used, the leader explains decisions, invites the follower to ask questions and provides clarification. In the leadership style of participating, the leader and follower share ideas and decision-making responsibility. The leader assumes the role of a facilitator. Finally, with delegating, the leader turns over responsibility for decision making and implementation of the tasks to the follower.

The key point is that follower behavior determines which leadership style the leader uses. Followers' behavior depends on their ability and willingness to do the job (maturity). According to Hersey and Blanchard's theory, leaders should use telling style with people who are unable and unwilling to do the task. The most effective style for those unable but willing to do the task would be selling. Participating style is appropriate for those able but unwilling to do the job and delegating style is most suited for those both able and willing (Kreitner & Kinicki, 1992; La Monica, 1994). According to this theory a leader is most effective when using a wide range of styles.

Path-Goal theory:

The Path-Goal theory stresses that the leader's responsibility is to increase subordinates' motivation to attain personal and organizational goals (Daft, 1994). The role of the leader is to clarify the paths to the rewards that are available and to increase the subordinates value and desire to get the reward. Thus the leader should consider carefully the personal characteristics of the employees and the work environment.

The Path Goal theory suggests that leaders can exhibit more than one leadership style (Appendix E). The four leadership styles identified by this theory are:

- Directive leadership occurs when the leader provides guidance to employees about what should be done and how to do it. Leadership behavior includes planning, making schedules, setting performance standards and goals, and stressing adherence to rules and regulations.
- The Supportive style involves showing concern for the welfare and needs of subordinates, being friendly and open-minded and treating employees as equals.
- The Participative style means that the leader consults with employees and considers their ideas when making decisions. The leader encourages group involvement and contributions.
- Achievement-oriented leadership occurs when the leader encourages employees to perform at their utmost. The leader stresses high quality performance and shows trust in employees abilities to attain high goals. (Daft, 1994; Kreitner & Kinicki, 1992. Du Brin, 1995). Subordinates as a variable was introduced by the Path-Goal theory (Marriner, 1988).

From the above-mentioned models, leadership behaviors are autocratic versus democratic, task oriented versus relations-oriented and directive versus participative.

**Transformational and Transactional Leadership model:**

The Transformational Transactional model is used in this study because it appears to go beyond other models. Transformational leadership is argued in the literature to promote a culture of excellence. It is more appropriate for professionals and for work requiring high levels of decision making and relative independence (Mc Danial & Wolf, 1992)

Bass (1990b) describes leadership behaviors by differentiating between transactional leadership and transformational leadership. Transformational leadership consists of four components: idealized influence (charisma),



inspiration, individualized consideration and intellectual stimulation. In contrast, transactional leadership is comprised of the following dimensions: contingent reward, active management by exception and passive management by exception. "Transformational leaders elevate the desires of followers for achievement and self-development, while promoting the development of groups and organizations" (Bass & Avolio, 1992, p.22). The transactional leader identifies subordinates' needs and wishes and then clarifies how those needs and wishes will be met in exchange for the subordinates' fulfillment of their work role. Transactional leadership uses a carrot or a stick principle (Bass, 1997).

Bass (1997) identified the transformational and transactional components as follows (p.133-134).

- Idealized influence: leaders demonstrate genuineness, emphasize trust, take stands on difficult matters, present their most important values, and emphasize the importance of purpose, commitment, and the ethical consequences of decisions.
- Inspirational motivation: leaders articulate an interesting vision of the future, challenge followers with high standards, talk optimistically with passion, and provide encouragement and meaning of what needs to be done.
- Intellectual stimulation: leaders question old assumptions, traditions, and beliefs, arouse in others innovative perspectives and ways of doing things, and encourage the expression of new ideas.
- Individualized considerations: leaders deal with others as individuals, consider their personal needs, abilities and desires, listen attentively, promote their development, advise, teach and coach.
- Contingent reward: leaders engage in a constructive path-goal transaction of reward for performance. They elucidate expectations, arrange mutually satisfactory agreements, negotiate for resources, exchange assistance for effort, and provide recommendations for successful follower performance.

- Active management by exception: leaders monitor followers' performance and take corrective action if variations from standards occur. They impose rules to avoid mistakes.
- Passive management by exception: leaders fail to interfere until problems become serious. They wait to take action until mistakes are brought to their attention.

## **2.4 Theoretical background**

In reviewing the literature on organizational behavior, it has been found that there is no single theory that explains the relationship between leadership behavior, job satisfaction, and patient satisfaction. " It seems that there is no single, general comprehensive theory, which explains job satisfaction" (Grunberg, 1979, in Mullins, 1996; p. 522). Some motivational theories like Maslow's theory and Herzberg's two- factor theory describe the factors that lead to motivation (Mullins, 1996). Theories of motivation, however, do not capture the influence of leadership behavior on job satisfaction and patient satisfaction. Thus, this study will be based on the Revised Causal Model developed by Agho, Price, and Mueller (1993), and it will use the Patient Satisfaction Model developed by Ware, et.al (1983). The Revised Causal Model is a model with nine exogenous variables that provides a comprehensive framework for analyzing and understanding employees' satisfaction. The Patient Satisfaction Model developed by Ware, et.al (1983) includes eight dimensions that correspond to the major characteristics of providers and services.

The leadership behavior of the manager was emphasized in several studies in relation to job satisfaction (McNeese-Smith, 1997; Morrison, et.al, 1997; McNeese-Smith, 1995; Medley, & LaRochelle, 1995). Bass (1990b) describes leadership behaviors by differentiating between transactional and transformational leadership behaviors. Transformational leadership includes four components: idealized influence (charisma), inspiration, individualized consideration and intellectual stimulation. Bass (1990) defines charisma as "a process of providing a



vision and sense of mission and gaining of respect, confidence and trust from followers" (p.22). Inspiration is a process in which leaders engage in confidence building of their followers, thereby influencing their ability to perform tasks and assignments successfully. Inspirational leadership has to do with the capacity of a leader to act as a role model for subordinates (Bass, 1990). Individualized consideration entails providing subordinates with support, encouragement, and the opportunities to learn and develop. Finally, intellectual stimulation "is a process whereby the leader provides a flow of new ideas which challenge followers and help them to view the new perspective" (Bryman, 1993, p.99). Transformational leaders have prominent ability to bring about improvement, innovation and change (Daft, 1994).

In contrast transactional leadership is comprised of the following dimensions: contingent reward, and management-by-exception. Contingent reward is a process in which the leader makes a deal with a worker by providing rewards for an decided on performance (Morrison, et. al, 1997). Followers are given a clear understanding of what is expected of them in order to be rewarded. Management-by-exception is a leadership behavior in which the leader intervenes when there is indication of something not going according to the plan, rules or standards (Bryman, 1993). The transactional leader identifies subordinates' needs and wishes and then clarifies how those needs and wishes will be met in exchange for subordinates fulfillment of their work role. Transactional leadership is consistent with the Path-Goal theory (Yammarino et. al, 1993).

Transactional leadership can be effective in-groups under stress by providing satisfaction through an immediate solution. Transformational leadership, however can stimulate groups to look for longer term solutions by concentrating on individuals' higher order needs (Medley & LaRochelle, 1995). Bass (1990) proposed that transactional and transformational leadership are somewhat complementary and both can be demonstrated by the same leader. Thus, this study is based on Transformational and Transactional leadership, which was initially developed by Burns (1978) and further refined by Bass (1985).

## 2.5 Conceptual framework

The conceptual framework used in this study is presented in figure (2.1) Demographic and personality variables include: gender, education, marital status, age, work motivation, positive affectivity, professional background, and years of experience. These variables are among the variables explored in the literature with some of them having a positive relationship to job satisfaction while others have negative relationships (Cavanagh, 1992; Bushy & Banik, 1991; Price, Mueller, 1981).

Leadership behaviors consist of either transactional or transformational leader behaviors. Transformational leadership includes four components: idealized influence, inspiration, individualized consideration and intellectual stimulation. Transactional leadership is comprised of contingent reward and management-by-exception. Environmental variables include socioeconomic, political and cultural factors.

Six indicators that measure job satisfaction were selected from the Revised Causal Model of Job Satisfaction (Agho, et. al, 1993). These indicators are autonomy, distributive justice, internal labor market, task significance, integration, and pay. In addition, another two dimensions are added which are workload and patient demand, and working conditions and job security. Workload and patient demand are added because these were among the variables (dimensions) that were used to measure physicians job satisfaction (Stevens, et.al, 1992; & Arnetz, 1997). Working conditions and job security are added because these are among the variables that nurses were least satisfied with (Hasheesh, 1993 & Abu- Ajamieh, 1991).

Patient satisfaction is based on six dimensions from Ware et.al (1983) and Messner & Lewis (1996). Interpersonal manner, finance, physical environment, accessibility, continuity of care, and technical quality will be used to measure patient satisfaction with hospital care.



The following are brief definitions of each variable in the conceptual framework.

- Job satisfaction: The degree to which individuals like their jobs. (Price and Mueller 1986).
- Autonomy: The degree to which employees have freedom to act independently on the job (Griffin et al, 1980).
- Distributive justice: The degree to which rewards and punishment are related to performance input (Price and Mueller, 1986).
- Internal labor market: The extent of available opportunity for upward mobility for employees who show progress in skills and knowledge.
- Task significance: The degree to which an individual's job contributes to the overall organizational work process (Mottaz, 1987).
- Integration: The extent of cohesiveness among employees in their work unit.
- Pay: Money received by employees for their services.
- Job security: Feeling free from fear and anxiety concerning issues such as fringe benefits, compensation and health insurance.
- Working condition: Anything called for as a requirement before performance or completion of the job. (The American Heritage Dictionary, 1992)
- Workload: The amount of work assigned for completion within a given period of time. (The American Heritage Dictionary, 1992).
- Work motivation: Belief in the centrality of work in one's life (Kanungo, 1982).
- Positive affectivity: The degree to which an individual is predisposed to be happy (Agho et al 1993).
- Cultural factors: Learned, shared, and transmitted values, beliefs, norms, and life practices of a particular group that guide thinking, decisions and actions in patterned ways (Leininger, 1985).
- Political factors: Those factors concerned with government of a nation or state (law and order).
- Economic factors: Issues related to the material needs of people (household,

leisure time)

- **Social factors:** Having to do with human beings living together as a group in a situation requiring dealings with one another.
- **Management:** The attainment of organizational goals in an effective and efficient manner through planning, organizing, leading, and controlling organizational resources (Daft, 1994).
- **Communication:** A process of seeking and receiving information and sharing it with others (Mintzberg, 1994).
- **Team building:** Encouraging, enabling and inspiring people to work together so as to achieve certain goals.
- **Motivation:** Making it possible for people to recognize and develop their potentials so as to achieve organizational and personal goals.
- **Decision-making:** The process of selecting one course of action from alternatives.
- **Patient satisfaction:** The degree of fulfillment of basic needs as perceived by patients (Ware, et.al, 1983).
- **Interpersonal manner:** Features of the way in which providers interact personally with patients (e.g., concern, friendliness, courtesy, respect).
- **Technical quality of care:** The competence of providers and adherence to high standards of diagnosis, treatment and care (e.g., thoroughness, accuracy, and unnecessary risks).
- **Accessibility:** The ability to gain access to health professionals' services and hospital facilities. (e.g. easiness to approach health professionals, and use hospital facilities).
- **Finances:** Factors involved in paying for medical services. (e.g., reasonable costs insurance coverage).
- **Continuity of care:** Constancy in provider and follow-up of clients. (e.g., see the same health provider, being referred to continue care).
- **Physical environment:** Features of the setting in which care is delivered. (e.g.,



orderly facilities and equipment, pleasantness of atmosphere, clarity of signs and directions.

- Transactional leadership : An exchange in which the leader rewards a subordinate for compliance with his or her expectations (Bryman, 1993, p. 98)
- Transformational leadership: An enhancement of followers' confidence and hence their expectations that they can attain greater performance (Bryman, 1993, p. 98).

### **Summary**

This chapter covered review of literature, theoretical background, and conceptual framework of the study. The literature review included job satisfaction models and studies, and patient satisfaction models and studies.

The main themes drawn out from the literature review are: 1) There is ample research findings showing that autonomy and the feeling of integration with immediate colleagues, other departments and one's own professional group are significantly associated with job satisfaction. Several studies documented the importance of autonomy as determinant of job satisfaction. 2) A plethora of research indicate that there is a significant and positive relationship between transformational leadership behavior and job satisfaction of health care professionals. 3) Patient satisfaction is a multidimensional concept, but the factors which affect patient satisfaction are not very clear and further research is required. However, some specific factors appear important such as interpersonal relationship, continuity of care, accessibility, physical environment, respect and communication.

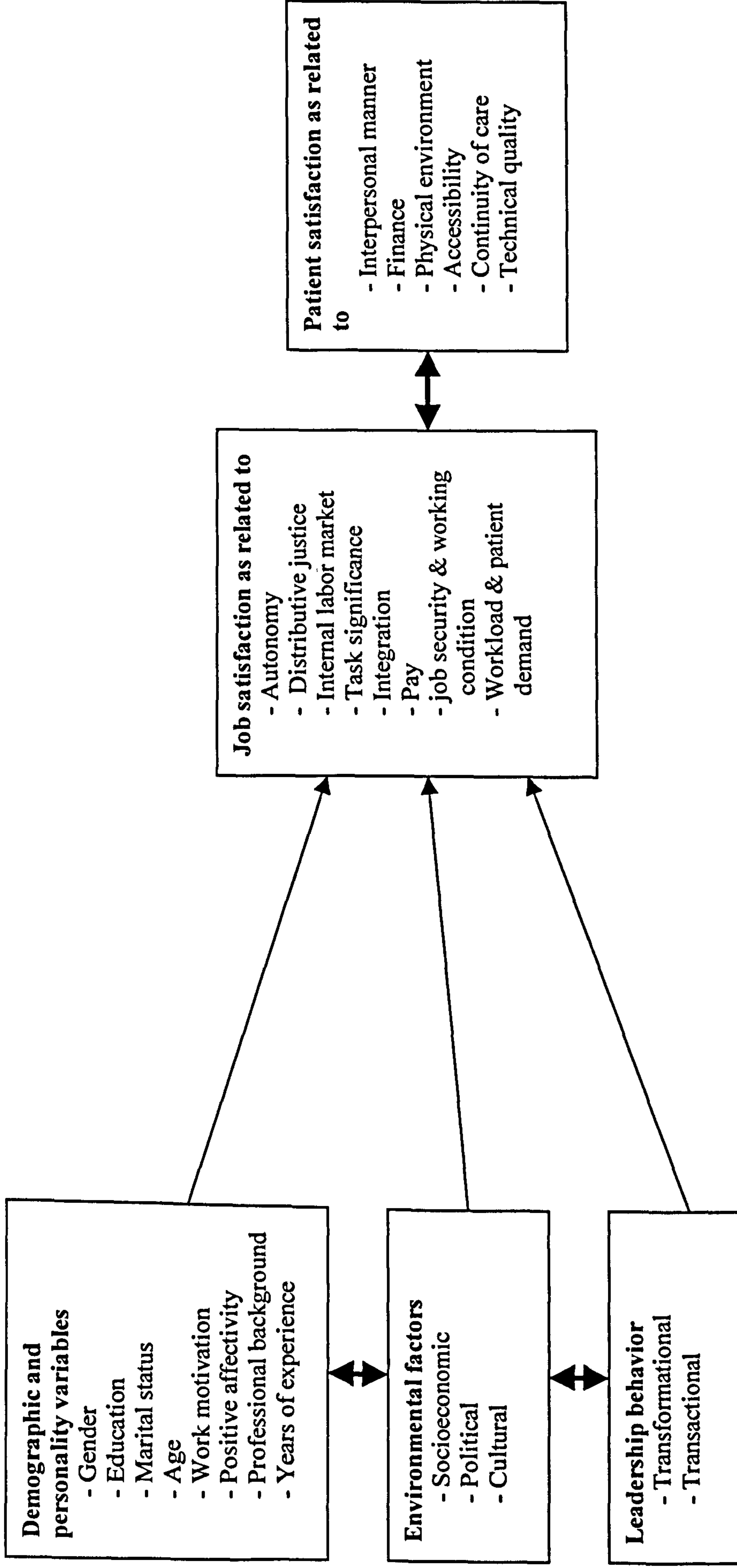


Figure 2.1: General model linking leadership behavior, environmental factors and personality variables with job satisfaction and patient satisfaction. Based on Revised causal model of job satisfaction by Agho, et.al (1993) patient satisfaction model by Ware, et.al (1983) and Messner & Lewis (1996) and leadership behavior by Bass & Avolio (1995).



## **Chapter Three**

### **Methodology**

#### **Introduction**

This chapter includes ten sections. The first section is an overview of the common methods used in nursing research. The second covers justification for using a quantitative correlational study design in this study. The third includes background information about setting of the study. The fourth identifies the study sample. The fifth presents the instruments used. The sixth deals with gaining access to the study's setting and ethical consideration. The seventh explains the process of data collection. The eighth gives an explanation about the data analysis process. The ninth provides detailed information about the pilot study. The final section presents the time frame for the study.

#### **3.1 Nursing research methods**

The nursing profession is constantly aiming at the continual development of a scientific body of knowledge. Nursing research is defined as "a scientific process that validates and refines existing knowledge and generates new knowledge that directly and indirectly influences nursing practice" (Bruns, & Grove, 1993, p.4). There are different methods of research used by nursing profession; among them are:

##### **1) Qualitative research**

Qualitative research involves the systematic collection and analysis of more subjective narrative materials; using procedures in which there is minimum imposed control (Polit & Hungler, 1995). Research that uses a qualitative approach 1) attempts to understand phenomenon rather than concentrating on specific concepts, 2) concentrates on the importance of people's interpretation of events, 3) collects information without formal, structure instruments 4) attempts to study the situation as it is and in totality 5) capitalizes on subjective information and 6) analyzes narrative information in an organized but intuitive

form (Polit & Hungler, 1995). The main approaches to qualitative research are: phenomenological, grounded theory, and ethnographic (Burns & Grove, 1997).

- Phenomenological research

The purpose of phenomenological research is to describe experiences as they are lived. The researcher uses observation, interactive interviews, videotape, and written descriptions by subjects as the means of collecting data. The outcome of analysis is a theoretical statement responding to the research question (Burns & Grove, 1997).

- Grounded theory research

Grounded theory research is an inductive research technique. This means that the research has its roots in the data from which it was derived (Burns & Grove, 1997). The steps of grounded theory are observing, collecting data, organizing data, and forming theory from the data at the same time. Interviews, observations, records, or a combination of those may be used to collect data. The result is a theory explaining the phenomenon under study.

- Ethnographic research

The purpose of ethnographic research is to examine issues related to culture that are of interest to the researcher. This may involve studying behaviors from within the culture or studying behaviors from outside the culture and examining similarities and differences across cultures (Burns & Grove, 1997). Data collection mainly involves observation and interview. The researcher may become part of the culture that is under observation. After data collection and before finalizing the data, the researcher has to validate the data with members of the culture (Burns & Grove, 1997).

## 2) Historical research

Historical research examines events of the past. Its process involves formulating an idea, developing research questions, developing an inventory of sources, clarifying validity and reliability of data, developing a research outline, and conducting data collection and analysis (Burns & Grove, 1997).



### 3) Quantitative research

Quantitative research involves the systematic collection of numerical information, where often there is considerable control, with analysis of information using statistical procedures. Research that uses a quantitative approach generally: 1) concentrates on a relatively small number of specific concepts 2) begins with preconceived idea or intuitions about how the concepts are interrelated 3) uses carefully planned for procedures and formal instruments to collect information 4) initiates control while collecting information 5) focuses on objectivity in the collection and analysis of information, and 6) analyses numerical information through statistical procedures (Polit & Hungler, 1993).

### 4) Triangulation

Triangulation is the use of two or more research methods in a single study (Mitchell & Jolley, 1992). It is frequently used in the examination of complex concepts. There are two different types of methodological triangulation (Burns & Grove, 1997): 1) within-method triangulation and 2) across-method triangulation. Within-method triangulation is used when the phenomenon being studied is multidimensional. Two or three quantitative instruments might be used to measure the same phenomenon. A cross-method triangulation involves combining research strategies from two or more research approaches in the same study. Methods from qualitative and quantitative research might be used in the same study. The literature identified four principles to apply with methodological triangulation: 1) the research question must be well focused, 2) the strengths and weakness of each selected methods need to balance each other, 3) the methods used need to be chosen according to their significance to the phenomenon being studied, and 4) the methodological approach needs to be monitored throughout the study (Mitchell & Jolley, 1992).

### 5) Experimental design

Experimental design plays an active role by introducing the intervention. "Experiments have the potential to provide the most evidence for the strength of

association between variables" (Talbot, 1995, p.218). Experiments are essential for testing hypotheses and establishing causality. A true experiment is characterized by manipulation, control, and randomization (Talbot, 1995). The required control and manipulation however, makes experimental design an inappropriate choice for many research problems especially in organizational behavior research. The experimental design includes pre-test post-test control group, post-test only control group, and Solomon four-group (Polit & Hungler, 1993).

#### 6) Quasi-experimental design

Quasi-experimental design is similar to experimental research because there is manipulation of an independent variable. It differs from experimental research in that either there is no control group or there is no use of randomization to assign subjects to groups (Talbot, 1995).

#### 7) Non-experimental design

Non-experimental design observes phenomena as they naturally occur without intervening in any way. There are two broad classes of non-experimental research: correlational and descriptive (Polit & Hungler, 1993). Correlational research is conducted after the variations in the independent variable have occurred in the natural situation. It examines relationships between variables and can be used for describing a relationship, predicting relationships among variables, or testing the relationships proposed by the theoretical framework. A representative sample of the study population is essential. In correlational designs, a large variance in the variable score is necessary to determine the existence of a relationship. There are three approaches to correlation research: descriptive correlational, predictive, and model testing (Burns & Grove, 1997).

The aim of a descriptive correlational design is to examine the relationships that exist in a situation. These studies are also used to develop hypotheses. In the descriptive correlational design variables in a situation that has already occurred or a currently occurring situation may be examined. There is however no control or manipulation of the situation (Burns & Grove, 1997).



The predictive designs are developed to predict the value of one variable based on values obtained from other variables. The aim of a predictive design is to predict the level of the dependent variable from the independent (Burns & Grove, 1997). The aim of the model testing design is to test the accuracy of a hypothesized causal model. This design requires that all variables relevant to the model be measured.

Descriptive research aims at observing, describing, and documenting aspects of the situation as they naturally occur. Sometimes this approach is used as a starting point for hypothesis generation or theory development. Examination of types and degrees of relationship is not the primary purpose of a descriptive study. It is used for justifying current practice, and determining what others in similar situations are doing. In descriptive research, there is no manipulation of variables involved. "Protection against bias is achieved by 1) linkage between conceptual and operational definitions of variables, 2) sample selection and size, 3) valid and reliable instruments, and 4) data collection procedures that achieve some environmental control" (Burns & Grove, 1997, p.251).

#### 8) Case study design

The case study design entails a thorough exploration of a single unit of study such as individual, group, institution, or other social unit. It is important in the case study design to examine all variables that might have an impact on the situation being studied (Burns & Grove, 1993). Case studies tend to be holistic rather than deal with isolated factors (Denscombe, 1998). The case study design allows for collecting information from a variety of sources. A well-designed case study can be used as evidence for or against theories. A case study may incorporate quantitative and qualitative elements.

### 3.2 Study design

The main aim of this study is to explore the relationship between leadership behavior, job satisfaction and patient satisfaction in two hospitals, one public and one private non-profit hospital in the West Bank.

The following tentative hypotheses were tested:

1. There is a relationship between health professionals' perceptions of leadership behavior of their leaders and their own job satisfaction.
2. There is a relationship between personal and demographic characteristics of health professionals and job satisfaction.
3. There is a relationship between environmental factors and health professionals job satisfaction.
4. There is a relationship between health professionals' job satisfaction and patient satisfaction with care.
5. There is a relationship between the perceived leadership behavior, job satisfaction and patient satisfaction.

"A hypothesis is a declarative statement about the relationship between two or more variables that predicts an expected outcome" (Lobinodo-Wood & Haber, 1994, p. 189). The literature acknowledged that "some correlational studies include a purpose and specific questions or hypothesis" (Burns & Groves, 1997, p.48).

Since the research method should be congruent with, or be able to effectively test the hypothesis, a quantitative design is demanded. Consequently, a quantitative correlation study design was used. This design was used to test the accuracy of the hypothesized conceptual causal model. The design requires that all variables relevant to the model be measured (Burn & Grove, 1997). There was no manipulation, randomization, or control over variables. The advantage of using a correlation design is "an increased flexibility when investigating complex relationship among variables"( LoBiondo, Wood & Haber 1994, p.236). The study was conducted in two hospitals in the West Bank from a total of 16 general non-governmental and governmental hospitals. Exploration of what is going on in the two hospitals is crucial because there has been no study conducted in Palestinian hospitals that examines patients satisfaction, staff satisfaction and leadership behavior. The situation in these two hospitals is studied as it is. There was no control over events unlike the experimental approach where there is



imposed control over variable(s). Two hospitals were selected for this study, Al-Makassed, and Ramallah. Al-Makassed hospital typically represents non-governmental hospitals, while Ramallah hospital is typical of what exists in public hospitals (under the Palestinian authority). Table 3.1 and 3.2 described non-governmental and governmental general hospitals in the West Bank and East Jerusalem.

**Table 3.1 Description of non-governmental general hospitals in the West Bank and East Jerusalem, 1999**

<b>Name/owner</b>	<b># of beds</b>	<b># of staff</b>	<b>Occupancy rate</b>
Al-Makassed	229	700	67%
Augusta Victoria	102	159	47%
St. Joseph's Hospital	73	95	70%
Qalqilia Hospital	38	64	107.5%
Al-Itihad	74	198	78.1%
St. Lukes	48	97	48.7%
Al Ahli Arab Hospital	82	142	69.3%
Arab Care	31	176	NA

Source: MoH, National strategic health plan, 1999 (p. 185 & 191).

**Table 3.2 Description of governmental general hospitals in West Bank 1999**

<b>Name/owner</b>	<b># of beds</b>	<b># of staff</b>	<b>Occupancy rate</b>
Jenin Hospital	86	107	88.2%
Tulkarem Hospital	67	101	80.3%
Rafydia Hospital	144	213	71.7%
Al-Watani Hospital	94	145	70%
Ramallah Hospital	128	320	83.2%
Jericho Hospital	44	46.5	54.4%
Beit Jala Hospital	70	149	84.5%
Hebron Hospital	147	270	85.9%

Source: MoH, National strategic health plan, 1999 (p.184).

### **3.3 Background information about settings of the study**

Palestine has an estimated population of 2,895,683 (Palestinian Central Bureau of statistic, PCBS, 1998). Approximately 1,022,207 reside in the Gaza strip and 1,873,476 in the West Bank including East Jerusalem.

The health services in the area are run by the Palestinian Authority (PA), the UNRWA, NGOs, and the private-for-profit providers. The bulk of the secondary level of health care is provided by the Palestinian Ministry of Health and non-governmental organizations, about 58 percent and 36 percent of all hospital beds respectively. There are eight general hospitals run by the PA. and eight general hospitals run by NGOs. (MoH, 1999).

For the purpose of this study Al-Makassed Hospital and Ramallah Hospital were selected as sites where the study was conducted. Al-Makassed hospital is a non-profit, general hospital, located in Jerusalem city. The hospital serves the West Bank and Gaza population. This situation has changed since the peace treaty of 1994, because Gazans and West Bankers have been denied entrance to



East Jerusalem without entry permits. However, Al- Makassed hospital still serves 254,387 patients who are referred by the Palestinian Authority from the different West Bank localities in addition to Jerusalem residents. The hospital has 700 employees, of whom 304 are nurses, 101 are physicians, 66 are technicians and 229 are employees working in administration and support services (table 3.3). The total number of beds is 221, running at an occupancy rate of 70-75% in 1998 (table 3.4).

**Table 3.3 Human resources in Al-Makassed, and Ramallah hospitals**

Types of employees	No. of employees / Makassed	No. of employees / Ramallah
• Administration and support services	229	86
• Nurses	304	137
• Specialists	38	34
• Residents	63	27
• Technicians	66	36
• Total	700	320

Source: Personal contact with hospital management, February 1999.

Ramallah hospital is located in Ramallah City in the Center of the West Bank. Ramallah has a population of 234,390 living in an area of approximately 770 sq.km. The total number of employees in Ramallah hospital is 320; out of which 137 are nurses, 60 physicians, 29 technicians, and 80 employees working in administration and support services (table 3.3). The hospital has a total number of 142 beds running at an occupancy rate of 86% in 1998 (Table 3.4).

**Table 3.4 Number of beds per department at Al-Makassed & Ramallah hospitals**

Department	No. of beds / Al-Makassed	No. of beds/ Ramallah
• General surgery and urology	41	33
• Orthopedic	28	-
• Open-heart surgery	8	-
• Adult ICU	5	6
• Internal medicine	24	25
• CCU & cardiac cath.	14	-
• Pediatric & peds. I.C.U	34	31
• Neonate	30	12
• Gynecology and obstetric	45	21
<b>Total</b>	<b>229</b>	<b>128</b>

Source: Personal contact with hospital management, February 1999.

### 3.4 Sample

Purposive sampling of hospitals was used since the investigator had background knowledge about the hospitals in the West Bank. Polit and Hungler (1995) stated that a "purposive sample is based on the belief that a researcher's knowledge about the population can be used to hand pick the cases to be included in the sample"(p.235). Purposive sampling involves the conscious selection by the researcher of certain subjects or elements or situations to include in the study (Burns & Grove, 1997).

Data were collected from:

1. All health professionals (physicians & nurses) who were in direct contact with adult patients, completed the job satisfaction and leadership questionnaires. Health professionals were selected from the following units: general surgery and urology, orthopedics, neurosurgery and cardiosurgery, adult intensive care, coronary care, medical (internal medicine) and gynecology and obstetrics units. Participants had at least 6 months of experience in one of the hospitals selected for this study, and were still



working in the selected hospitals. The sample size was 230 health professionals.

2. Adult discharged patients who stayed in the hospital for at least 3 days in the units from which health professionals were selected. Patients were 15 years or older and mentally able to be interviewed. The sample size was the same as health professionals. That is, 230 patients.

### **3.5 Instruments**

The data collection tools used in this study were the Job Satisfaction Questionnaire, Patient Satisfaction Questionnaire and Multifactor Leadership Questionnaire. Since all instruments were written in English, translation to Arabic by two English language teachers was done. The Arabic version was then back-translated into English and then examined and compared with the original version. There was no particular difficulty found in translating and back-translating.

The Job Satisfaction Questionnaire and Patient Satisfaction Questionnaire were distributed to three experienced nurse academics who had considerable research background. These experts looked at the content, clarity and relevance of the instruments. Experts made a number of comments that were incorporated into final formats. The changes made on the questionnaires did not substantially alter the instruments. The changes were mainly language related.

#### **Job Satisfaction Questionnaire:**

The job satisfaction questionnaire consisted of two sections: section one included demographic and personality variables (10 questions), while section two included sixteen items related to socioeconomic, political and cultural factors, thirteen items related to satisfaction with management practices, and 38 items to measure job satisfaction.

Job satisfaction items were based on the Revised Price & Mueller causal model (Agho, Mueller & Price, 1993). Cronbach's alpha for the instrument

ranged from 0.72 to 0.95 with an average of 0.85. Also, some items were selected from an instrument developed by Stevens, Philipsen, & Diederiks (1992), since the Price and Mueller satisfaction questionnaire was not specific enough to be administered to physicians. Reliability analysis for items included in Stevens et.al (1992) instrument showed Cronbach alpha's range from 0.60-0.72.

Response to items were asked following a Likert scale ranging from 1 (strongly dissatisfied) to 5 (strongly satisfied), resulting in a possible score for job satisfaction of 38 to 190. The items in the job satisfaction instrument represent eight dimensions of satisfaction: nine items on autonomy (33 to 41), one item on internal labor market (42), five items on distributive justice (43-47), six items on task significance (48-53), six items on integration (54-59), three items on pay (60-62), four items on job security and working conditions (76-79), and four items on work load and patient demand (80-83). (Appendix F)

### **Patient Satisfaction Semi Structure Interview**

The patient satisfaction questionnaire included fifty-five items related to patient satisfaction and ten general open-ended questions related to patient illness and experience in the hospital.

The patient satisfaction questionnaire items were taken from two sources; Ware, et.al. (1983) and Messner& Lewis (1996). The Ware et.al measurement scale is shown to have good internal reliability. Cronbach's alpha for the instrument ranged from 0.43 to 0.94. Estimates of test-retest reliability were obtained by computing Product Moment correlation (r), which ranged from 0.62 to 0.82.

The item stem was structured as a statement of opinion and response choices of Likert-type scale ranging from strongly agrees to strongly disagree. Some unfavorably worded items (item number 1, 3, 5, 11, and 24) were included to control for bias due to acquiescent response set, Which is "a tendency to agree with statement of opinion regardless of content "(Ware et.al, 1983, p. 251).

For the favorably worded items, "strongly agree" equaled 5 and "strongly



disagree” equaled 1. For the unfavorably worded items, “strongly agree” equaled 1 and “strongly disagree” equaled 5. The Likert-type approach has been used because it has several advantages: 1) the use of identical response scales for all items facilitates the task of the interviewers in filling in the questionnaire. Once the interviewees become familiar with the response choices, they can listen to each statement and quickly indicate their response; 2) the Likert scales give respondents the freedom to make choices among a wide range scale unlike the nominal-dichotomous choice, thus it yields more information; 3) "responses to Likert-type items can be analyzed by more powerful statistical tests than nominal-dichotomous items, because Likert-type items yield interval data" (Mitchell & Jolley, 1992. P.45); and 4) the use of a five-point scale enables interviewees to choose as precisely as possible their responses toward services and provider, unlike a response scale with only two choices.

The main disadvantage of Likert-type items is that participants hesitant to select from fixed-alternatives. However, in an interview, the interviewer can get around this by reading the question as if it was open ended question. Then, the interviewer would record the response under the suitable choice (Mitchell & Jolley, 1992).

Although in this approach there is more concentration on quantitative measure of patient satisfaction, interviewees had the chance to comment after any statement if they wanted to provide more information related to the service or service provider. Thus, they were given the chance to express themselves in their own terms.

The dimensions that were included in the patient satisfaction questionnaire are: interpersonal manner (items 5, 6, 8, 11, 13, 14, 16, 19, 24, 26, 30, 33, 35, 36, 37, 39, 43,45,46), technical quality (items 4, 9, 10, 12, 15, 17, 18, 20, 27, 29, 31, 32, 34, 38, 47,48,49,50,51), accessibility (items 1, 2,7,22,23,25), finances (items 53, 54, 55), continuity of care (items 3,21,28,52), and physical environment (items 40,41,42,44). (Appendix G)

## **Multifactor Leadership Questionnaire**

The Multifactor Leadership Questionnaire (1995) consisted of 45 items. These items describe leadership behavior. Response to the items is given on a 4 point Likert scale ranging from 0 (Not at all) to 4 (frequently). The MLQ-5x generates two scores: one for transformational leadership (TF), and one for transactional leadership (TA). Four factors are associated with a TF leadership: charisma, individualized consideration, inspirational motivation and intellectual stimulation. Two factors describe TA leaderships: contingent reward, and management-by exception. The MLQ-5x was selected because it has been widely reported as valid and reliable and has been used previously in a variety of settings (Bass & Avolio, 1995; Medley & LaRochelle, 1995). MLQ-5x has been used and tested in nearly 200 research programs, doctoral dissertations and masters theses in different countries among which the Arab countries. Reliabilities for the total items and for each leadership factor scale ranged from .74 to .94 (Bass & Avolio, 1995). Permission was granted from the Mind Garden to use and to translate MLQ-5x (Appendix H)

### **3.6 Gaining Access and Ethical Consideration**

In order to gain access to Ramallah, and Al-Makassed hospitals, the General Director of hospitals at the Ministry of Health (Palestinian Authority) and the administrative director at Al-Makased hospital were formally approached. A written letter describing the purpose of the study was sent and they were asked to grant their permission to conduct the study. Their response was very positive.

As more details about the study were developed the Research Committee at Al-Quds University, which has responsibility for giving ethical approval for research, was approached and drafts of the proposal and the questionnaires were submitted to the committee. Approval was granted. (Appendix I).

In order to maintain ethical standards in this study, the researcher was



concerned with the following issues:

1. The protection of anonymity and confidentiality.
2. The rights of participants to give informed consent to participate in the study.
3. The right of potential participants not to participate in the study or to withdraw  
at any stage after commencement without any positive or negative consequences occurring.
4. The right of participants to be treated with respect, dignity and courtesy.  
(Talbot, 1995; Mitchell & Jolley, 1992).

1. The protection of anonymity and confidentiality. Potential participants were assured that anonymity and confidentiality would be maintained at all times, and the data provided by participants would be used for research purposes and would be expressed in general terms only. No names or codes or any other mechanisms would be used to trace responses back to an individual participant. In addition envelopes were furnished along with each individual questionnaire (MLQ-5x & job satisfaction questionnaire). The respondent was asked to place the completed questionnaire in the envelope and subsequently in a box in the reception area in their hospitals.

2. The right of participants to give informed consents to participate in the study. The questionnaire cover letter included information about the nature of the study, importance of the study, method of data collection and a statement assuring voluntary participation. Participants had the chance to ask questions they had, related to the research by providing telephone numbers for participants to call.

3. The right of potential participants to refuse to participate in the study or to withdraw at any stage after commencement without any positive or negative

consequences occurring. Assurance that this would be the case was indicated in the cover letter. Voluntary participation was stressed at all times.

#### 4. The right of participants to be treated with respect, dignity, and courtesy.

When conducting the semi-structured interviews, participants were treated with respect, dignity and courtesy:

- Information about the research purpose and method of data collection were explained to the participants. The participants were also informed that they had full freedom to withdraw from the study at any time if they felt the need to do so.
- Discharged patients were asked if they were willing to participate in the study and if they agreed to participate, a schedule for the interview was set by the interviewer, so that patients would not have to wait too long.
- The interviewer started by reducing the participants' discomfort by greeting and by showing willingness to answer any questions the participant had.
- Participants were given the chance to express their ideas, comments or feelings regarding their experience in the hospital and in the study.

At the end of the interview, the interviewer reassured the participant that his/her participation in the study was highly appreciated.

### 3.7 Data Collection

After sending a formal letter to the Ministry of Health and to Al-Makassed Hospital, explaining the purpose of the study, and how the study was to be conducted, permission was granted from the general director of hospitals at the Palestinian Ministry of Health (Appendix J) and from the medical director at Al-Makassed Hospital to conduct the study (Appendix K).

Data collection from health professionals and patients.

In order to qualify for inclusion in the study, health professionals had to be employed by Al-Makassed or Ramallah Hospitals. After receiving permission to conduct the study, the researcher personally distributed the Job Satisfaction and



the Multifactor Leadership Questionnaires (MLQ-5x) to health professionals. Questionnaires with envelopes were distributed to health care professionals who worked in the general surgery, orthopedic, open-heart surgery, adult intensive care, coronary care, medical (internal medicine) and gynecology and obstetrics units. Health care professionals were asked to fill in the Job Satisfaction Questionnaire in which they indicated how satisfied they felt. A 5-point response scale ranging from 1 (strongly dissatisfied) to 5 (strongly satisfied) was used for all job satisfaction items. Respondents were also asked to rate how frequently their leader exhibited the target behaviors using the MLQ-5x. A 4-point response scale ranging from 0 (not at all) to 4 (frequently, if not always) was used for all MLQ-5x items. Health care professionals were asked to carefully read the consent form and the instructions, and they were asked to put the completed questionnaires in the envelopes, and then in the box provided in the reception area.

Interviews with patients were conducted at the same time as the collection of data from health professionals. A semi structured patient personal interview was used because: 1) it could yield statistically valid measure of patient satisfaction; 2) it would allow patients to share their comments with the interviewer 3) it was applicable to individuals unable to read (Merkouris et.al, 1999).

The researcher selected six fourth year nursing students, who had successfully passed a course in research methodology as part of their study towards a BSN degree, to aid the researcher in conducting the interviews. Students also had to be good in communication skills to be selected. Students were happily agreed to participate in collecting the data as part of their university requirements, in which each student has to spend 300 hours voluntary work. The researcher trained the selected students to conduct the interviews. The training was conducted as follows:

The morning session: Introduction to the nature of the study and its objectives,

sites, methods of communication and interviews, and discussion of the interview instructions.

The afternoon session Explaining the students' role in collecting the data and assigning to them the patients units from which they had to collect the data.

Role playing in which the group was divided into pairs. One played the role of the patient and the other played the role of the interviewer and visa versa.

At the end of the sessions students were encouraged to come back to the researcher if they have any concerns or questions.

Actual interviews took place soon after discharge in the patient's room if he/she was staying alone or in a private room where he/she could share comments in privacy. This was done for several reasons:

- Patient might be reluctant to say anything negative while still dependent on staff.
- While the patient is still under care, he/she might not be objective and comprehensive in evaluating the services.
- While the patient is still recovering from injury or illness, he/she tends to be preoccupied with his/her well being (Ford & Back 1997).

The discharged patients were selected from the following units: general surgery, orthopedics, open-heart surgery, adult intensive care, coronary care, medical (internal medicine) and gynecology and obstetrics units. Adult patients units were chosen because the patients are likely to be aware of and could evaluate the health care services during their stay.

Face to face interviews were conducted on-site in the form of an exit interview so as to have the best response rate and to minimize recall errors. Ware, et.al (1983) suggested that patients who were more satisfied with the quality of their care are less likely to return questionnaires if the mail-back method is used. This in return can increase sampling error which results in decreasing the usefulness and representativeness of information. Furthermore, most people in



Palestine, especially those who live in remote areas in the West Bank do not have telephone service. In addition, it is difficult to trace patients because there are no specific addresses in the West Bank and no mailing list is available. Semi structured interviews were used to increase response rate, to allow the interviewer to uncover emotions of the participants through observation and to provide clarification when necessary (Fitzpatrick, 1993).

The interviewer contacted the unit's head nurse and after informing her/him about the aim of study and the procedure, she/he was asked to provide the interviewer with the names of the discharged patients who met the requirements of the study. Then the interviews were scheduled. If a patient was in a hurry to leave the hospital, he/she was put at the head of the list. All the interviews were held in the morning from 9-12. The average duration of the interview ranged from 10-20 minutes.

The interview proceeded as follows:

a) The interviewer started the interviews by introducing her self to the patient (b) informing the patient about the purpose of the study (c) assuring confidentiality and anonymity (d) explaining that there are no right or wrong answer to the questions (statements) pertinent to patient's recent stay at the hospital. (e) acquiring the patient's verbal approval for participation (f) informing the patient that the interview would take 10-20 minutes and that he/she could stop the interview at any time if he/she felt uncomfortable.

The interviewers asked patients to evaluate their level of satisfaction on a four- point likert scale and to share any comments about the hospital services. The question and response categories were read out aloud to the patients by the interviewers. Then, patients were asked to respond to general questions related to intention of the patient to use the same hospital again, as well as recommending the hospital to others. Patients were asked to share if they have experienced anything good or bad which they did not expect during their stay and if they recommend any changes in the hospital services. Patients were asked about previous hospital admissions, duration of hospitalization, reason for admission

and how their health condition improved. At the end of the interview patients were asked about their demographic data (age, sex, educational background and place of residence).

### **3.8 Data analysis**

Examination of the descriptive statistics of all related variables included in the study was evaluated to determine frequencies, percentages, ranges and means. Correlation coefficient and multiple regression analysis were used, using a forward stepwise elimination procedure in order to examine the effects of the various independent variables considered in the study on the dependent variables: staff satisfaction and patient satisfaction.

The Pearson correlation coefficient is used to measure the degree to which two variables are linearly related (Shott, 1990, p.270). The regression procedure is appropriate in that it allows the researcher to consider the influence of several independent variables on the dependent variable of interest (Matus and Frazer, 1996). "Multiple regression is used to estimate the effects of a variable in causal model with two or more independent variables" (McClendon, 1994, p. 60). "The purpose of a regression analysis is to predict or explain as much of the variance in the values of the dependent variable as possible" (Burns & Grove, 1997, p. 481). The forward elimination procedure was chosen to determine the maximum R-square that could be obtained when all variables were entered.

### **3.9 Pilot Study**

A pilot study took place in November 1998 in order to improve any aspects of the study and to detect any problems that might occur before conducting the main study. "A pilot study also allows the investigator to determine the reliability of the measuring instruments" (Talbot, 1995, P.74). Piloting has been conducted in order to test response rate and to modify any part of the study before the start of the main study.



## Sites:

Al-Husein and Augusta Victoria Hospitals were selected as sites where the pilot study was conducted.

Augusta Victoria is a non-profit, general hospital, located in Jerusalem city. The hospital has 175 employees of whom 66 are nurses, 16 physicians, 12 technicians and 81 employees working in administration and support services. The total number of beds is 110.

Al-Husein Hospital is a government run hospital, located in the West Bank. The total number of beds is 75. The hospital has 161 employees of whom 53 are nurses, 35 physicians, 19 technicians and 54 employees working in administration and support services.

## Data collection:

After sending a formal letter to the Ministry of Health and to Augusta Victoria Hospital, explaining the purpose of the study, and how the study would be conducted, permission was granted from the general director of hospitals at the Ministry of Health (Palestinian Authority) to conduct the pilot study in Al-Husein hospital.

The investigator visited Al-Husein hospital and met with the hospital director, nursing director, and the head nurse of the surgical department. During the meeting the investigator gave an explanation about the purpose of the study and how it would be conducted. At the same time, the investigator obtained data about the number of the surgical staff. All arrangements concerning patients' interviews in Al-Husein hospital were discussed and agreed upon.

Permission was granted by the general manager of operations at Augusta Victoria Hospital, who in-turn sent a memo to the surgical department staff and to the patient service manager asking them to cooperate with the investigator. The investigator met with the patient service manager, nursing director, and the head nurse of the surgical department and explained the purpose of the study and how it would be conducted. At the same time the investigator obtained data regarding the number of the surgical staff. All arrangements concerning patients'

interviews in Augusta Victoria Hospital were discussed and agreed upon.

The management practices questionnaire was distributed with an envelope by the investigator to top and mid-line managers (hospital director and his/her assistant, nursing director and his/her assistant and the head nurse of the surgical units), a total of ten managers in both hospitals. The total number of returned questionnaires within ten days to the reception areas was eight (80%) from both hospitals. At the same time thirty-one job satisfaction questionnaires were distributed to staff members in the surgical units in both hospitals (nurses, physicians and support services personnel). The total number of returned questionnaire within ten days to the reception areas was 25 (80%) from both hospitals.

The occupancy rates in Augusta Victoria Hospital and Al-Husein Hospital were 77% and 85% respectively through the first three quarters of 1998 (communication with patient admission and registration departments in both hospitals, 1998). Nine discharged patients from each hospital were interviewed during November 1998. In the first ten days of November interviews were conducted in Augusta Victoria, then within one week interviews were conducted in Al-Husein hospital. The investigator visited the surgical department each day and obtained a list of discharged patients. An interview schedule was arranged each day with the discharged patients. Patients were interviewed in their rooms or in the waiting areas according to patient convenience.

#### Report on the Pilot Study:

Data analysis was carried out using SPSS (PC). Frequencies, percentages, and means were obtained. Regression analysis was not done because the sample size was small, and only two departments were used at the pilot stage.

Overall, managers, staff members and patients were very cooperative. Although the purpose of the study was clearly stated in the consent form, some managers were defensive. This was clearly noticed by the investigator. These managers were in the position of having to explain why their hospital was not



efficiently run. They attributed the inefficiency mostly to the hospital system, which is under the control of the Ministry of Health.

#### Reliability of the instruments:

Reliability testing for both the job satisfaction and patient satisfaction questionnaires was done using SPSS version 8. The internal consistency of the instruments and the major scales of job satisfaction and patient satisfaction were examined using Cronbach's alpha.

The coefficient alpha for the job satisfactions instrument (38 items) was .9609. The alpha for sub scales ranged from .7658 – .8748. The coefficient alpha for the socioeconomic, political and culture items was .7893. The coefficient alpha for the management practices items was .9430.

The coefficient alpha for the patient satisfaction instrument (54 items) could not be calculated because the number of cases was too few. (18 cases). The alpha for the sub scale ranged from .5391 – .8884. It is clear that there is a problem in finance items. It was noticed earlier in the pilot phase and it was decided to add one item related to medical insurance coverage because most patients are medically insured. The item is "medical insurance coverage should pay for more expenses than it does".

Also there was a problem in the items related to continuity of care ( $\alpha = .5391$ ). After going through the patient satisfaction instruments and mainly the "Newcastle Satisfaction with Nursing Scales", it was determined that one item needed to be added, which was: "Nurses told the next shift what was happening with my care".

#### Conclusion:

Results of the pilot study have shown that the patient satisfaction and job satisfaction instruments have good internal consistency. For the job satisfaction instrument the alpha for each of the sub scales was .76 or higher. For the patient satisfaction instrument the alpha for each of the sub scales was .69 or higher, with the exception of the sub scales for continuity of care (.54).

For the management practice questionnaire, it seemed that the questionnaire was irrelevant because the mean score for both departments were very high and this was not expected. The Multifactor Leadership Questionnaire (MLQ-5x) was used in the main study. Health professionals were asked to describe their perceptions of their leaders' behaviors.

In the patient satisfaction questionnaire, one item related to parking space was deleted because it was irrelevant. Most respondents commented that they used public transportation or a relative drove them to the hospital. One item that related to medical insurance coverage was added "medical insurance coverage should pay for more expenses than it does". The majority of respondents indicated that they were medically insured. Another item related to continuity of care was added, "Nurses told the next shift what was happening with my care".

In the job satisfaction questionnaire, an overall job satisfaction item was added "overall how satisfied are you with your current job", to compare between the aggregate mean score of the different dimensions of job satisfaction and overall job satisfaction mean score.

Overall, the Pilot study went well, with minor problems which were handled easily. The main study was conducted in both AL-Makassed and Ramallah Hospitals as planned for.

### **3.10 Study's time scale**

The proposal development, review of the literature, preparing for and conducting the pilot study constituted the MPhil. Data collection, analysis, critical appraisal of the conceptual framework leading to the body of knowledge in nursing and management sciences and writing of the dissertation constituted the Ph.D. The time scale for this study was five years. The work in this study was conducted according to the following phases:

First phase: Review of the literature, and proposal development 32 months.

Second phase: Data collection, data entry and data analysis 12 months

Third phase: Writing the dissertation 16 months.



## **Summary**

This chapter provides detailed information about the study methodology. It provides justification for the study design and description of the study setting and the sample. In addition it describes the instruments and data collection and analysis process. A description of the pilot study was also included.

## **Chapter Four**

### **Instruments' Psychometric properties**

#### **Introduction**

This chapter includes the psychometric properties of the instruments used in this study including reliability and validity. Psychometric properties of the instrument include internal reliability and construct validity for Job Satisfaction, Patient Satisfaction and Multifactor Leadership Questionnaires.

Internal consistency of the instruments using Cronbach's alpha test was performed. The construct validity of the instruments was examined by using factor analysis. Principal Component Extraction method was used. The Rotation method was varimax with Kaiser normalization (Burns & Grove, 1997). Varimax Rotation "is a type of rotation in factor analysis used to accomplish the best fit and the factors are un-correlated" (Burns & Groves, 1997, p. 497).

#### **4.1 Reliability of the instruments**

Reliability testing is concerned with how consistently and accurately the measurement technique measures the concept of interest. It is concerned with such characteristics as stability, equivalence and homogeneity (Burns, & Grove, 1997). In this study the statistical test used for internal consistency was Cronbach's alpha coefficient. Cronbach's alpha " assesses the internal consistency of the instrument by correlating each item with all other possible combination of items" (Talbot, 1995, p. 277). This procedure examines the extent to which all the items in the instrument assess a construct or constructs within the same domain. This method works quite well in attitude studies because it requires only one administration. Thus, this method was chosen for this study.

Typically, a reliability coefficient of 0.8 is considered the lowest acceptable level for a well-developed instrument. For a newly developed tool, a reliability of 0.7 is considered acceptable (Burns & Grove, 1997).



### **Job satisfaction questionnaire**

The total job satisfaction questionnaire (26 items) reliability test was as high as 0.93. The alpha for sub scales ranged from 0.55- 0.89 as shown in table 4.1. The coefficient alpha for the socioeconomic, political and cultural items was 0.72.

### **Multifactor leadership questionnaire**

The total MLQ (25 items) reliability test was 0.87. The alpha for transformational and contingent reward was 0.94 and the alpha for transactional (Management by exception active & management by exception passive) was 0.51 as shown in table 4.2. This is consistent with past research. Lowe et. al (1996) found that transformational and contingent reward displayed internal consistencies above 0.80. However, Bass, et.al (1996) reported that MBEA and MBEP had weaker reliabilities, with Cronbach's alpha ranging from 0.58 to 0.70.

### **Patient satisfaction instrument**

The alpha coefficient for the patient satisfaction instrument (37 items) was 0.94. The alpha for the scale ranged from 0.54 - 0.94 as shown in table 4.3.

**Table 4.1 Internal reliability estimates for the identified factors for Job Satisfaction**

No.	Factor	# of items	Cronbach's Alpha	# of cases
F I	Autonomy	5	0.89	153
F II	Job security & working condition	4	0.84	153
F III	Integration	3	0.76	153
F IV	Distributive justice	3	0.87	153
F V	Pay & equity	4	0.83	153
F VI	Work flexibility	2	0.81	153
F VII	Workload & value	2	0.55	153
F VIII	Work nature & Professionalism	3	0.67	153

**Table 4.2 Internal reliability estimates for the identified factors for leadership behaviors (MLQ-5x)**

Scale	# of items	Cronbach's Alpha	# of cases
Transformational and contingent reward	18	0.94	153
Transactional (Management by exception active & management by exception passive)	7	0.51	153



**Table 4.3 Internal reliability estimates for the scale of Patient Satisfaction**

Scale	#of items	Cronbach's Alpha	# of cases
Qualifications & interpersonal Relationship	14	0.94	201
Procedural adequacy (information sharing)	8	0.89	201
Accessibility	4	0.54	201
Health teaching & discharge	3	0.88	201
Physical environment	4	0.70	201
Finance	2	0.66	201
Approachability	2	0.61	201

#### **4.2 Construct validity of the instruments:**

The validity of an instrument "is a determination of the extent to which the instrument actually reflects the abstract construct being examined" (Burns & Grove, 1997, p.330). A factor analysis procedure is performed to examine the relationship among the various items of each instrument in the study. Factor analysis is an analytic technique that permits the reduction of a large number of interrelated variables to a smaller number of latent variables. Factor analysis uses the smallest number of explanatory concepts to explain the maximum amount of variance in a correlation matrix (Talbot, 1995; Burns & Grove 1997). The investigator used the Principal Component Extraction method. The Rotation method was Varimax with Kaiser Normalisation. Based on the literature, this method is the most accurate, common and suitable for attitudinal research studies (Burns & Grove, 1997).

#### **Job satisfaction instrument**

Results of the factor analysis provided a listing of eight factors with an Eigen value above one. An Eigen value of 1 or greater indicates that the factor

possesses at least as much total variance as contained in a single item (Yamashita, 1995; Talbot, 1995; Burns & Grove, 1997). Eigen values are the sum of the squared weights for each factor and it is the measure of how much variance a linear combination explains. Based on the factor extraction data, Eigen value, scree plot (is a test to indicate the point at which little additional information will be obtained by including more factor), variance, eight factors were identified. The percentage of variance and the scree test indicated that eight factors were substantially above chance levels and accounted for 67.941% of the variance.

A factor loading of 0.40 was used as a cut off point for the elimination of items in this study. The minimum cut off point that is acceptable is 0.30 (Burns & Grove, 1997). The factor loading indicates the extent to which a single factor is related to the cluster of variables. The factor loading of each item was examined. None of the items had a factor loading below 0.4. However, eleven items loaded on two factors were eliminated. The items that were deleted are as follows:

- Item 38      Your ability to set the pace of your own work.
- Item 41      The freedom to use your own judgment
- Item 46      The way performance appraisal is conducted at your employment site.
- Item 50      Achieving something that you personally value.
- Item 51      The input you have into major organizational decisions.
- Item 52      The work you do is appreciated by administration and your colleagues.
- Item 53      The chance to be "somebody" in the community as a result of your job.
- Item 54      Relationship with your fellow workers.
- Item 56      Relationship between management and workers in your unit.
- Item 80      Your work load in general.



Item 81 Time available for you to conduct research.

It was relatively easy to name all factors, except for two, for which the naming was agreed upon after consulting three academic nurse experts from Al-Quds University. The eight factors that resulted from clustering of the variables were titled as follows:

- Factor I Autonomy (items 33, 34, 35, 36, 37)
- Factor II Job security & Working condition (items 76, 77, 78, 79)
- Factor III Integration (items 57, 58, 59)
- Factor IV Distributive justice (items 42, 43, 44)
- Factor V Pay & equity (items 45, 47, 60, 61)
- Factor VI Work flexibility (items 39, 40)
- Factor VII Workload & value (items 49, 83)
- Factor VIII Work nature & professionalism (items 48, 62, 82)

The identified eight factors represented 67.941% of the total variance. These eight factors were used for further statistical analysis. Table 4.4 shows factor analysis results that describe the main constructs of job satisfaction derived from the respondents.

**Table 4.4 Factor loading, means and standard deviations for the Job Satisfaction items**

<b>Item #</b>	<b><u>Factors &amp; Items</u></b>	<b>Factor loading</b>	<b>Mean</b>	<b>SD</b>
	<b>Factor I Autonomy</b>			
Q33	The freedom to choose your own method of working	0.69	3.20	1.06
Q34	The amount of responsibility you are given	0.76	3.24	1.11

Q35	Your opportunity to use your abilities	0.08	3.11	1.25
Q36	The opportunities to make your own decisions	0.77	3.13	1.25
Q37	Your inputs into decisions that affect your practice	0.68	2.75	1.21
<b>Factor II Job security and working conditions</b>				
Q76	The level of security you feel in the job	0.61	2.41	1.18
Q77	Your feelings about compensation, health insurance and fringe benefits	0.82	2.01	1.00
Q78	Your feeling about working conditions in the hospital	0.73	2.07	0.97
Q79	Your feeling about work environment in the hospital	0.70	1.97	0.96
<b>Factor III Integration</b>				
Q57	Group participation in the unit activities	0.79	3.35	1.14
Q58	Discussion of work problems with coworkers	0.76	3.21	1.13
Q59	Appreciation among staff	0.68	3.05	1.14
<b>Factor IV Distributive justice</b>				
Q42	The chances of promotion in your work	0.60	2.03	1.12
Q43	Your chances of promotion as compared with your colleagues	0.72	2.46	1.18
Q44	The recognition you get for good work as compared to others	0.64	2.77	1.19



**Factor V Pay and equity**

Q45	Your rate of pay as compared to your colleagues who are at the same level	0.68	2.80	1.27
Q47	The way reward is distributed	0.46	1.95	0.97
Q60	Your rate of pay	0.80	2.34	1.25
Q61	Your pay compared to the amount of work you do	0.81	2.09	1.11

**Factor VI Work flexibility**

Q39	Initiating changes in the way work is done	0.68	2.78	1.13
Q40	The chance to do different things from time to time	0.74	2.69	1.12

**Factor VII Workload and Value**

Q49	The feeling of doing something which is really worthwhile	0.54	3.46	1.00
Q83	Your feeling about patient demands and workload	0.68	2.75	1.18

**Factor VIII Work nature and professionalism**

Q48	The amount of variety in your job	0.59	2.76	1.05
Q62	Your expectation for salary increase	0.60	2.35	0.93
Q82	Time available for your own professional growth	0.40	2.10	.99

**Multifactor leadership questionnaire**

Results of the factor analysis provided a listing of 7 sub scales with an Eigen value above 1.0. Seven sub scales were identified based on the factor

extraction data, Eigen value, scree plot and variance. One sub scale contained only one item, therefore it was eliminated. In this study, the leadership components included in the TF leadership were: individualized consideration, idealized influence, inspirational motivation, intellectual stimulation, and three items of contingent reward. Management by exception (active) and management by exception (passive) were identified as components of transactional leadership. The scree test and percentage of variance indicated that the seven factors were above chance levels and accounted for 66.615% of the variance. A factor loading of 0.4 was used as a cut off point for the elimination of items. The factor loading of each item was examined and none of the items had a factor loading below 0.4. However, six items loaded on two factors were eliminated. The items that were eliminated were: items 2, 11, 21, 25, 26 & 36.

The identified sub scales represented 60.148% of the total variance. These six sub scales were used for further statistical analysis. Table 4.5 shows factor analysis results that describe the main constructs of leadership behavior derived from the respondents.

**Table 4.5 Factor loading, means and standard deviations for MLQ items**

<b>Factors &amp; Items</b>	<b>Factor loading</b>	<b>Mean</b>	<b>SD</b>
<b>Factor I Transformational leadership</b>			
<b>Sub scale I</b>			
Item 31	0.79	1.60	1.27
Item 34	0.76	2.02	1.20
Item 27	0.75	1.87	1.24
Item 30	0.72	1.73	1.29
Item 18	0.70	1.57	1.37



Item 32	0.69	1.52	1.15
Item 16	0.69	1.77	1.12
Item 35	0.66	2.30	1.18
Item 15	0.65	1.86	1.29
Item 10	0.70	1.82	1.21
Item 1	0.60	2.11	1.10
Item 23	0.59	2.24	1.15
<b>Sub scale II</b>			
Item 14	0.71	2.00	1.81
Item 13	0.69	2.07	1.21
Item 8	0.68	2.16	1.26
Item 9	0.68	1.71	1.33
<b>Sub scale III</b>			
Item 29	0.81	1.42	1.23
Item 19	0.78	1.32	1.25
<b>Factor II Transactional leadership</b>			
<b>Sub scale IV</b>			
Item 22	0.76	2.03	1.22
Item 24	0.73	2.16	1.19
<b>Sub scale V</b>			
Item 3	0.73	1.65	1.28
Item 4	0.70	2.16	1.23
<b>Sub scale VI</b>			
Item 12	0.46	1.86	1.41
Item 17	0.76	1.85	1.14
Item 20	0.47	1.52	1.29

In this study, the sub scale associated with transformational and transactional leadership is at variance with those achieved by Bass (1985a) with business and military leaders. The major difference that was found between health professional leaders and industrial leaders involved the sub scale contingent reward. Health professionals associated contingent rewards with transformational but not transactional leadership. This is congruent with Medley and LaRochelle's findings in their study of leadership skills (1995). It seems that the nature of work in human service organizations is different from the work in industrial and military organizations, where Bass and his colleagues tested the MLQ (Medley & LaRochelle (1995). In health professions, especially in medicine and nursing, it is uncommon for an individual to get special recognition or to receive financial reward for outstanding performance. This might be due to the fact that, in bureaucratic organizations, leaders at mid and lower levels of the hierarchy have little or no control over rewards (Yammarino, et.al, 1993).

### **Patient Satisfaction**

Results of the factor analysis provided a listing of eleven factors with an Eigen value above 1.0. Based on the factor extraction data, Eigen value, scree plot and variance, eleven factors were identified. Three factors (9, 10 and 11) contained only one item, therefore they were deleted. The remaining seven factors were given names. The scree test and percentage of variance indicated that the eleven factors were solidly above chance levels and accounted for 66.033 of the variance. A factor loading of 0.4 was used as a cut off point for the elimination of items. The factor loading of each item was examined and one item had a factor loading below 0.40. This item (46) was eliminated. Ten items loaded on two factors were eliminated. The items that were deleted were as follows:

Item 4      Doctors are thorough when examining me.



- Item 5 Doctors act like they are doing their patients a favor by treating them.
- Item 16 Nurses do their best to keep patients from worrying.
- Item 19 Nurses do care if patients worry.
- Item 21 Nurses check patients to see how they are doing.
- Item 26 Nurses in this hospital treat patients with respect.
- Item 27 Nurses give treatments and nursing care (eating, bathing, dressing, getting into chair) quickly when asked.
- Item 32 Hospital workers explain to me what they are doing when taking care of me.
- Item 34 Hospital staff explain to patients what they are doing when taking care of them.
- Item 43 My family and visitors are treated in a kind, caring, and friendly way.

Three items (38, 44 & 52) did not fit in the clusters and therefore they were eliminated. The eight factors that resulted from clustering of the variables were named as follows:

- Factor I Qualifications and interpersonal relationship: items 8, 10, 13, 14, 18, 25, 29, 30, 31, 33, 35, 36, 37 & 39
- Factor II Procedural adequacy: items 6, 9, 12, 15, 17, 20, 47 & 48
- Factor III Accessibility: items 3, 22, 23 & 24
- Factor IV Health teaching & discharge: items 49, 50 & 51
- Factor V Physical environment: items 40, 41, 42 & 45
- Factor VI Finance: items 53 & 54
- Factor VII Approachability: items 2 & 7

The identified seven factors represent 56.192% of the total variance. These seven factors were used for further statistical analysis. Table 4.6 shows factor

analysis results that describe the main constructs of patient satisfaction derived from the respondents.

**Table 4.6 Factor loading, means and standard deviations for the patient satisfaction items**

<b>Item #</b>	<b>Factor &amp; items</b>	<b>Factor loading</b>	<b>Mean</b>	<b>SD</b>
	<b>Factor I - Qualifications &amp; interpersonal relationship</b>			
Item 39	I am treated in a kind, caring, and friendly way	0.79	4.15	0.79
Item 33	Hospital staff treat patients with respect and kindness	0.77	4.11	0.86
Item 29	Hospital staff work well together	0.74	3.93	0.89
Item 36	Hospital workers are polite, helpful, respectful and are there when needed	0.72	4.07	0.89
Item 18	The care I have received from nurses during my stay in the hospital is just about perfect	0.71	3.96	1.01
Item 30	All hospital workers make sure privacy is respected	0.69	3.93	0.89
Item 8	Doctors in this hospital treat patients with respect	0.67	4.30	0.74
Item 31	I trust the skills and abilities of hospital workers	0.67	3.93	0.96
Item 37	My special needs and desires are taken care of	0.64	3.87	1.04



Item 14	Doctors respect their patient's feelings	0.64	4.00	0.84
Item 35	Hospital staff do care if patients worry	0.64	3.79	0.05
Item 10	Doctors are as thorough as they should be	0.51	3.98	0.84
Item 25	If I have a question, I can ask nurses for help without any problem	0.50	3.98	0.88
Item 13	Doctors do care if their patients are worried	0.45	3.76	1.07

## **Factor II Procedural**

### **Adequacy (information sharing)**

Item 20	Nurses explain to the patients about treatments	0.76	2.91	1.31
Item 9	Doctors explain the patient's medical problem to him/her	0.74	3.14	1.30
Item 15	Doctors explain to patients why they order lab tests, x-rays and certain treatments	0.73	2.84	1.39
Item 12	Doctors explain the side effects of the medicine they prescribe	0.73	2.61	1.36
Item 47	Tests, treatments, diet, use of equipment, and medications are explained in a way you can understand	0.69	2.77	1.39
Item 48	Results of tests, treatments, medications and procedures are	0.65	2.67	1.46

	explained in a way you can understand			
Item 6	Doctors tell their patients what to expect during treatments	0.57	3.10	1.42
Item 17	Nurses advise patients about ways to avoid illness or injury	0.55	3.17	1.39
<b>Factor III Accessibility</b>				
Item 22	Nurses let me tell them everything that I think is important	0.64	3.92	0.94
Item 23	Nurses answer call lights very quickly	0.60	3.78	1.15
Item 3	I hardly ever see the same doctor during my stay in the hospital	0.69	3.17	1.35
Item 24	Nurses act like they are doing patients a favor in taking care of them.	0.65	3.89	1.06
<b>Factor IV Health teaching &amp; discharge</b>				
Item 51	You could understand the instructions the hospital gave when planning for discharge	0.77	3.32	1.17
Item 49	Discharge instructions are clear and complete	0.67	3.40	1.16
Item 50	Information is provided about possible problems to watch for after you go home	0.65	3.20	1.22



**Factor V Physical  
environment**

Item 42	Signs and directions are easy to follow	0.68	3.48	1.11
Item 45	Visiting times are good for your family	0.66	3.66	1.02
Item 41	The telephone lights, bed controls, and call buttons work and are easy to reach	0.55	2.89	1.35
Item 40	My room is clean and is quiet	0.48	3.38	1.30

**Factor VI Finance**

Item 53	Your hospital bill is received right away, is correct, and is easy to understand	0.80	3.24	0.76
Item 54	The amount charged for medical care and hospital services is reasonable	0.78	3.04	0.83

**Factor VII Approachability**

Item 2	Doctors let me tell them everything that I think is important	0.58	4.14	0.92
Item 7	If I have a medical question, I can ask my doctor for help without any problem	0.43	3.89	0.99

**Summary:**

This chapter included the psychometric properties of the instruments used in this study. Internal consistency and construct validity are presented. Internal consistency for Job Satisfaction, Patient Satisfaction and Multi-Factor Leadership Questionnaire were 0.93, 0.94 and 0.87 respectively.



## Chapter Five

### Findings

#### Introduction

The aims of this study were: 1) To explore the relationship between the perceived leadership behavior (transformational and transactional behavior) and job satisfaction by using multiple regression analysis, 2) To describe the relationship between the personal and demographic characteristics of staff and job satisfaction by using multiple regression analysis, 3) To determine the relationship between environmental factors such as socioeconomic, political and cultural influences and job satisfaction by using Pearson correlation and multiple regression analysis, 4) To examine the relationship between staff job satisfaction and patient satisfaction by using Pearson correlation and multiple regression analysis, 5) To determine the relationship between leadership behavior, job satisfaction and patient satisfaction by using Pearson correlation and multiple regression analysis.

In order to achieve the aims of the study the following tentative hypotheses were formulated: 1) There is a relationship between health professionals' perceptions of the leadership behavior of their leaders and their own job satisfaction, 2) There is a relationship between the personal and demographic characteristics of health professionals and job satisfaction, 3) There is a relationship between environmental factors and health professionals job satisfaction, 4) There is a relationship between health professionals' job satisfaction and patient satisfaction with care, 5) There is a relationship between the perceived leadership behavior, job satisfaction and patient satisfaction.

A hypothesis is "a declarative statement about the relationship between two or more variables that predicts an expected outcome" (Lobinodo-Wood & Haber,

1994, p. 189). Burns and Groves (1997) stated that "some correlational studies include a purpose and specific questions or hypothesis" (p.48).

This chapter consists of two parts: first, descriptive statistics of the participants in the study and second, results of hypothesis testing.

Descriptive statistics include frequency distributions, means, standard deviations and ranges for personal, demographic and organizational characteristics of the participants (health professionals, patients and the described managers). The responses of patients to open-ended questions are presented. Means, standard deviations and ranges for the components of the Job Satisfaction Questionnaire, Patients Satisfaction Questionnaire and MLQ-5X are included. The results of the five formulated hypotheses are also presented.

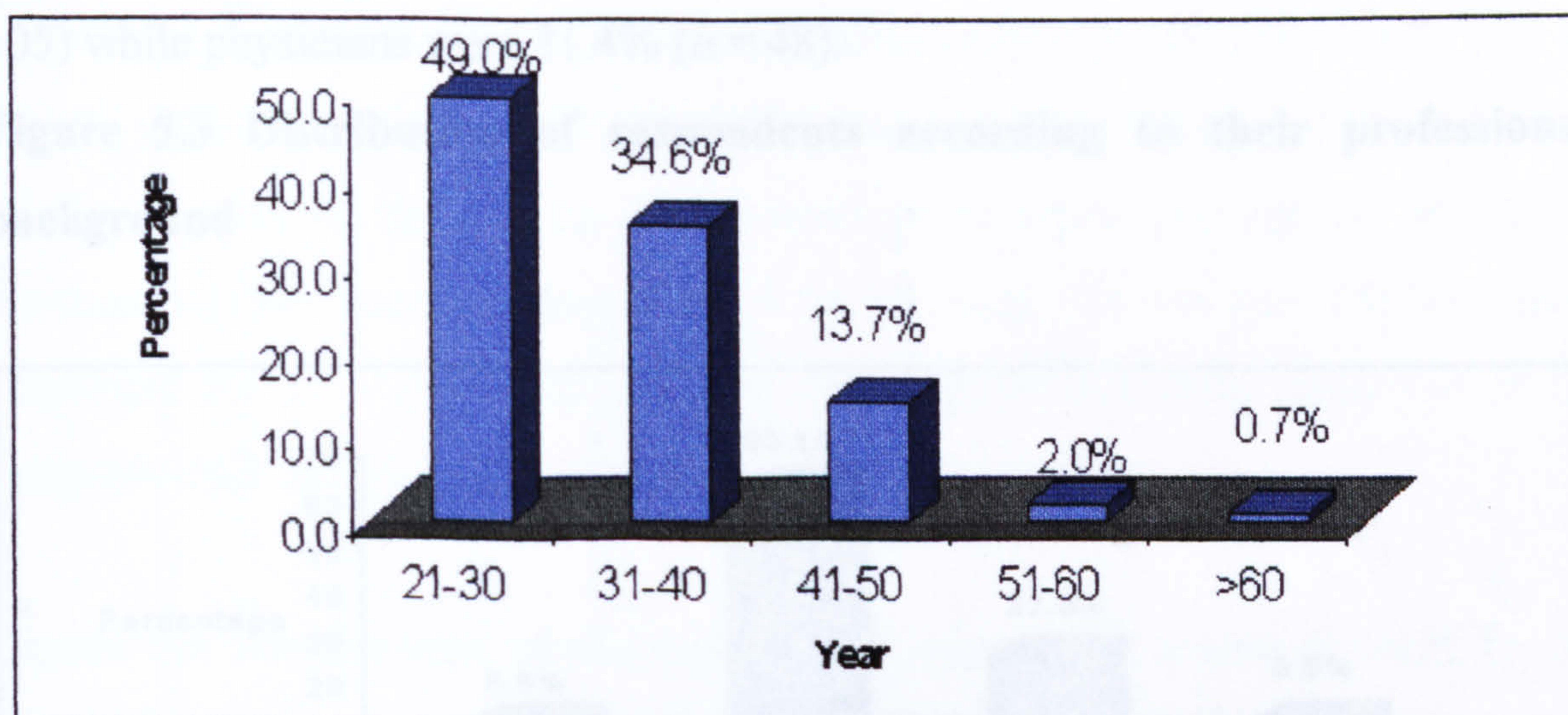
Pearson product-moment correlation coefficient and multiple regression were used to analyze the relationship between the selected variables in the proposed conceptual framework. The variables are personal and organizational characteristics of health professionals, selected environmental variables, leadership behavior, job satisfaction and patient satisfaction.

### **5.1 Personal and organizational characteristics of health professionals who participated in this study**

Nurses and physicians in both Makassed and Ramallah hospitals, who had been working in adult patient units for at least 6 months, were targeted for participation in the study. Two hundred and thirty envelopes that containing both MLQ-5X and job satisfaction questionnaires were distributed. A total of 171 participants returned the questionnaires. All questionnaires were scrutinized for completeness and incomplete questionnaires were not used. The final response rate was 66.5% (N= 153). One hundred fifty three participants completely filled both job satisfaction questionnaire and MLQ-5X. The age of respondents ranged from 21 to over 60 years. The majority 83.6% (n=128) were between 21-40 years of age and 2.7% (n= 4) were over 50 years of age as shown in figure 5.1.

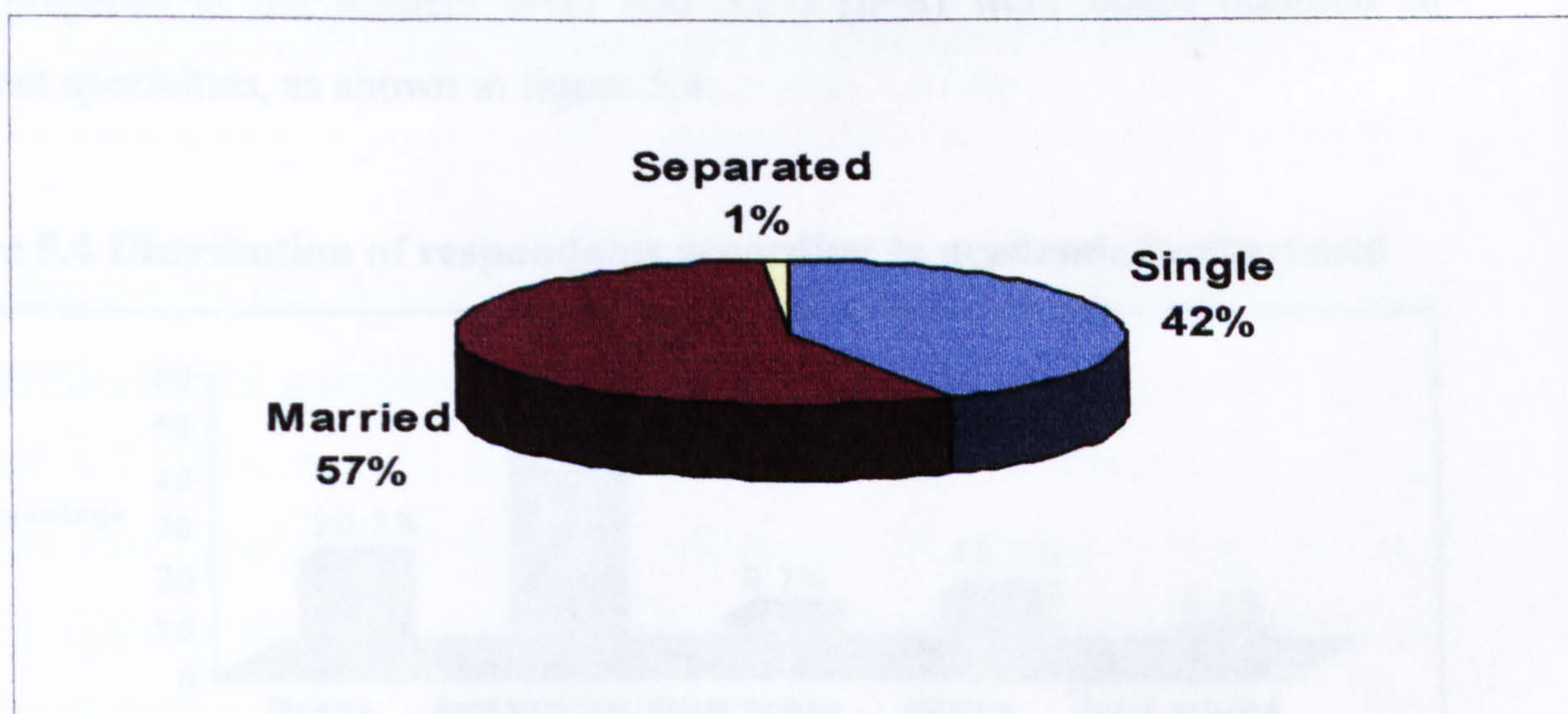


**Figure 5.1 Distribution of respondents by age**



Male respondents accounted for 38.6% (n=59) while, female respondents were 61.4% (n=94). Fifty-six point nine percent (n=87) reported being married, while 41.8% (n=64) reported being single and 1.3% (n=2) reported being separated. This is shown in figure 5.2.

**Figure 5.2 Distribution of respondents according to marital status**

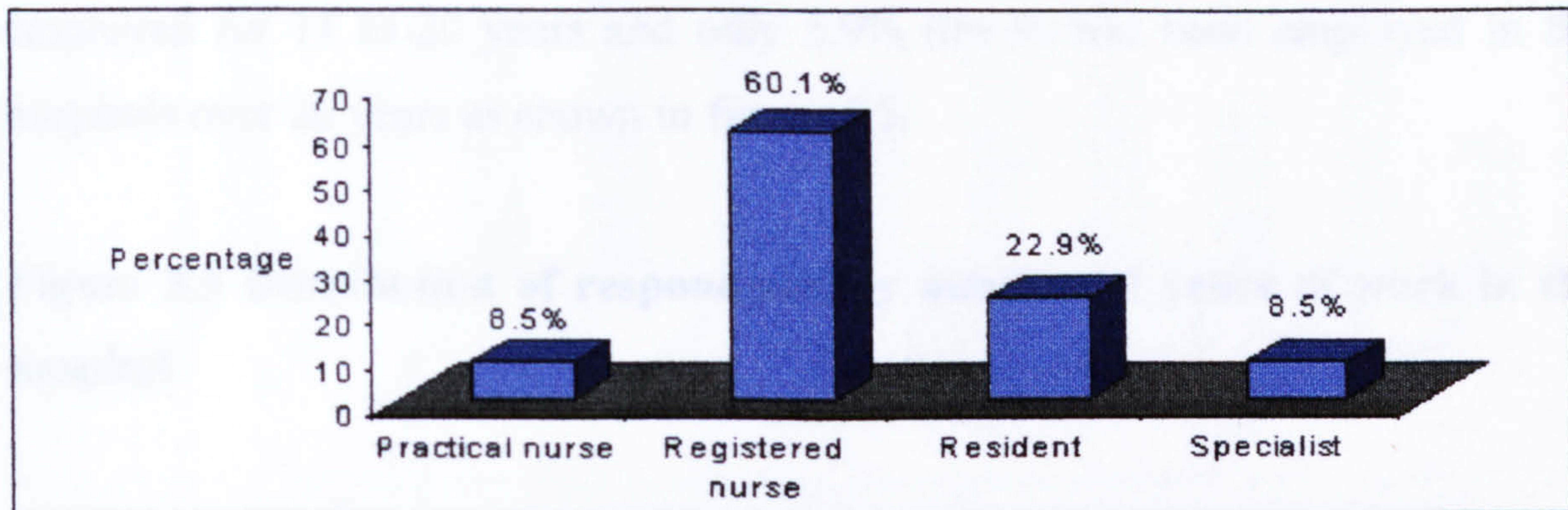


Of the 153 participants in the study, 60.1% (n=92) were registered nurses, 22.9% (n=35) were residents, 8.5% (n=13) were specialists and 8.5% (n=13)



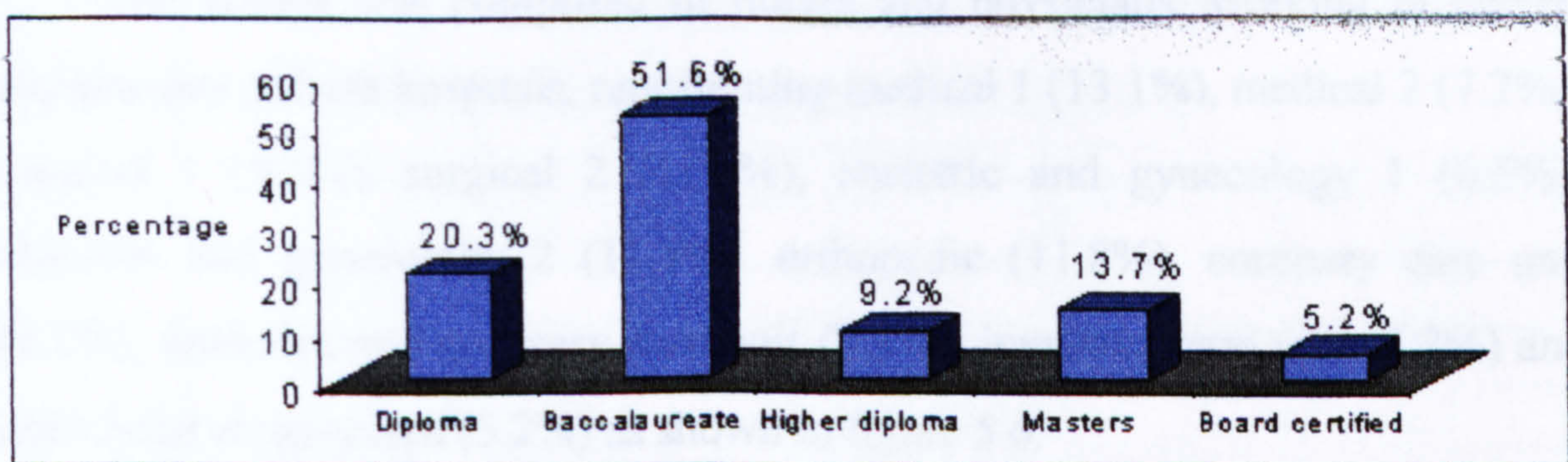
were practical nurses as shown in figure 5.3. Nurses accounted for 68.8% (n = 105) while physicians were 31.4% (n = 48).

**Figure 5.3 Distribution of respondents according to their professional background**



The majority of respondents worked full-time with only 3.9% working part timer. Baccalaureate degree education was the highest preparation for 51.6% (n=79) of the respondents, while 20.3% (n=31) had a diploma degree (two years). Nine point two percent (n=14) were prepared at a higher diploma level, 13.7% (n=21) were prepared at the masters level and 5.2% (n=8) were board certified in different specialties, as shown in figure 5.4.

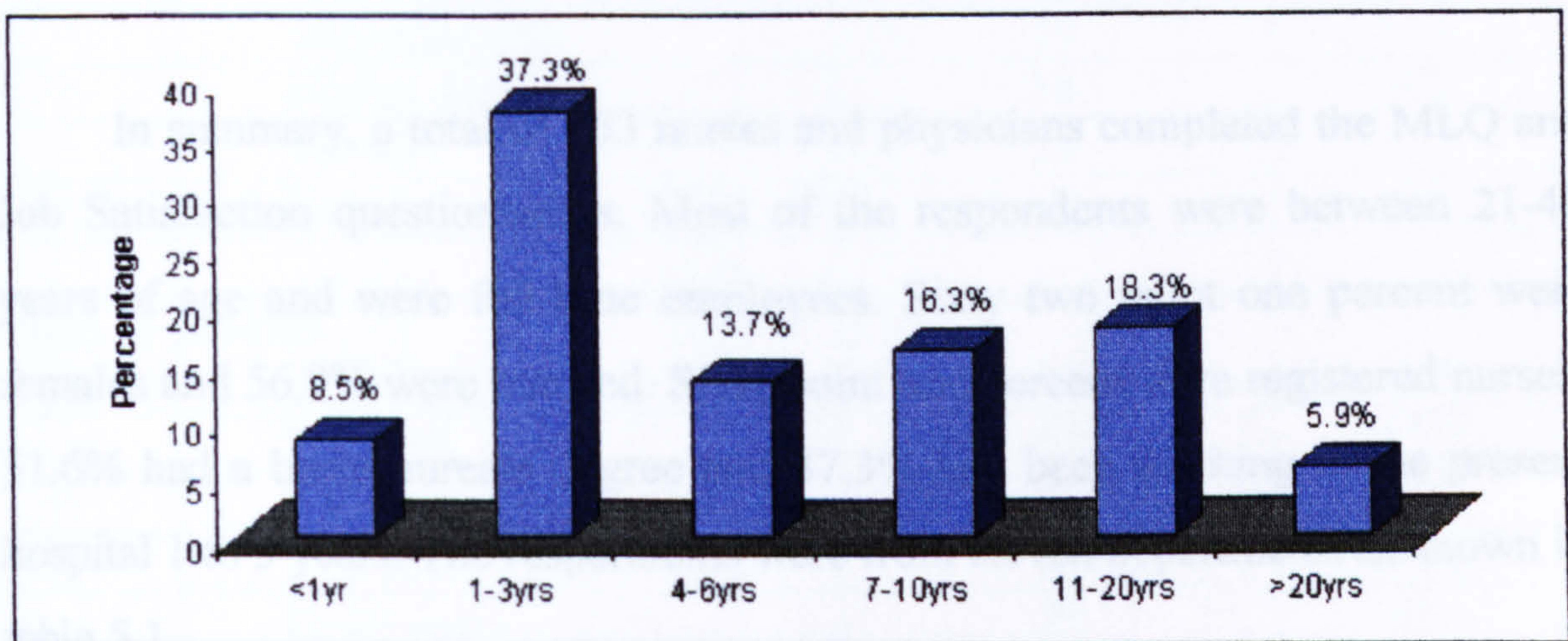
**Figure 5.4 Distribution of respondents according to academic background**





The participants' work experience at the hospital ranged from 6 months to over 20 years. Only 8.5% (n= 13) of the participants reported less than 1 year of tenure with the hospital. Of all the participants, 37.3% (n= 57) had been employed with the hospital for one to three years. Thirty percent (n= 46) of the participants had been employed for 4 to 10 years, 18.3% (n= 28) had been employed for 11 to 20 years and only 5.9% (n= 9) had been employed in the hospitals over 20 years as shown in figure 5.5.

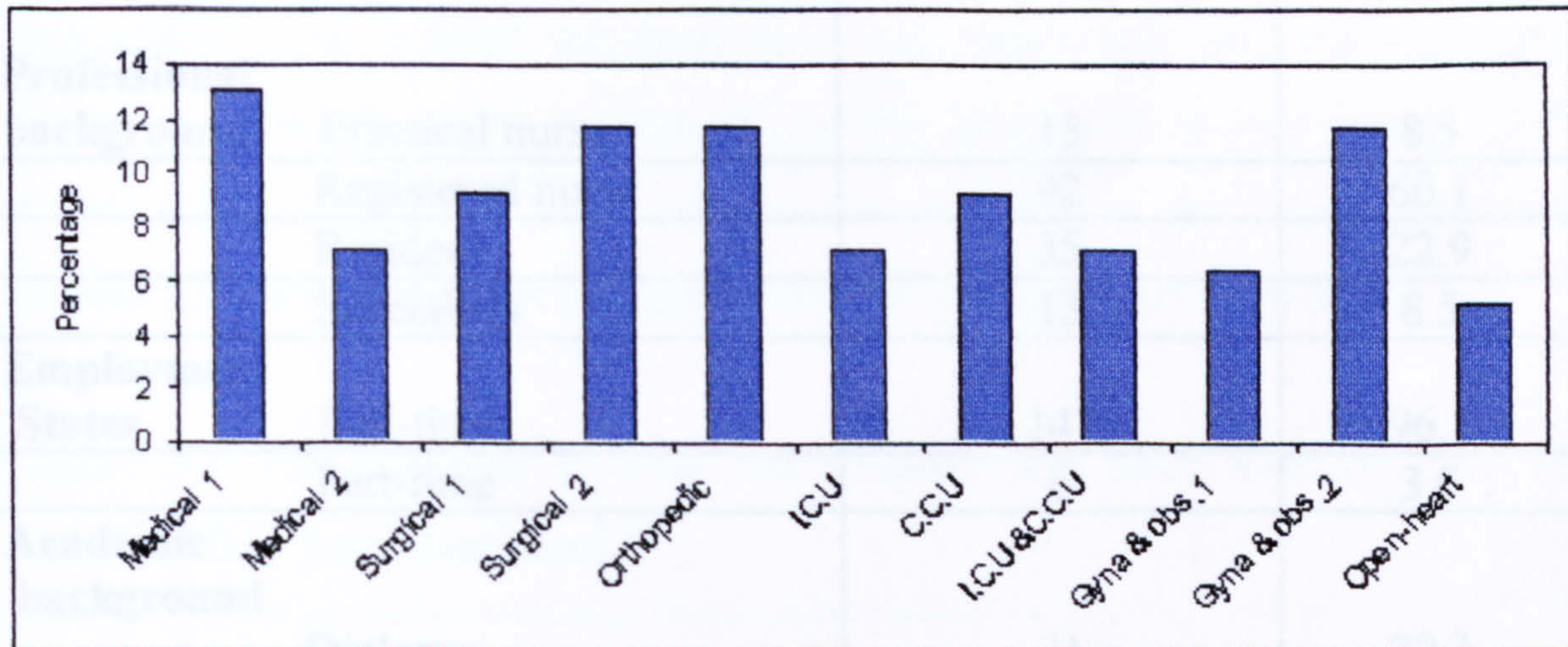
**Figure 5.5 Distribution of respondents by number of years of work in the hospital**



The sample was composed of nurses and physicians, working in eleven departments in both hospitals, representing medical 1 (13.1%), medical 2 (7.2%), surgical 1 (9.2%), surgical 2 (11.8%), obstetric and gynecology 1 (6.5%), obstetric and gynecology 2 (11.8%), orthopedic (11.8%), coronary care unit (9.2%), intensive and coronary care unit (7.2%), intensive care unit (7.2%) and open heart surgery unit (5.2%) as shown in figure 5.6.



**Figure 5.6 Distribution of respondents according to work area**



In summary, a total of 153 nurses and physicians completed the MLQ and Job Satisfaction questionnaires. Most of the respondents were between 21-40 years of age and were full-time employees. Sixty two point one percent were females and 56.9% were married. Sixty point one percent were registered nurses, 51.6% had a baccalaureate degree and 37.3% had been working in the present hospital 1 to 3 years. The respondents were from eleven departments as shown in table 5.1.

**Table 5.1 Percentage and frequency distributions of selected personal and organizational characteristics of the respondents (N=153)**

	<b>Attributes</b>	<b>Frequency</b>	<b>Percent</b>
<b>Age</b>	21-30 years	75	49.0
	31-40 years	53	34.6
	41-50 years	21	13.7
	51-60 years	3	2.0
	60+	1	0.7
<b>Gender</b>	Female	94	61.4
	Male	59	38.6



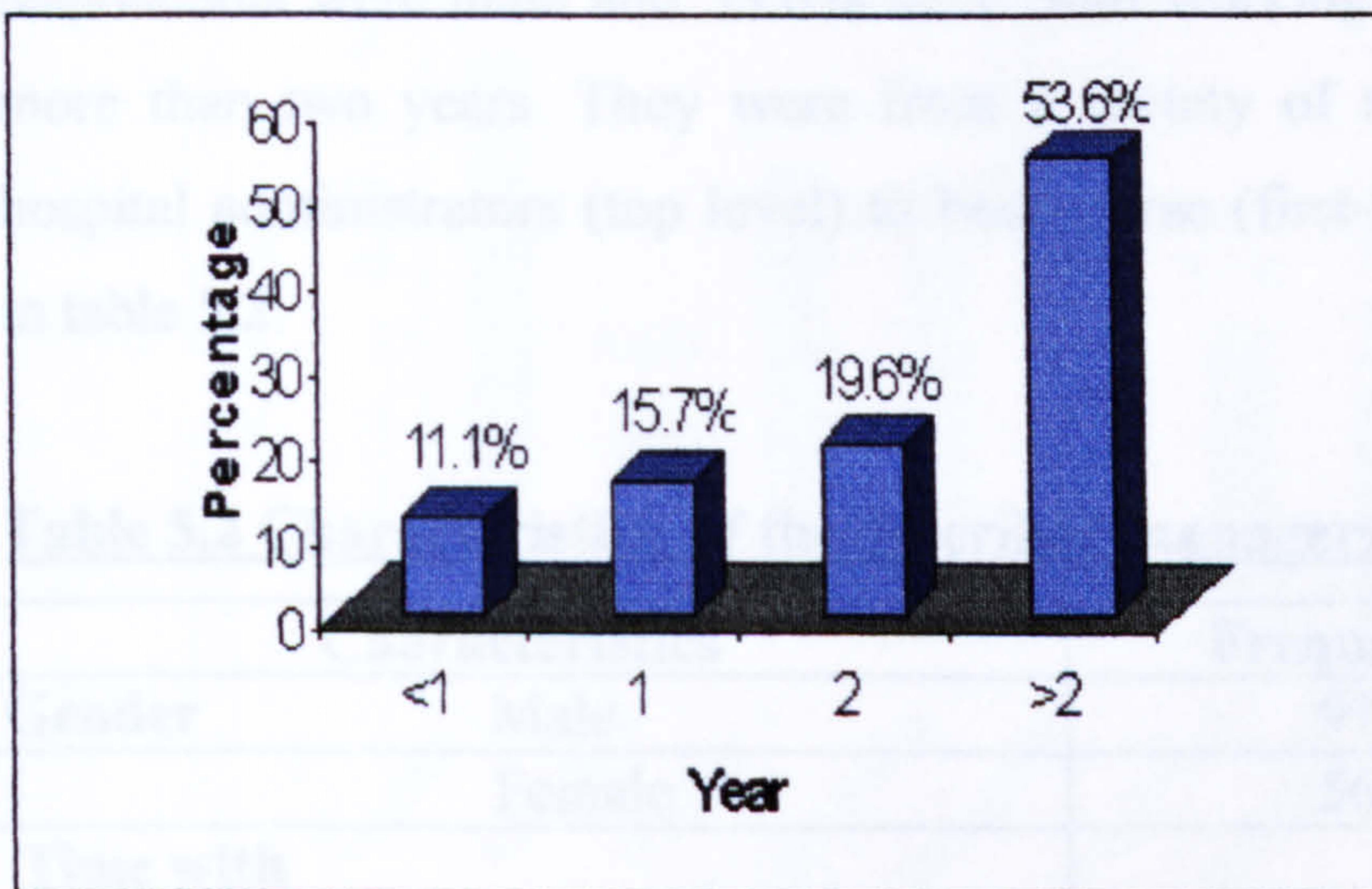
<b>Marital Status</b>	Single	64	41.8
	Married	87	56.9
	Separated	2	1.3
<b>Professional background</b>	Practical nurse	13	8.5
	Registered nurse	92	60.1
	Resident	35	22.9
	Specialists	13	8.5
<b>Employment States</b>	Full-time	147	96.1
	Part-time	6	3.6
<b>Academic background</b>	Diploma	31	20.3
	Baccalaureate	79	51.6
	Higher diploma	14	9.2
	Masters	21	13.7
	Board certified	8	5.2
<b>Time in present hospital</b>	6-11 months	13	8.5
	1-3 years	57	37.3
	4-6 years	21	13.7
	7-10 years	25	16.3
	11-20 years	28	18.3
	Over 20 years	9	5.9
<b>Area of Work</b>	Medical department 1& 2	31	20.3
	Surgical department 1& 2	32	20.9
	Obstetric/gynecology 1& 2	28	18.3
	Orthopedic department	18	11.8
	I.C.U& C.C.U	11	7.2
	C.C.U	14	9.2
	I.C.U	11	7.2
	Open-heart Surgery	8	5.2



## 5.2 Managers' demographic and personal characteristics.

In this study, 63.4% (n=97) of the respondents described their managers as male and 36.6% (n=56) as female. Fifty three point six percent (n=82) of the respondents have worked for more than two years with the managers they described. Nineteen point six percent (n=30) have worked two years, 15.7% (n=24) have worked one year, and 11.1% (n = 17) of the respondents have worked six months with the managers they described, as shown in figure 5.7.

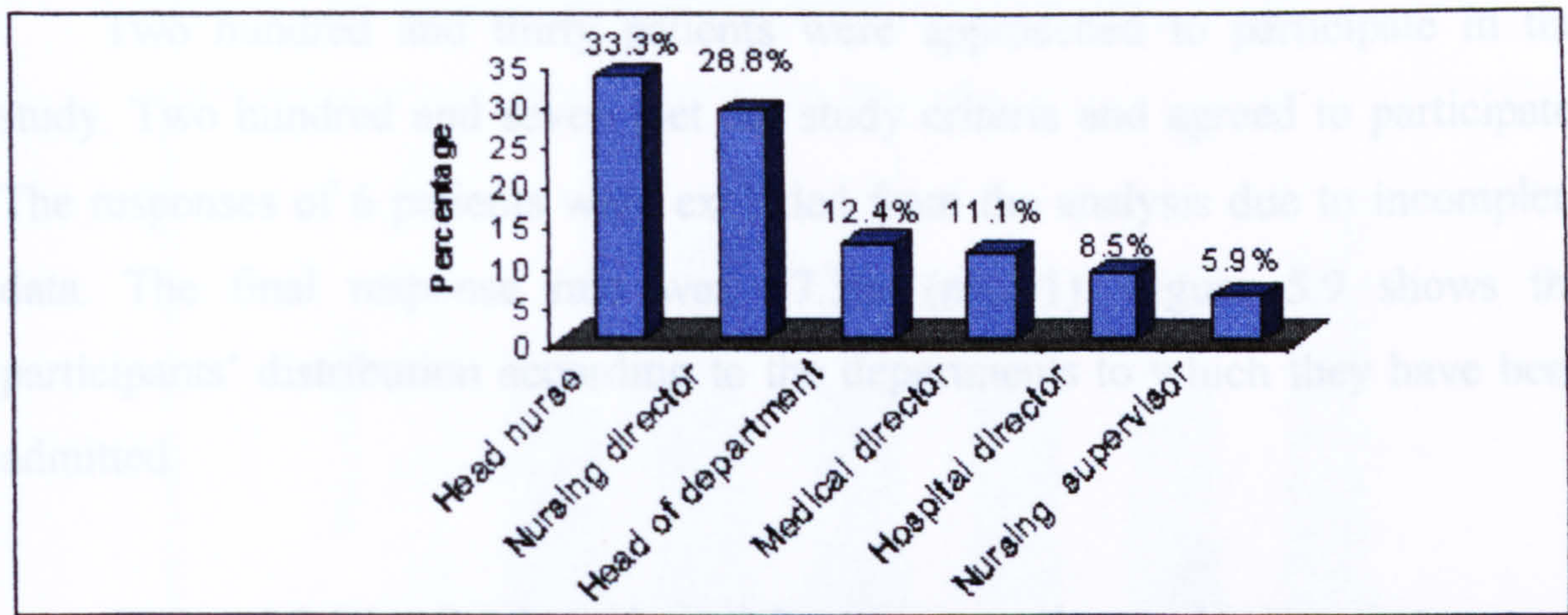
**Figure 5.7 The amount of time the respondents have worked with the manager they have described**



Thirty three point three percent (n=51) of the respondents described were head nurses and 28.8% (n=44) were nursing directors. Twelve point four percent (n=19) were head of in-patients units (specialists), 11.1% (n=17) were medical directors, 8.5% (n=13) were hospital administrators and 5.9% (n=9) were nursing supervisors, as shown in figure 5.8.



**Figure 5.8 The position of the manager the respondents described**



In summary, sixty three point five percent of the managers described by the respondents were male and 53.6% have been working with the respondents for more than two years. They were from a variety of management levels, from hospital administrators (top level) to head nurse (first-line managers), as shown in table 5.2.

**Table 5.2 Characteristics of the described managers**

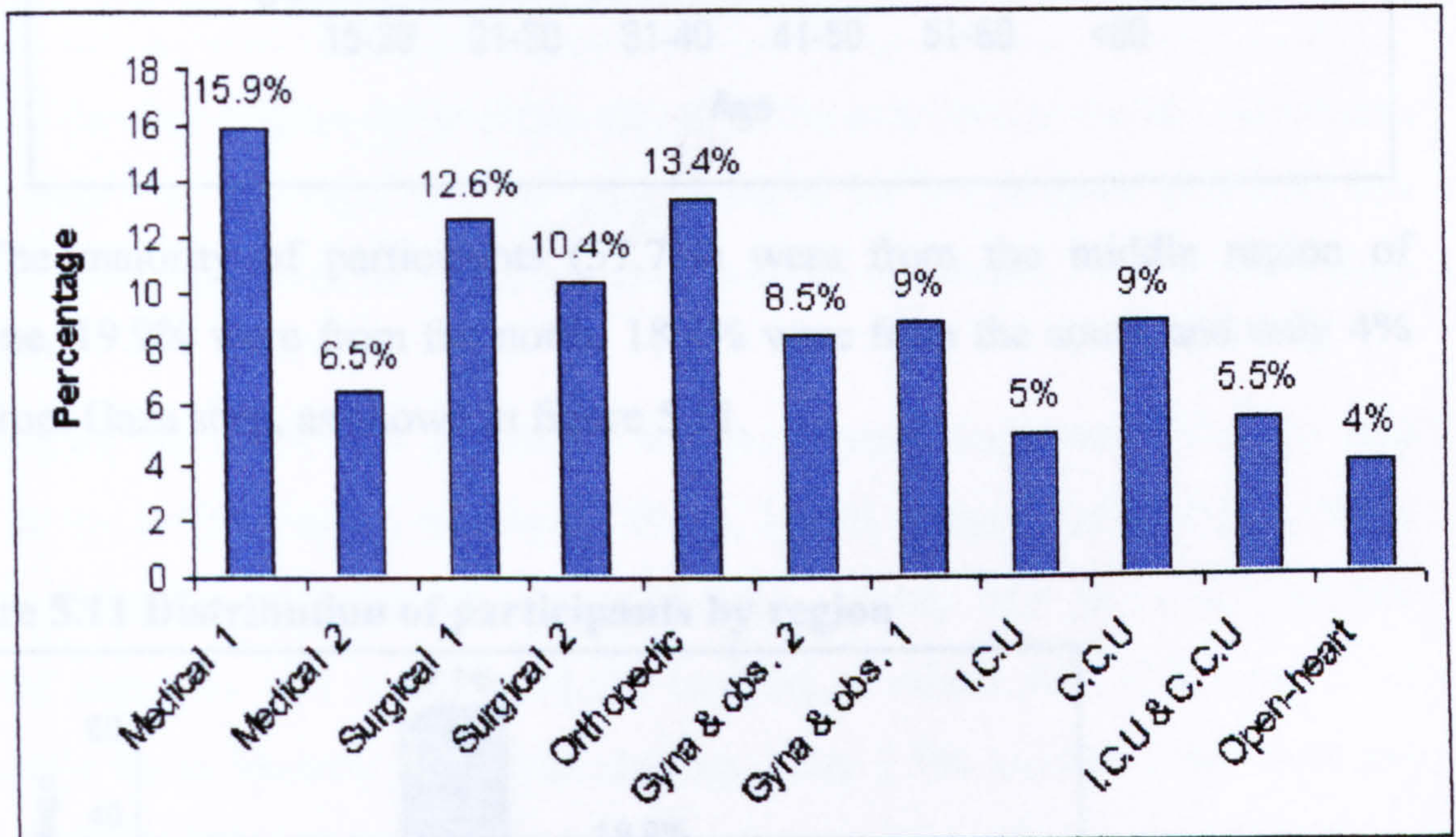
Characteristics		Frequency	Percent
<b>Gender</b>	Male	97	63.4
	Female	56	36.6
<b>Time with respondent</b>	Six months	17	11.1
	1 year	24	15.7
	2 years	30	19.6
	2+	82	53.6
<b>Position</b>	Hospital administrators	13	8.5
	Medical director	17	11.1
	Nursing director	44	28.8
	Nursing supervisor	9	5.9
	Head nurse	51	33.3
	Head of department	19	12.4



### 5.3 Patients personal and demographic characteristics

Two hundred and thirty patients were approached to participate in the study. Two hundred and seven met the study criteria and agreed to participate. The responses of 6 patients were excluded from the analysis due to incomplete data. The final response rate was 87.3% (n=201). Figure 5.9 shows the participants' distribution according to the departments to which they have been admitted.

**Figure 5.9 Distribution of participants according to department**

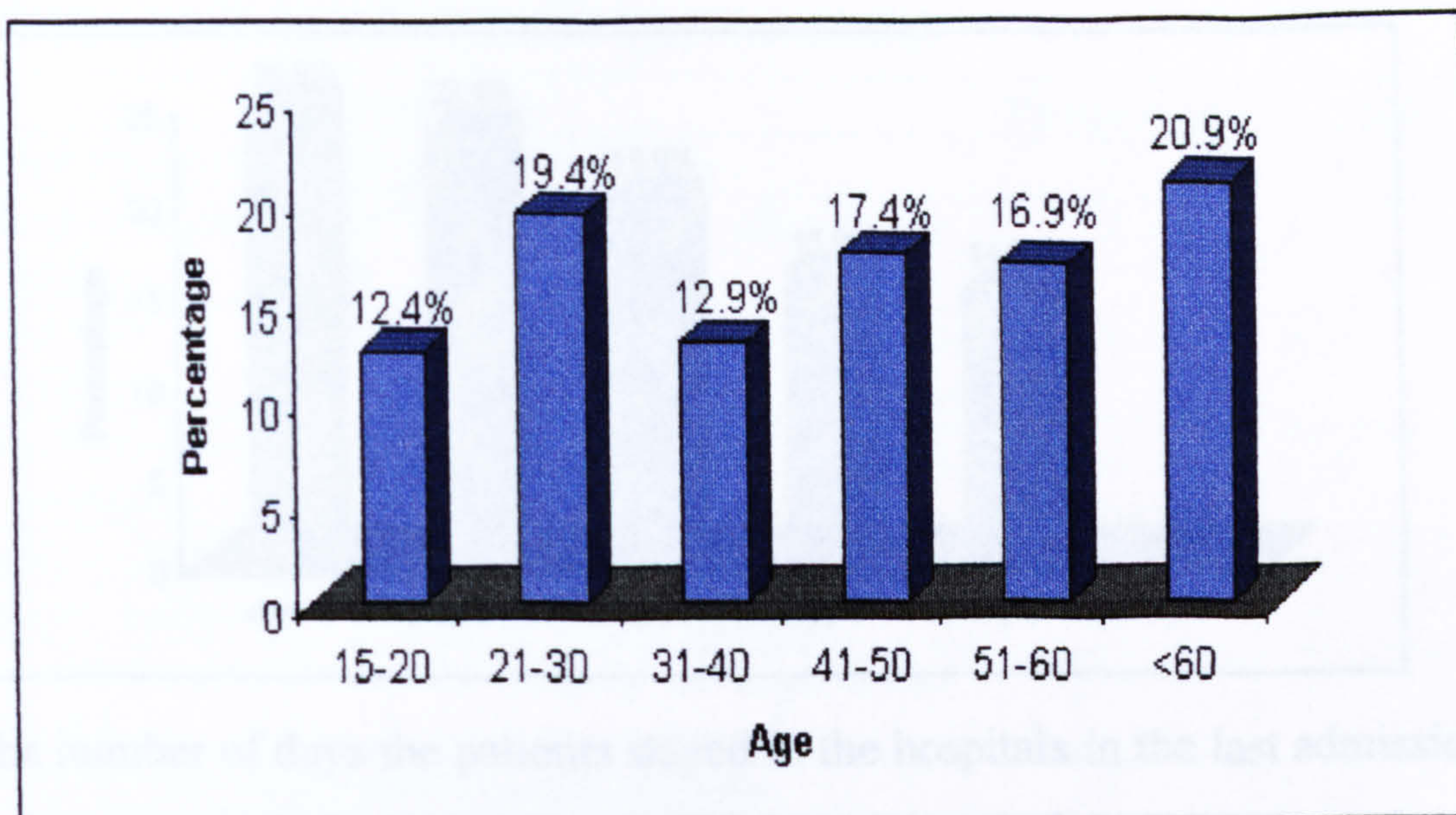


Forty-five point three of the respondents were male and fifty-four point seven were female. The age categories of the respondents are shown in figure 5.10. Age of the participants ranged from 15 to 90 years (M= 44.1, SD = 18.8).

Figure 5.10 indicates that 24.9% of the participants had no education, 23.4% had primary (first grade to sixth grade) school education, 19.9% had elementary (seventh grade to ninth grade) school education, 15.9% had secondary (tenth grade to twelfth grade) school education and 15.9% reported college education.

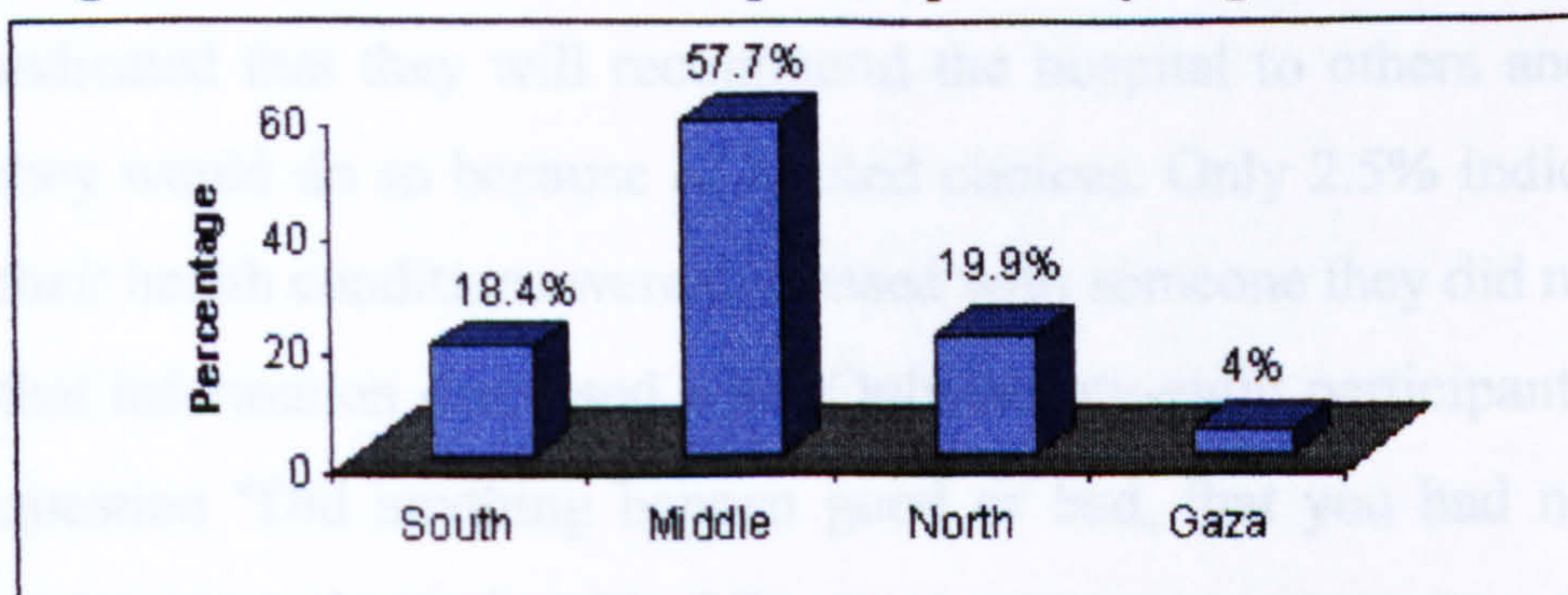


**Figure 5.10 Distribution of participants according to age**



The majority of participants (57.7%) were from the middle region of Palestine, 19.9% were from the north, 18.4% were from the south and only 4% were from Gaza strip, as shown in figure 5.11.

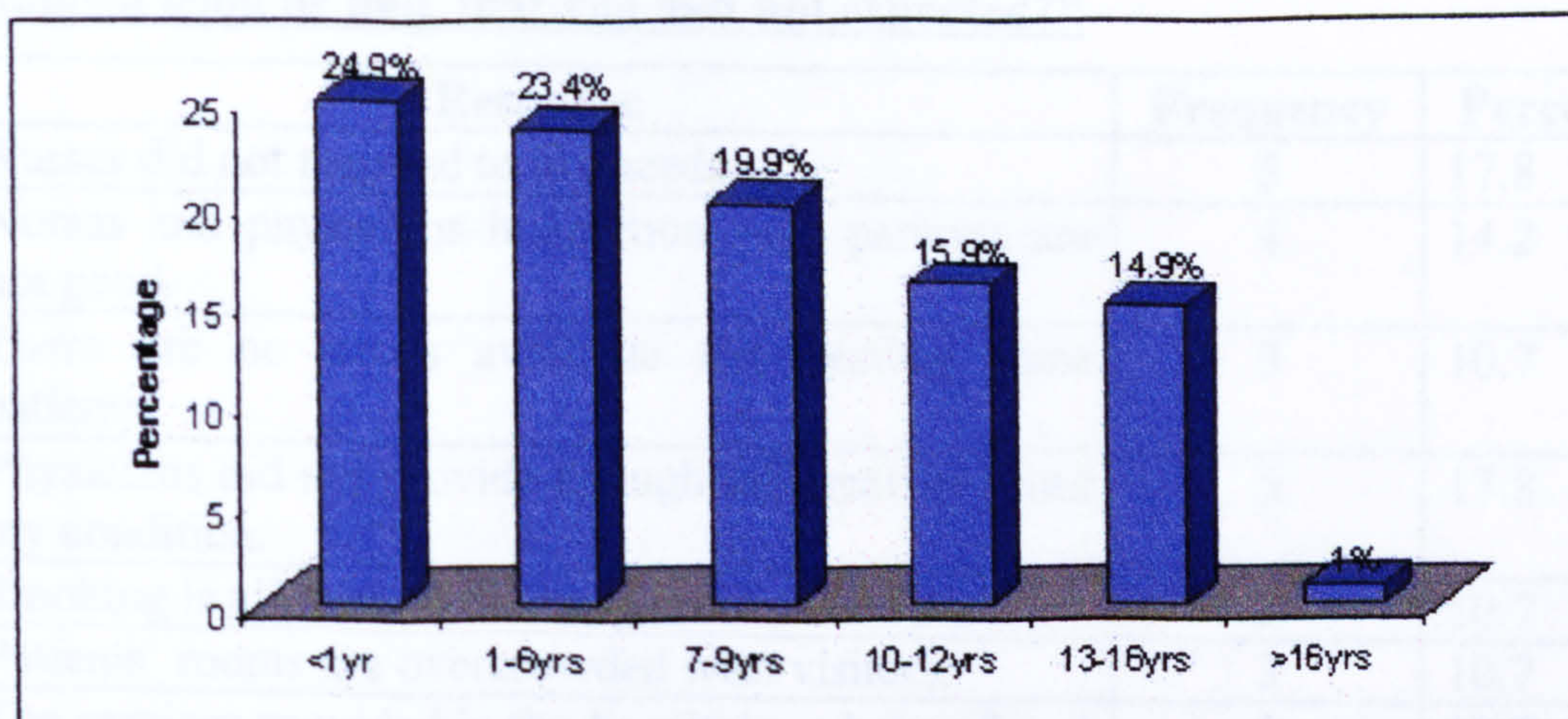
**Figure 5.11 Distribution of participants by region**



Education ranged from 0 to 18 years ( $M = 6.9$ ,  $SD = 5.1$ ). Figure 5.12 indicates that 24.9% of the participants had no education, 23.4% had primary (first grade to sixth grade) school education, 19.9% had elementary (seventh grade to ninth grade) school education, 15.9% had secondary (tenth grade to twelve grade) school education and 15.9% reported college education.



**Figure 5.12 Distribution of participants by years of education.**



The number of days the patients stayed in the hospitals in the last admission ranged from 3 to 150 days. Twenty six percent of the participants indicated that they had been patients in the hospitals over the past year while 74% had not been admitted.

Eighty six point one percent of the participants indicated that they will return to the hospital again and out of those, 19.6% indicated they would do so because there are no other choices available. Eighty one point one percent indicated that they will recommend the hospital to others and 20.8% indicated they would do so because of limited choices. Only 2.5% indicated that they felt their health conditions were discussed with someone they did not want to have that information discussed with. Only twenty-eight participants responded to the question "Did anything happen good or bad, that you had not expected?" The answers are shown in table 5.3.



**Table 5.3 The participants' responses to the questions. "Did anything happen good or bad, that you had not expected?"**

<b>Response</b>	<b>Frequency</b>	<b>Percent</b>
Nurses did not respond to my needs.	5	17.8
Nurses and physicians interaction with patients are not good.	4	14.2
There are no drugs available for treating some patients.	3	10.7
Physicians did not provide enough information about my condition.	5	17.8
Smoking is allowed in the hospital.	3	10.7
Patients' rooms are overcrowded with visitors.	3	10.7
The services provided in the hospital are better than I expected.	3	10.7
I received medication that I should not have.	1	3.5
The amount of money charged for the services in the hospital is too high.	2	7.1

One hundred eight participants responded to the question "If you could change one thing about your stay what would it be?" The responses are shown in table 5.4.



**Table 5.4 The participants' responses to the question "If you could change one thing about your stay, what would it be?"**

<b>Response</b>	<b>Frequency</b>	<b>Percent</b>
Cleanliness and ventilation of patients' rooms.	60	55.5
Organizing visiting times and providing comfortable waiting areas.	34	31.4
To enhance hospital workers interaction with patients.	27	25
To provide patients' rooms with suitable beds, cupboards, call lights and telephones.	23	21.2
To provide the hospital with enough materials, equipment and devices.	22	20.3
To provide means for privacy (curtains, enough space between beds).	18	16.6
To enhance the hospital management system (planning and control).	17	15.7
To provide good quality food.	17	15.7
To make sure that drugs are available.	14	12.9
To enhance the situation in the emergency department (space, location, and organization of work).	10	9.2
To work on maintenance of the hospital departments.	7	6.4
Some of the hospital staff need to be replaced with more qualified staff.	4	3.7

One hundred eighty eight participants responded to the question "How did you get better as a results of your stay at the hospital?" The answers are shown in table 5.5.



**Table 5.5 The participants responses to the question "How did you get better as a result of your stay at the hospital?"**

Response	Frequency	Percent
Medications, treatment and rest helped me to recover.	62	33
My health situation improved because of good care and interaction with hospital staff.	44	23.4
My health situation did not improve.	44	23.4
I recovered because I had surgery.	32	17
I don't know.	6	3.2
<b>Total</b>	<b>188</b>	<b>100%</b>

In summary, the patient population was about evenly divided by gender, although there were slightly more females than males. Most were older than 40 years of age. Around 40% of the participants had less than 7 years of education, while 24.9% had no education (less than 1 year). Length of stay was 3-6 days for most of the respondents (57%), while 49 (25%) had been hospitalized for 3 days. Fifty-two respondents (26%) had been hospitalized at least once in the last 12 months before the current admission, as shown in table 5.6.

**Table 5.6 Demographic characteristics of patients (N=201)**

	Frequency	Percent
<b>Gender</b>		
Female	110	54.7
Male	91	45.3
<b>Age</b>		
15-20	25	12.4
21-30	39	19.4
31-40	26	12.9
41-50	35	17.4
51-60	34	16.9
60+	42	20.9
<b>Education / years</b>		



< 1	50	24.9
1-6	47	23.4
7-9	40	19.9
10-12	32	15.9
13-16	30	14.9
16+	2	1.0
<b>Length of stay in present hospital unit (days)</b>		
3-6	115	57.2
7-10	50	24.9
11-14	20	9.9
15-18	9	4.5
19+	7	3.5
<b>Hospital admission during the past year</b>		
Previous admission	52	25.9
No previous admission	149	74.1

#### **5.4 Health professionals job satisfaction**

The total job satisfaction score was calculated as well as calculation of the individual score for the eight dimensions of job satisfaction. Overall means, standard deviations and ranges were determined for total job satisfaction and the eight dimensions. The job satisfaction scores for all health professionals who participated in the study were calculated. The total score for the 26-item job satisfaction questionnaire ranged from 26 to 118. A higher score indicates a greater job satisfaction. The mean score for total job satisfaction was 69 with a standard deviation of 17.7. This means that in a normal distribution 68% of the respondents had a job satisfaction score that ranged between 51.3 and 86.7. This indicates that respondents were not extremely satisfied or extremely dissatisfied. The job satisfaction components with the highest scores were autonomy and integration, while job security and working condition had the lowest mean scores, as presented in table 5.7.



**Table 5.7 Range, means and standard deviation for each component of job satisfaction**

<b>Component</b>	<b>Mean</b>	<b>SD</b>	<b>Range</b>
Autonomy	15.5	4.9	5 - 25
Job security and working condition	8.5	3.4	4 - 20
Integration	9.6	2.8	3 - 15
Distributive justice	7.5	3.1	3 - 15
Pay and equity	9.2	3.8	4 - 18
Work flexibility	5.15	2	2 - 10
Workload and value	6.2	1.8	2 - 10
Work nature and professionalism	7.2	2.3	3 - 14
Total job satisfaction (sum of the 26 items)	69	17.7	26 - 118
Overall job satisfaction	2.8	1.2	1 - 5

In response to the direct question "overall how satisfied are you with your current job", 15.7% were strongly dissatisfied, 32.7% were dissatisfied, 12.4% were uncertain, 35.9% were satisfied and 3.3% were strongly satisfied.

### **5.5 Patient satisfaction**

Total scores, means, standard deviations and ranges for total patient satisfaction and the seven dimensions were computed. The total score for the 37-item patient satisfaction questionnaire for all participants ranged from 61 to 184. A higher score indicates higher patient satisfaction. The mean score for total patient satisfaction was 131.2 with a standard deviation of 23.1. This means that 68% of the respondents had patient satisfaction scores that ranged between 108.1 and 154.3. This shows that the participants were not extremely satisfied or extremely dissatisfied. The patient satisfaction components with the highest mean scores were qualification and interpersonal relationship and accessibility



while, health teaching and discharge and finance had the lowest mean scores, as shown in table 5.8.

**Table 5.8 Ranges, means and standard deviation for each component of patient satisfaction**

<b>Component</b>	<b>Mean</b>	<b>SD</b>	<b>Range</b>
Qualification and interpersonal relationship	55.6	9.5	21 - 70
Procedural adequacy (information sharing)	23.2	8.2	8 - 40
Accessibility	14.8	2.9	5 - 20
Health teaching and discharge	9.9	3.2	3 - 15
Physical environment	13.4	3.5	4 - 20
Finance	6.3	1.4	2 - 10
Approachability	8.1	1.6	2 - 10
Total patient satisfaction (sum of the 37 items)	131.2	23.1	61 - 184
Overall patient satisfaction	3.81	1.10	1-5

### **5.6 Leadership behavior as perceived by health professionals**

Transformational and transactional leadership score was determined as well as means and standard deviations. The total score for the 18-item transformational leadership ranged from 0 to 72. The mean score for transformational leadership was 33.3 with a standard deviation of 15.5. The total score for the 7-item transactional leadership ranged from 0 to 23. The mean score for transactional leadership was 13.3 with a standard deviation of 4.2 as shown in table 5.9.



**Table 5.9 Ranges, means and standard deviation for leadership behavior**

<b>Leadership behavior</b>	<b>Mean</b>	<b>SD</b>	<b>Range</b>
Transformational	33.3	15.5	0 - 72
Transactional	13.3	4.2	0 - 23

Correlation of transformational and transactional factors with eight job satisfaction components revealed that there were significant positive correlation found between transformational leadership scores and the eight job satisfaction components. While, there were no significant correlation found between transactional leadership scores and the eight job satisfaction components as shown in table 5.10.

**Table 5.10 Correlation of transformational and transactional factors with eight job satisfaction components**

<b>Job satisfaction components</b>	<b>TF Factors</b>	<b>TA Factors</b>
Autonomy	0.47 **	-0.07
Job security and working condition	0.46 **	0.10
Integration	0.49 **	-0.06
Distributive justice	0.49**	0.01
Pay and equity	0.45 **	-0.01
Workload and value	0.38 **	-0.03
Work nature and professionalism	0.41 **	0.01

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



## 5.7 Hypothesis testing

First hypothesis: there is a relationship between health Professionals' perception of leadership behavior of their leaders and their own job satisfaction.

Transformational leadership was found to be in correlation with job satisfaction while, transactional leadership was not found in correlation with job satisfaction. Transformational leadership was positively and significantly correlated with job satisfaction at ( $r = .66$ ,  $p = 0.05$ ) as shown in table 5.17. The results of multiple regression analysis indicate a positive and highly significant association between transformational leadership and job satisfaction ( $B = 0.71$ ,  $t = 9.45$ ,  $p = 0.001$ ) which means that on the average, job satisfaction increases 0.71 unit for each measurement unit increase in staff's perception of a transformational leadership behavior. However, there was no significant influence of staff's perception of a transactional leadership behavior on job satisfaction. This analysis also indicates that leadership behavior accounts for 37.5% of the variance in job satisfaction as shown in table 5.11.

**Table 5.11 Multiple regression analysis of leadership behavior on job satisfaction**

	Unstandardized Coefficient (B)	R Square	t value	P
Transformational	0.71	0.375	9.49	.001

Dependent variable: Job satisfaction

Second hypothesis: there is a relationship between personal and demographic characteristics of health professionals and their own job satisfaction.

The personal and demographic characteristics included in this study were gender, education, marital status, age, work motivation, positive affectivity, professional background and experience. Three variables; gender, marital status,



and professional background were entered as dummy variables into the multiple regression analysis. Gender was recorded so male equaled 1 and female equaled 0. Marital status was recorded so married equaled 0 and not married equaled 1. Professional background was recorded so physicians equaled 0 and nurses equaled 1. Academic background was recorded so diploma equaled 0 and all others assigned the number 1. Typically, the variables in a regression analysis equation should be of a numerical level of measurements. However, categorical or dichotomous measures can be transferred to dummy variables (Burns & Grove, 1997).

Positive affectivity was the only personal variable found to be correlated with job satisfaction. Positive affectivity was positively correlated with job satisfaction ( $r = 0.35$ ,  $p = 0.01$ ) as shown in table 5.13. The results of the regression analysis are presented in table 5.12. Data indicate that all the above mentioned personal and demographic characteristics accounted only for 17.2% of the variance in job satisfaction. The two variables that significantly predict job satisfaction were work motivation ( $B = - 3.26$ ,  $t = -2.44$ ,  $p = .05$ ) and positive affectivity ( $B = 2.72$ ,  $t = 4.79$ ,  $p = .001$ ). This means that on the average job satisfaction decreases 3.26 units for each measurement unit increase in work motivation and increases 2.72 for each measurement unit increase in positive affectivity. It seems that, individuals who are driven towards work and work ethics expect more out of their work in terms of work set ups and achievements of personal goals. Therefore, they are likely to be less satisfied especially if it is problematic.



**Table 5.12 Multiple regression analysis of selected personal on demographic characteristics and job satisfaction**

	Unstandardized Coefficient (B)	Beta	R square	t value	p
Work motivation	-3.26	-.198	0.172	-2.44	.05
Positive affectivity	2.72	.384		4.79	.001

Dependent variable: Job satisfaction

Third hypothesis: there is a relationship between satisfaction of health professionals with selected environmental factors and their job satisfaction.

A positive correlation was found between socioeconomic factors and job satisfaction at ( $r = 0.46, p = 0.01$ ). A positive correlation was found between political factors and job satisfaction at ( $r = 0.43, p = 0.01$ ). A positive correlation was found between cultural factors and job satisfaction at ( $r = 0.37, p = 0.01$ ), as presented in table 5.13. The results of the regression analysis showed that socioeconomic, political and cultural variables accounted for 34.1% of the variance in job satisfaction as shown in table 5.14. The three Variables significantly predict job satisfaction. However, the variables that influence job satisfaction the most is socioeconomic, then political and then the cultural factor as reflected by Beta coefficient in table5.14.



**Table 5.13 Correlational matrix of selected demographic, environmental independent variables and job satisfaction ( Spearman's rho)**

	Work motivation	Years of experience	Age	Positive affectivity	Socio-economic	Political factor	Cultural factor
Work motivation	1.000						
Years of experience	-.31**	1.000					
Age	-.23**	.62**	1.000				
Positive affectivity	-.03	-.04	.12	1.000			
Socio-economic	.03	.16*	.24**	.46**	1.000		
Political Factor	.10	-.03	.14	.28**	.31**	1.000	
Cultural factor	-.03	.02	.08	.31**	.35**	.56**	1.000
Job satisfaction	-.16*	-.04	.01	.35**	.46**	.43**	..37**

\*correlation is significant at 0.05 level (2-tailed)

\*\*correlation is significant at 0.01 level (2-tailed)

Prior to conducting the regression analysis, the correlation matrix was examined for evidence of multicollinearity. A correlation matrix (table 5.13) of the independent variables showed no evidence of multicollinearity because none of the standardized regression coefficients have values above 1 and none of the independent variables have bivariate Spearman's rank-order correlation coefficient greater than 0.65 (Burns & Grove,1997). Spearman rho, a nonparametric test is used instead of Pearson's Product-Moment correlation coefficient because some of the independent variable scores are not normally distributed (skewed).



**Table 5.14 Regression analysis of environmental factors on job satisfaction**

**(N = 153)**

	Unstandardized Coefficient	Beta	R square	t value	p
Socioeconomic	1.38	.351	0.341	4.81	.001
Political	1.68	.223		2.69	.008
Cultural	1.08	.165		2.02	.045

Dependent variables: Job satisfaction

To test the first part of the model which, included selected personal and demographic and organizational characteristic variables of health professionals, environmental factors, and leadership behaviors and their relationship to job satisfaction

A stepwise multiple regression analysis was performed. A stepwise regression analysis is used to determine which variables make a significant contribution to the variance in job satisfaction. In the stepwise regression approach, as variables are added into the model, the variables that lose their significance are dropped (Agresti & Finlay, 1997). This procedure was chosen to determine the maximum R-square that could be achieved when all variables were entered. Table 5.15 shows the remaining variables that contribute to the variance in job satisfaction. The variables that significantly predict job satisfaction were transformational leadership behavior (B= .55, t= 8.66, P= .0001), socioeconomic factor (B= 1.21, t= 5.27, P= .0001), political factor (B= 1.71, t= 3.87, p= .0001) and work motivation (B= -2.95, t= -3.33, p= .001). This means on average for each measurement unit increase in transformational leadership behavior, socioeconomic, and political factor, job satisfaction increases .55, 1.21, and 1.71 unit respectively. However, Job satisfaction decreases 2.95 for each measurement unit increase in work motivation. Furthermore, the variable that influences job satisfaction the most is transformational leadership, then socioeconomic, then



political and finally work motivation. The results showed that transformational leadership, socioeconomic, political and work motivation account for 57.6% of the variance in job satisfaction.

**Table 5.15 Multiple regression analysis of selected personal and demographic variables, environmental factors, and leadership behavior on job satisfaction in a stepwise regression**

	Unstandardized Coefficient (B)	Beta	R square	t value	P
Transformational	.55	.48	0.576	8.66	.0001
Socioeconomic	1.21	.31		5.27	.0001
Political	1.71	.23		3.87	.0001
Work motivation	-2.95	-.18		-3.33	.001

Dependent variable: Job satisfaction

Fourth hypothesis: there is a relationship between job satisfaction of health professionals and patient satisfaction with care.

To test this hypothesis, the average job satisfaction score and patient satisfaction score were calculated for each of the eleven departments and it was used for further analysis. Thus, the department was the unit of analysis. This kind of analysis was chosen because health professional and patient ratings are treated equally within each department.

Pearson correlation and multiple regression were used to test the relationship between job satisfaction and patient satisfaction. Pearson correlation coefficient between job satisfaction and patient satisfaction scores for the eleven departments are ( $r = .88$ ,  $p = .001$ ) as shown in table 5.17. The result of regression analysis shows a positive and highly significant association was found between job satisfaction and patient satisfaction ( $B= 1.66$ ,  $t= 5.57$ ,  $p= .001$ ). which means that on the average patient satisfaction increases 1.66 unit for each measurement unit increase in job satisfaction. The analysis also indicates that job



satisfaction accounts for 77.5% of the variance in patient satisfaction as shown in table 5.16.

**Table 5.16 Regression analysis of patient satisfaction on job satisfaction (N = 11)**

	Standardized Coefficient (B)	R square	t value	P
Job satisfaction	1.66	0.775	5.57	.001

Dependent variable: Patient satisfaction

Fifth hypothesis: there is a relationship between perceived leadership behavior, job satisfaction and patient satisfaction.

Product-moment correlation coefficient and multiple regression were used to test the hypothesis. A positive correlation was found between job satisfaction, transformational leadership and patient satisfaction. There was no significant correlation found between transactional leadership and patient satisfaction, as presented in table 5.17.

**Table 5.17 Pearson correlation coefficient between leadership behavior, job satisfaction and patient satisfaction (N =11).**

	Patient satisfaction	Job satisfaction	Transformational	Transactional
Patient satisfaction	1.000			
Job satisfaction	.880**	1.000		
Transformational	.714*	.664*	1.000	
Transactional	-.443	-.315	-.605*	1.000

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

\* Correlation is significant at the 0.05 level (2- tailed)



The results of the regression analysis showed that job satisfaction, transformational and transactional leadership accounted for 81.4% of the variance in patient satisfaction as shown in table 5.18. Job satisfaction accounted for 77.5% of the variance in patient satisfaction as shown in 5.16. Thus, transformational and transactional leadership added an additional 3.9% of the variance only. The result showed that only job satisfaction significantly predicts patient satisfaction ( $B= 1.41$ ,  $t= 3.38$ ,  $p= .01$ ). This means that on the average patient satisfaction increases 1.41 unit for each measurement unit increase in job satisfaction.

**Table 5.18 Regression analysis of job satisfaction, leadership behavior on patient satisfaction (N = 11)**

	Standardized Coefficient	R square	t value	p
Job satisfaction	1.41	0.814	3.381	.012
Transformational	.27		.559	.594
Transactional	- 1.08		- .578	.581

Dependent Variable: Patient satisfaction

### Summary

This chapter presented the psychometric properties of the instruments used in this study, descriptive statistics of the participants in the study and results of hypotheses testing. The main findings can be summarized as follows:

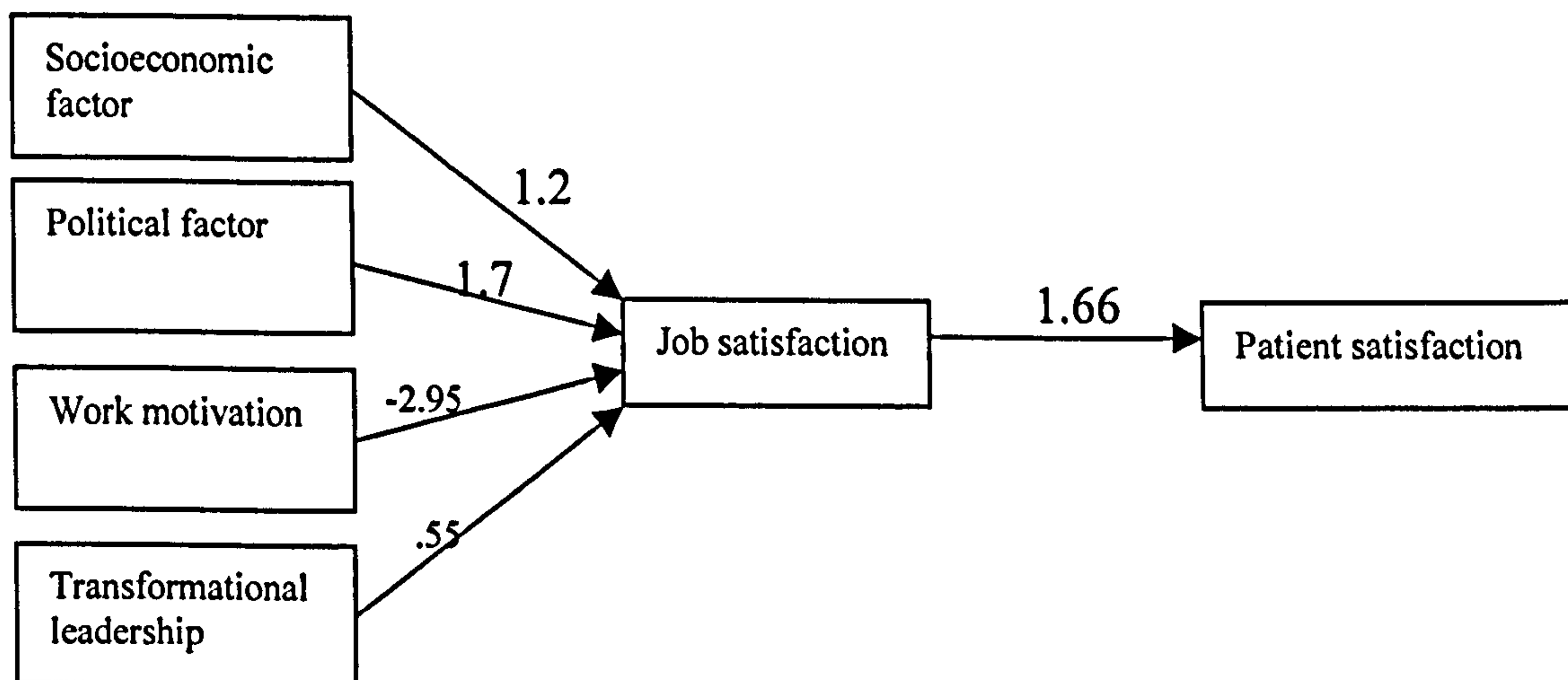
- 1- A positive significant correlation was found between transformational leadership and job satisfaction.
- 2- Leadership behavior accounted for 37.3% of the variance in job satisfaction.
- 3- Personal and demographic characteristics of health professionals accounted for 17.2% of the variance in job satisfaction. The two variables that significantly predict job satisfaction were work motivation and positive affectivity. Work motivation has a negative effect on job satisfaction.



- 4- There was positive and significant correlation between environmental factors (socioeconomic, political and cultural factors) and job satisfaction. Environmental factors accounted for 34% of the variances in job satisfaction.
- 5- The result of the stepwise multiple regression showed that transformational leadership, socioeconomic and political factors and work motivation accounted for 57.6% of the variance in job satisfaction.
- 6- There was positive and significant correlation between job satisfaction and patient satisfaction. Job satisfaction accounted for 77.5% of the variance in patient satisfaction.
- 7- The results of the regression analysis showed that job satisfaction, transactional and transformational accounted for 81.4% of the variance in patient satisfaction. However, job satisfaction accounted for 77.5% of the variance in patient satisfaction.

The results showed while health professional's job satisfaction is the main predictor of patient satisfaction, job satisfaction is partly influenced by transformational leadership, work motivation, political and socioeconomic factors as shown in figure 5.13

**Figure 5.13: Causal pathways**





## **Chapter Six**

### **Discussion**

#### **Introduction**

This chapter includes interpretation of the study findings in relation to previously conducted studies. At the beginning, a critical analysis of the research's findings will be presented. It will also encompass a critical analysis of research design, methodology, tools, procedures and limitations incorporated in the study . Additionally, it presents respondents' characteristics. Job satisfaction and staff's perception of leadership behavior was discussed in relation to the Palestinian context and in reference to the international literature. The last part includes discussion of patient satisfaction findings. The chapter also encompasses discussion of the relationship between perceived leadership behavior, staff's job satisfaction and patient satisfaction.

#### **6.1 Revisiting the aims of the study**

The primary aim of this study was to test the proposed conceptual framework, most particularly by exploring the relationship between perceived leadership behavior, job satisfaction and patient satisfaction, and exploring the relationship between personal characteristics of staff and environmental factors and job satisfaction. In order to achieve such an aim, five hypotheses have been formulated and correlational design has been used. Burns and Groves (1997) stated that "some correlational studies include a purpose and specific questions or hypothesis" (p.48). Pearson Product-Moment Correlation, Spearman rank-order correlation coefficient, and Multiple Regression were used to test the hypotheses.

#### **6.2 Methodological considerations**

A quantitative correlational design was mainly used to describe the relationship between leadership behavior, job satisfaction and patient satisfaction. A correlational design was chosen as recommended by previous



research findings (Brink & Wood, 1998). Correlational studies are the method of choice when the goal of the research is prediction of relationships (Shaughnessy & Zechmeister, 1997). There was no control over the independent variables and no manipulation. A quantitative data collection method was used with health care professionals (physicians and nurses) and patients.

Despite some of the arguments developed in chapter three (Methodology), a correlational quantitative design methodology was chosen for the present study as it was thought that this design might help in refining the relationships between the variables. Therefore the conceptual framework can be modified accordingly. The advantage of using a correlational design is increased flexibility when investigating complex relationships among variables (LoBiondo-Wood & Haber, 1994). Therefore, it has been the design of choice for this study.

### **6.3 The tools employed in data collection**

There were three tools employed in the data collection. The first was the job satisfaction questionnaire that was based mainly on Price & Mueller's instrument (Agho, Mueller & Price, 1993). The second tool was the Multifactor Leadership Questionnaire (Bass & Avolio, 1995) that was administered to identify leadership behavior. The two tools were simultaneously administered to health care professionals. The third was the Patient Satisfaction questionnaire that was adapted from Ware et.al (1983) and Messner & Lewis (1996). The Patient Satisfaction questionnaire was used in semi structured interviews with patients.

Content validity of job and patient satisfaction questionnaires were established by giving them to three experts who were asked to critique the instruments for content, clarity and relevance. Experts made a number of comments that were incorporated into the final formats (Appendix A & B). Construct validity of the questionnaires was examined by using factor analysis techniques. Cronbach's alpha test was performed to check for internal consistency of the instruments.



Although translation and back translation of the questionnaires was done, there might have been some problems because they were designed originally for use with English speaking populations. The other thing that might have confounded the results is the use of categories in the questionnaire, mainly in items related to demographic variables. The use of categories resulted in loss of some information.

#### **6.4 Adequacy of the sample size**

Purposive sampling was used to select the two hospitals. This was done based on the investigator's knowledge about the population. Brink and Wood (1998) argued that systematic sampling techniques or convenience samples may be used if the researcher is unable to use a random sample. All health care professionals (nurses and physicians) working in adult patient units at the two selected hospitals were asked to participate in the study. Questionnaires were distributed to 230 health care professionals. During the same period 230 discharged patients were approached to be interviewed. Because it was not feasible, health care professionals were not matched with the patients for whom they cared. A Functional nursing care delivery system was mainly used in the two hospitals. Functional nursing is characterized by the absence of an identifiable principal caregiver for each patient, as nurses are allocated to tasks rather than to patients on a shift by shift basis (Adams et. al, 1998). Therefore, analysis on the relationship between job satisfaction and patient satisfaction could not be done at the individual level.

Sample size in a correlational study must be large enough to make it possible to observe the variance on all the variables under study and must fit with the needs of the statistical techniques to be used for data analysis (Burns & Grove, 1997; Brink & wood, 1998). It is argued that 10 to 15 subjects per independent variable is appropriate for multiple regression (Kerlinger and Pedhazur, 1973; Thorndike, 1978). Other researchers suggested computing the number of independent variables and ensuring minimum, a 5:1 ratio of subjects



to independent variables for a large effect size and a 20:1 for small effect size (Tabachnick & Fidell, 1989).

For the first part of the conceptual framework in this study thirteen independent variables were correlated and regressed to job satisfaction. The number of returned and useable job satisfaction questionnaires was 153, thus the ratio of subjects per independent variable was 11:1. For the second part of the conceptual framework, eleven adult patient units were used in testing the relationship between job satisfaction and patient satisfaction. Therefore, sample size was eventually adequate considering the cost and time available.

### **6.7 Statistical analysis and the use of correlation and multiple regression**

In choosing the most appropriate tests for the study, there were several considerations that needed to be taken into account including the level of measurement of data to be analyzed, research questions that needed to be answered and research design (Burns & Grove, 1997). For the purpose of this study, Spearman rank-order and Pearson Correlation Coefficient and multiple regression using a forward stepwise elimination procedure were used. The correlation coefficient measures the degree of linear association between two variables (Shott, 1990). "Multiple regression provides a means of measuring the effects of several factors concurrently" (Brink & wood, 1998, p.172).

### **6.8 Limitations**

Several limitations in this study merit mentioning. First, the fact that this study was cross-sectional may raise concerns about generalizability of the findings to some extent. This design is not as strong as the longitudinal design but due to limited time available and scarcity of resources, cross-sectional design was used. Eventually, this does not alter the fact that a longitudinal study is required to further explore the relationship between job satisfaction, patient satisfaction and perceived leadership behavior. The limitation of this study are those common in cross-sectional study. Cross-sectional surveys evaluate the situation at a particular time, while the concepts under study (job satisfaction,



patient satisfaction and leadership behaviors) could be influenced by time, situation and so on. Using research designs with longitudinal method of data collection could also delve into more accurate information about the concepts under study. In this study, it is hoped that a foundation has been laid for further research exploring and testing the relationship between job satisfaction, patient satisfaction and perceived leadership behavior. Thus one should be careful about generalizing findings from one study. Replication of the study is needed.

Second, Data collection for both perceived leadership and job satisfaction were exclusively reliant on self-reported instrument. Self-report surveys may be inaccurate because respondents are sometimes reluctant to describe precisely their experiences, attitudes or feelings (Burns & Grove, 1997).

Third, the instruments used in this study have not been previously tested in the Palestinian culture. However, Multifactor Leadership Questionnaire has been used and tested in the Arab countries for its psychometric properties (Bass & Avolio, 1995). Moreover, the researcher maintained reliability and validity via several methods as detailed in chapters 3 & 4. Three experienced nurse academics who had considerable research background looked at the content, clarity and relevance of the instruments. The changes made were mainly language related. Internal consistency of the instruments were examined using Cronbach's alpha test. The construct validity of the questionnaires was evaluated by using factor analysis.

Fourth, one criticism that might be raised is that the relationship between leadership behavior, job satisfaction and patient satisfaction may be spurious. There might be other variables not measured in this study, which account for the association.

Fifth, subjects in this study were restricted to only two hospitals (11 units) because of limited financial support and time restrictions, therefore, generalization of the findings of this study should be cautious. Therefore, larger scale research are needed that incorporate larger size sample.



Sixth, including both nurses and physicians might have altered the results, as the medical and nursing professions are not homogeneous. A more homogeneous sample (all nurses or all physicians) might control the influence of intervening variables such as the nature of work.

### **Health care professionals' characteristics**

Eighty-three point six percent of the respondents were between 21- 40 years of age. This finding reflects the demographic characteristics of the Palestinian population. Palestine has a young population. Children under 14 years old comprised about 47 percent of the total population, and life expectancy rate was 71.35 years in 1997 (Palestinian National Health Plan, 2000). Nurses accounted for 68.6% while, 31.4% were physicians. Male respondents accounted for 38.6% while, females were 61.4%. Although, the majority of respondents were female, 63.4% of the managers in this study were male, which reflects the trends in health care of promoting males to management positions rather than females. This reflects the cultural values in which women's position in Palestine is somewhat inferior to that of men. A woman's managerial role is viewed within the context of her being a woman rather than her managerial skills and abilities (Hammad, 1989). However, one can conclude that changes in the attitude towards women in management have improved her position. This might be due to the exposure to the Western societies and to the political role that women in Palestine played. Abu-Znaid (1990) found in his study of business culture in the West Bank that only 7.3% of managers were females. Fifty-six point nine percent of the respondents were married, 41.8% were single and only 1.3% were separated. This was expected in a society with high marriage and low divorce rates. The registered crude divorce rate in Palestine during 1999 was 1.13 per 1000 population (PCBS,1999). Sixty percent of the participants were registered nurses and 51.6% of them were holding a baccalaureate degree in nursing. This reflects the new trend in Palestine, which encourages hospitals to employ



baccalaureate holders. In addition, nurses are eager to continue their education and this has been reflected in the increase in the number of upgrading programs (there are four upgrading programs from diploma to baccalaureate) in Palestine and thus in the growing population of degree nurses. Twenty two point nine percent were holding a Masters degree or higher diploma and 5.2% were medical board certified (specialists). This means that specialty programs should be developed and designed for both nurses and physicians. Three point six percent of the participants were part-timers which may indicate that employers are not considering a part-time employment policy in health care organizations. Fifty one percent of the respondents had 1- 6 years of work experience and only 5.9% had more than 20 years experience in the hospital in which the study was conducted.

#### **6.10 Health care professionals' job satisfaction**

A mean of 69 of a possible 130 on the job satisfaction instrument indicates that health care professionals who participated in the study were not extremely satisfied or extremely dissatisfied. In general, nearly 40% of the participants reported being satisfied in their jobs. Autonomy and integration had the highest mean scores, while job security and working conditions had the lowest mean scores. This is congruent with Herzberg's two-factor theory, which proposes that satisfaction with both motivator factors (such as integration, recognition, autonomy and advancement) and hygiene factors (such as working conditions and organizational policies) are crucial for job satisfaction levels.

These findings are also consistent with previous job satisfaction studies. Several studies documented the importance of autonomy as a determinant of job satisfaction and job retention levels for nurses and physicians (Lichtenstein, 1984; Goodell and Coeling, 1994). There is profound evidence showing that increased autonomy is attributed significantly to job satisfaction (Weisman & Nathanson, 1985; Loher et. al, 1985; McClosky, 1990; Kramer & Schmalenburg, 1991; Cavanagh, 1992; Agho et. al, 1993; Blegen, 1993; Acron et al, 1997; Fung-Kam, 1998). Autonomy is reflected in the amount of professional freedom



permitted to health care professionals upon carrying out their responsibilities. It is worth noting that professional autonomy is the most commonly recognized factor affecting nurses' job satisfaction (Wade, 1999).

" The need for autonomy is a personality trait that could contribute to individual differences and affect job satisfaction" (Fung-Kam, 1998 p.356). A professional's autonomy is influenced by organizational context and structure (empowerment and application) and the individual's belief that he or she possesses the freedom to act (readiness and valuation) (Niedz, 1998). Orientation to work, individualism or collectivism also, influence one's perception of autonomy. "Individualists emphasize values such as autonomy, competitiveness, achievement and self-sufficiency while, in collectivist cultures, values such as interpersonal harmony or group solidarity prevail" (Andrews, 1998, p.31). In meta-analysis, study of the relation of job characteristics to job satisfaction, Loher et. al (1985) found that job autonomy correlated significantly with job satisfaction. Burdi and Baker (1999) indicated that young physicians who perceived themselves as having less freedom to undertake eight common patient-care activities were significantly less satisfied than those who perceived themselves as having freedom. Warren et. al (1998) in their study of the impact of autonomy on set work conditions and to the ability to make clinical decisions, and on physicians' satisfaction, they found that physicians' participation in the Individual Practice Association predicted higher satisfaction.

Professionals, as indicated in this study, exercised some degree of autonomy in performing their roles, which makes them somewhat but not highly satisfied. In a bureaucratic organization where decisions are made at the upper management level, satisfaction level decreases and turnover rates increase (Bushy & Banik, 1991; Matus & Frazer, 1996). Empowering employees to make decisions and solve work place related problems can offer the clients high quality services and outcomes. Consequently, the organization ends up with satisfied customers and lower costs (McGraw, 1992).



There is also ample research findings showing that the feeling of integration with immediate colleagues, other departments and one's own professional group is significantly associated with job satisfaction (McClosky, 1990; Robinson et al., 1993; Blegen, 1993; Decker, 1997; Fung-Kam, 1998; Collins, et al., 2000). Satisfaction comes from collegiality and friendship as well as from respect and cooperation (Ndiwane, 1999). McCloskey (1990) concluded that although, nurses want autonomy, they want to maintain close work relationships at the same time. Whitley and Putzier (1994) argued that nurses continually express the need to work with colleagues (nurses and physicians) who support their work and with whom they are able to form a high level of professional relationships. It is argued that unless organizational structure permits easy communication, interpersonal relationships, and supportive organizational climate, nurses tended to be dissatisfied and not interested in work (Bushy & Banik, 1991; Smith, 1995; Irvine & Evans, 1995; Henderson, 1995; Abu-Hamad, 2001). In other words, coworker cohesion predicted more intent to stay in the job (Schaefer & Moos, 1996). Palestinians are community oriented (collectivistic culture), they value relationships and interaction. Even at work, employees very much appreciate family like interactions. According to Hammad (1989) Palestinian society is a collectivism in which the individual is less important than the community. As a result management accepts decisions based mainly on family relations, friendship or political grounds, rather than on logic, objectivity and scientific methods. Andrews (1998) stated that "in many collectivist cultures, people expect to find satisfaction in job-related relationship, have less clearly delineated boundaries between work and leisure, and focus on the present" (p.31). However, some individuals in Palestine, especially those who are exposed to the Western culture, exhibit a combination of both collectivism and individualism.

The findings of this study regarding job security and working condition support Hashish's (1993) findings, in which 75.5% of nurses working in Al-Makassed hospital were feeling insecure in their jobs and 77.3% were dissatisfied with working conditions. It can be argued that health care



professionals who are dissatisfied with their working conditions might find it difficult to ignore their problems and to deal effectively with those of their clients. Providing the desired working conditions is likely to increase job satisfaction and to promote an organizational climate in which interaction between providers and clients will be more effective (Weisman & Nathanson, 1985).

There is no clear picture in the literature regarding the role of salary on job satisfaction. Salary was weakly associated with job satisfaction (Cavanagh, 1992). In other studies pay was ranked as an important satisfying factor (Zuraikat & McCloskey, 1986; Hammad, 1989; Abu-Ajamieh, 1991; Goodell and Goeling, 1994). On the other hand, Matus and Frazer (1996) reported no statistically significant relationship between salary and job satisfaction. In general nurses and physicians in Palestine are not well paid in the governmental institutions. The status of nurses in terms of pay and equity is still below the desired levels as perceived by Palestinian nurses (Sharkawi, 2000). In cultures experiencing difficult economical conditions, people tend to be more concerned about money for satisfying their basic needs (Al-Ma'aitah, et.al, 1996). In general in the Arab societies, salary is more valued than in the Westren societies because there are no other security means such as retirement, welfare, and social security benefits. In addition, salary could carry a social message as individuals link status to income, which makes it a method of recognition in Palestinian society (Abu-Hamad, 2001).

Regarding the relationships between demographic variables and job satisfaction, the findings of previous studies were varied and inconsistent (Blegen, 1993; Agho et al,1993). Job satisfaction had no relationship to total nursing experience in some studies (Blegen, 1993). Several studies concluded that females are more satisfied than their male counterparts (Acron et al., 1997; Arnetz, 1997; Abu-Hamad, 2001). Al-Ma'aiteh, et. al (1996) found that men were more dissatisfied on a number of variables (such as financial rewards, type of work, career future and trust in management) than women.



The role of education and experience in relation to job satisfaction has been studied extensively. Total experience had no relationship to job satisfaction (Blegen, 1993; Decker, 1997). The level of education slightly and negatively influenced job satisfaction (Cavanagh, 1992; Blegen, 1993). Baccalaureate and higher degree holders in some studies are associated with less satisfaction (Blegen, 1993). This might be explained by: 1) individuals with higher education tend to have increased job opportunities outside their work place, 2) higher qualifications may lead individuals to develop higher expectations of their jobs and 3) highly educated nurses experience gaps between what they know and what they are actually allowed to do.

The literature indicated inconsistent findings concerning age and satisfaction (Matus & Frazer, 1996). Age was positively associated with job satisfaction (Blegen & Mueller, 1987). Burdi & Baker (1999) found that physicians' satisfaction declined with age. However, Freeborn (2001) found that older physicians had higher levels of satisfaction. Older individuals are generally found to have higher levels of job satisfaction, either because they might have more experience that enables them to advance to higher positions within their career ladders or because they have developed their adaptive skills (Weisman & Nathanson, 1985; Decker, 1997). Others found that the correlation between age and job satisfaction was very small (Belgen, 1993).

In this study, one should not conclude that the selected personal and demographic characteristics are not important because they were excluded in the stepwise regression analysis. These variables accounted for 17.2% of the variance in job satisfaction.

Two personality dimensions were included in the study of job satisfaction (positive affectivity and work motivation). Positive affectivity was found to have a significant positive correlation with job satisfaction. This certainly is consistent with the findings of Agho et. al (1993). Those who are happy in their life in general are more likely to be more satisfied with their jobs. Contrary to Agho et. al's (1993) findings, work motivation was found to have a significant negative



correlation with job satisfaction. It seems that those who exhibit high motivation to work and find that their work is actually not stimulating and challenging will become dissatisfied in their jobs. These findings along with Agho et. al's (1993) findings, add to the evidence that individual personality differences, and not only the job characteristics, are important in explaining job satisfaction.

### **6.11 Perceived leadership behavior**

The findings of this study indicated that health professionals in both hospitals do perceive their leaders as demonstrating TF and TA leadership styles. However, the factors associated with TF and TA styles are different from those obtained by Bass (1985a). In this study contingent reward is found to be a component of TF leadership not of TA leadership. This result is congruent with Medley and LaRoche's findings. Medley & LaRoche (1995) explained that in health care professions, it is unusual for an individual to be financially rewarded for outstanding performance unlike business and military services where Bass tested the Multifactor Leadership Questionnaire.

Financial rewarding is not usually practiced in Palestinian health care institutions and this might be due to limited and possibly mal-distributed financial resources. Contingent reward also, is not within the scope of manager's responsibilities in Palestine. Most health care organizations especially in the public sector, have highly centralized structures with little room for managers to practice contingent rewarding.

Health professionals in this study associated only management by exception with TA leadership. This indicates that health professionals view behaviors connected with TA leadership unfavorably in relation to their jobs. This is also consistent with Medley & LaRoche's study of nurses.

Correlation indicated a significant positive relationship between TF leadership behavior of the managers as perceived by health care professionals and health care professionals self-reported job satisfaction. Similar results were reported by previous research (Singer & Singer, 1989; McDaniell & Wolf, 1992;



Medley & LaRoche, 1995; Morrison, et. al., 1997). McNeese-Smith (1993, 1995) found that in each leadership practice (challenging the process, inspiring a shared vision, enabling others to act, modeling the way and encouraging the heart) there was a statistically significant, positive correlation between the managers' scores on the five leadership behaviors as rated by their employees, and employees' scores on job satisfaction. Singer & Singer (1989) found that transformational leadership behavior is associated with higher levels of subordinate satisfaction. Other researchers found a positive correlation between perceived participative management style using Likert's management systems theory and staff nurse satisfaction (Lucas, 1991; Nakata and Saylor, 1994).

Correlation between transactional leadership and job satisfaction was found negative and not significant. This does not correspond with the results reported by Stordeur et. al (2000) who found that two components of transactional style (contingent reward & active management by exception) were positively related to job satisfaction. Passive management by exception, the other component of transactional style is negatively related with job satisfaction (Morrison et. al, 1997; Stordeur et. al, 2000).

This study provided support for the impact of transformational leadership on job satisfaction. Leadership behavior was the critical variable in the stepwise regression model and accounted for 37.5% of the variance in job satisfaction. Transformational leadership explains a significant proportion of variance in job satisfaction, similar to the findings of Stordeur et. al (2000), while transactional style did not contribute significantly to job satisfaction. Storduer et. al found that transactional style accounts for less variance in job satisfaction than transformational leadership.

It seems that transformational leadership is paramount to health care organization because there is a relationship between TF leadership and job satisfaction. In this study the major contributors to the variance in job satisfaction (57.6%) were transformational leadership, socioeconomic, political and work motivation. Gender, education, marital status, professional background,



experience, age, positive affectivity and transactional leadership were excluded by the stepwise regression analysis.

### **6.12 Patient satisfaction**

Approximately half of the interviewed patients were hospitalized for 3 to 6 days. The mean score for patient satisfaction was 131.2 of a possible 185 indicating that patients were not extremely satisfied or extremely dissatisfied. Accessibility, approachability, and qualification and interpersonal relationship had the highest scores. Health teaching and discharge, and finance on the other hand had the lowest mean score.

Health education is very important for complete recovery and health maintenance. Patients' expectations of care and information they receive usually shape their judgement of care (Abramowitz, 1987; Merkouris, 1999). The findings of this study reveal that health education and instructions provided to patients were not adequate. The reasons for this might be that nurses have no time to adequately teach patients and talk to them because non-patient care responsibility are assigned to nurses (Williams, 1998). Moreover, physicians working in hospital settings are occupied with curing patients and rarely practice health teaching.

The patient satisfaction mean score with information sharing was 23.2 of a possible 40. This means a lot should be done in this area. A standard should be established regarding information giving that could be used as a guideline for health professionals. At the same time it could be used as an evaluation tool for performance (Merkouris, 1999). The importance of sharing information and keeping patients well informed and the failure of health professionals to carry out this responsibility has been a major issue in the literature (Walsh and Walsh, 1999). Ways of effectively conveying health information to patients needs to be explored. Arabs have predominantly oral culture, so ways to enhance written instructions and information must be discussed. Bond and Thomas (1991) argue



that adequate information sharing is a necessary condition for patient empowerment.

The mean score for satisfaction with physical environment was 13.4 of a possible 20 indicating that the patients were not quite happy. In addition, patients' comments to open-ended questions indicate that the majority of patients were unhappy with the physical and environmental conditions, mainly cleanliness, ventilation, waiting areas, and visiting times. Patients acknowledge crowdedness and lack of quietness during visiting hours as areas that need improvements. Patients also raised the issue of lack of ventilation and cleanliness especially in toilets. The patient service manager or hospital steward should pay attention to the hotel services. In addition, nurses should check and ensure the quality of these services as part of their professional nursing responsibility (Strasen, 1988).

Patient satisfaction is directly related to patients' intention to return and intention to recommend services to others (Beck & Larrabee, 1996; Abramowitz et. al, 1987). However, in this study the limited choice of available services affects patients' intention to return or their recommending of services to others as mentioned by some of the respondents.

A positive correlation was found between patient satisfaction and satisfaction of health care professionals. This is congruent with findings of previous research (Weisman & Nathanson, 1985; Linn, et. al, 1985). However, this is incongruent with other study findings in which there was no significant correlation between patient satisfaction and provider satisfaction (Goodell, & Coeling, 1994; Anderson & Maloney, 1998). Patient satisfaction is important to health care providers for determining outcomes, retaining a patient base and providing quality care (Anderson & Maloney, 1998).

### **Summary:**

This chapter incorporates interpretation of the study findings in relation to previously conducted studies. A critical analysis of research design,



methodology, tools and procedures are included. Furthermore, it presents health care professionals' characteristics and their job satisfaction and their implication in the Palestinian culture. The staff's perception of leadership behavior was discussed in relation to the Palestinian context and in reference to the international literature. Finally, patient satisfaction findings are discussed with some elaboration on their indications.



## **Chapter Seven**

### **Implications and Conclusions**

#### **Introduction**

In this study, the researcher explored the relationship between perceived leadership behavior, staff's job satisfaction and patient satisfaction in the Palestinian context through using a quantitative correlational design. It is important to elucidate here that this is the first study that investigates the relationship between the three previously mentioned concepts in the Palestinian context. It adds to the understanding of these concepts in a community that exists outside the cultures in which the concepts were originally developed and investigated. Additionally, it could be helpful for managers to better understand the relationship between the concepts in Palestinian and analogous cultures.

Building on the findings of this study which have been analyzed by reference to the international literature, the researcher identified three main themes that incorporate the major contributions in this study. The first theme discusses the contribution of the study to developing body of knowledge. The second theme deals with the implication of the research globally. The last theme is related to the Palestinian health care organizations.

#### **7.1 Contribution of the study to body of knowledge**

This study contributes to the proposition that transformational-transactional leadership model is a global concept which can be applied to different situations. Bass argues that "there is universality in transactional-transformational leadership model and specificity should be considered and understood as a result of certain attributes of cultures" (Bass,1997, p. 130). Singer & Singer (1989) suggest that the preference towards transformational leadership is a common one and not sensitive to situational restraints.

The attention to leadership behavior is crucial to organizations' outcomes. McNeese (1995) concluded that leadership behaviors could significantly



influence employees' outcomes in very different settings and conditions. This study concluded that there is a relationship between leadership behavior, job satisfaction and patient satisfaction. In the literature, it was found that there is a correlation between leadership behavior and effectiveness, commitment, productivity and satisfaction (Morrison et al, 1997; Medley & LaRoche, 1995; McNeese-Smith, 1995; Nakata & Saylor, 1994). Morrison et. al (1997) found that both transformational and transactional leadership behaviors were positively related to job satisfaction. However, transformational leadership appears to have a powerful influence on job satisfaction more than transactional leadership. McDaniel and Wolf (1992) found that transformational leadership is related positively to work satisfaction. Other researchers found that transactional leadership style in the health care context did not positively influence subordinate job satisfaction (Medley & LaRoche, 1995). The findings of this study is consistent with the literature in which TF leadership is positively correlated to health professionals' job satisfaction and TA leadership was not related to job satisfaction. It was inspiring to replicate the importance of the concept of transformational leadership in the Palestinian context. In this study, transformational leadership behavior has a correlation with job satisfaction and accounts for a major element of job satisfaction.

Any society is part of the universe, no society occurs in vacuum. As a subsystem, society is affected by what surrounds it. No society is found in isolation, it is affected by other societies. Globalization of media has facilitated the spread of leadership approaches. Media has its influence on the spread of information and knowledge. However, organizations and cultures have influence on leadership styles demonstrated by managers (Bass, 1997). Participative management, for example cannot be applied as easily in an authoritarian society as in a democratic society. According to Bass (1997) transformational leadership can be democratic and participative or autocratic and directive. 'Knowledge explosion and expansion requires more envisioning, enabling and empowering leadership" (Bass, 1997, p. 131).



The findings of this study support Bass's contention about the universality in the transactional-transformational leadership model. Bass and Avolio (1992) argue that the best leaders demonstrate both transformational and transactional qualities. The transactional-transformational leadership paradigm applies to the management in the Palestinian context with some exception. In this study, contingent reinforcement (reward and punishment) was part of transformational leadership. This can be attributed to lack of financial resources, which are available under the control of managers and supervisors.

Leadership in the Palestinian context includes both transactional-transformational leadership qualities. Transformational leaders are expected to be visionary, charismatic, motivate others to work and achieve their goals at the same time to be able to use contingent reward for followers performance (Bass, 1985a). It is important for top health care managers to use transformational leadership behaviors to establish standards for organizational leadership. It is essential that managers serve as role models, trainers and teachers. Transformational leadership includes idealized influence, intellectual stimulation, inspirational motivation and individualized consideration.

Leaders who are oriented to idealized influence provide their subordinates with vision and sense of mission and gain their respect, trust and confidence (Morrison, Jones & Fuller, 1997). Leaders use their influence to disseminate the mission and vision throughout the organization, so employees believe, adhere and successfully implement organization's mission and goals. Intellectual stimulation is a process whereby the leader enhances the employees' awareness toward organization's challenges from a new inspiring perspective (Dunham-Taylor, 2000). Inspirational leaders engage in confidence building and provide support for followers to perform successfully their tasks and assignment (Bass, 1990b). Individualized consideration entails providing support and encouragement for employees while maintaining a concern for the distinctiveness of the individuals and the groups (Coeling & Cukr, 2000).



The linkage among concepts may strengthen or weaken as one moves from one culture to another. Cultural and organizational situations influence leadership behaviors (Bass, 1990). Cultural values, beliefs and norms affect leader-follower relations. Congruent with the literature, the study concludes that health professionals are satisfied with leaders who demonstrate transformational leadership qualities. McDaniel and Wolf (1992) argued that transformational qualities are more harmonious for professionals whose work requires a high levels of decision making and relative autonomy.

The findings demonstrate the importance of autonomy and integration as factors affecting job satisfaction of health care professionals. Professionals, as indicated in this study, exercised some degree of autonomy in performing their roles which makes them somewhat satisfied. It is worth noting that professional autonomy is the most documented factor affecting nurses' job satisfaction (Wade, 1999). Autonomy is reflected in the amount of professional freedom allowed to health professionals upon carrying out their responsibilities. The findings also support the contention that feeling of integration with colleagues and one's own professional group is associated with job satisfaction. McClosky (1990) concluded that although, nurses value their autonomy, they want to maintain close work relationship with their colleagues at the same time.

Regarding the relationship between selected personal and demographic and environmental variables with job satisfaction, the results of this study along with Agho et. al's (1993) findings, add to the evidence that individual personality differences, and not only the job characteristics are important in explaining job satisfaction. Positive affectivity was found to have a significant positive correlation with job satisfaction while, work motivation had a significant negative correlation. In addition cultural, socioeconomic and political factors were positive and significantly correlated with job satisfaction. However only socioeconomic, political and work motivation account for the variance in job satisfaction.



Job satisfaction in this study is associated with patient satisfaction and this is congruent with findings of previous research (Weisman & Nathanson, 1985 ; Linn, et.al, 1985). Job satisfaction also accounts for a major component of patient satisfaction.

## **7.2 Implication of the research globally**

The study examined the relationship between perceived leadership behavior, health care professionals' job satisfaction and their patients' satisfaction in a culture that is entirely different from the cultures in which leadership theories, satisfaction models and motivation theories were initially developed. Consistent with the international literature, the findings of this study reveal that there is a relationship between leadership behavior, job satisfaction and patient satisfaction.

The study highlights that leadership behavior is a global concept. The leadership style varies according to the situation in the same organization and in the same culture and it does so in the different cultures. Leaders can use democratic, autocratic or a laissez-faire style depending on the situation.

A successful organization needs among other resources, leaders who have concern for organization as well as for the people. It might be argued that the more understanding leaders develop about organizations and about people's behaviors and expectations at work the more they will be capable of managing their organizations effectively (Mullins, 1999). Health care managers globally need to look at their leadership behavior while influencing, supporting, communicating and motivating their employees. Leadership qualities remain a crucial factor in managing the stressful work environment of the health care organizations. Kouzes and Posner's (1988) research on leadership identified strategies such as being supportive, showing interest, caring and providing recognition as important aspects of leaders' behaviors.

The rapid changes and the global reform in the health care organizations, require health care leaders who can apply modern approaches in management.



Today's leader with transformational characteristics is the one who will guide and support people through the unstable healthcare environment. A number of behavioral patterns emerge as key traits for leaders, such as individual consideration, intellectual stimulation, inspirational motivation and idealized influence. Health care leader must show real concern and confidence in each person's ability to perform. Transformational leaders motivate others by encouraging them to be curious and try new ideas and view challenges from a new perspective (Marlow, 1996).

The dramatic and rapid changes occurring in health care present several challenges and opportunities for health care professionals. Thus, the most important task for leaders is acting as a catalyst for empowering staff to make decisions about their work and help them to maximize the use of available resources. Today's leader needs to be responsive, flexible and able to communicate self-esteem, energy and enthusiasm

The findings related to job satisfaction could be useful in other countries and are applicable in other places with varying degrees of strength. The study concludes that many of the factors that enhance health care professionals' satisfaction are almost the same. As a result of their distinctive professional qualities, most health care professionals value significantly their work autonomy, integration, interaction and team work. The concept of autonomy is considered as one of the main traits of any profession. Globally, health care professionals seek independent practice as part of their identity. At the same time, integration and collaboration amongst health care professionals are greatly appreciated by health care professionals. Thus, managerial strategies that take into account the importance of autonomy at work and involvement and interaction are most likely to enhance job satisfaction. To improve health care professionals' job satisfaction, managers are required to work with them toward providing a more trusting and motivating environment. This could be achieved through creation of shared vision, empowerment, participation, networking, and collaboration. Such



approaches can be suitable and helpful to all health care professionals from different cultures.

The findings of this study support the proposition that patient satisfaction is a multidimensional concept. Factors such as communication, respect, continuity of care, accessibility, technical skills, interpersonal relations, choice, physical environment and support services all influence patient satisfaction.

### **7.3 Implication to the Palestinian health care organizations.**

The study is a unique initiative to provide a picture about leadership behavior in the Palestinian health care organizations. Studying leadership behavior and its relationship to job satisfaction and patient satisfaction is vital in a society undergoing a critical historical transitory period, in terms of building, reforming and developing its institutions as the case in Palestine. The study concludes that there is a relationship between TF leadership behavior, job satisfaction and patient satisfaction. The findings of this study are helpful and enlightening in many ways, and have several important implications for policy makers, health care managers at different level and educators of health professionals.

Since transformational (TF) leadership was associated directly with job satisfaction and indirectly with patient satisfaction, leaders and managers should be encouraged to practice and develop TF leadership behaviors. It is imperative that TF leadership prevents turnover and promotes staff retention, a finding with economic implications for management of health care institutions. Job satisfaction is viewed as integral to employees' retention. A plethora of research supports the positive relationship between job satisfaction and staff retention (Kramer & Schmalenburg, 1990; Cavanagh & Coffin, 1992; McDanniel & Wolf, 1992; Borda & Norman, 1997). Job satisfaction is related causally to turnover (Lichtenstein, 1984; Price & Mueller, 1986, 1991; Cavanagh, 1987, 1990, 1992; Irvine & Evans, 1995). Turnover creates instability in the organization and is expensive in terms of labor cost associated with orientation



and training of new employees and in terms of patient satisfaction (Kangas, et. al, 1999). Therefore managers in health care institutions should take a more active leadership role and they should concentrate on the factors that increase job satisfaction. Health care managers should develop more effective integrative strategies by adopting more caring, supportive and sharing environment.

The study provides signals to policy makers and managers about health care professionals' job satisfaction and the possible strategies that could improve it. Policy makers and health care managers should continue to reinforce autonomy and integration and should pay serious attention to working condition, job security, distributive justice, work flexibility, workload, work nature and professionalism. Moreover, health care managers should work on developing a more positive atmosphere in the organizations through enhancing integration and mutual relationship. These strategies can help health care professionals to counterbalance work stresses and help them to meet difficulties associated with the rapid changes, political instabilities and uncertainties in Palestine.

Palestinian community is perceived of being collectivist, valuing group integration, and interaction. Thus managers can make use of such characteristics in developing more effective multidisciplinary working teams. The researcher believes that team concepts should also be endorsed in the curricula for educating health professionals. Utilizing multidisciplinary educational programs can help in bridging the gap amongst health professions. It can also enable them to interact, network and develop professional relationships and teams.

At this stage of Palestinian national development, health care institutions require leaders who help move workers toward self-actualization and inspire them with the vision of what can be achieved. There is a need for leaders who help employees to perform and achieve far beyond work expectations. Accordingly, health care managers who develop modern managerial strategies which take into account peoples' concern are more



capable of tackling employees and organizational issues. TF leadership behavior which include intellectual stimulation, individualized consideration, inspirational motivation and idealized influence could be helpful strategy (Bass,1985).The researcher argues that training sessions to develop managers' abilities to deal with employees and organizational issues, could be fruitful in this regard. Health care organizations need to have clear policies concerning recruitment, selection and training of their managers. Health care managers need to develop their managerial expertise mainly their interpersonal skills so as to be able to motivate their employees. Teamwork also, is one of the areas that need to be emphasized.

In health care organizations, it is crucial to recruit employees who demonstrate transformational qualities and to further develop those qualities. It is also important to create structures that reinforce these qualities. A decentralized environment reinforces transformational qualities such as individual considerations and individual contributions (McDaniel & Wolf, 1992).

Health care organizations in Palestine nowadays are facing major challenges. Scarce resources, increased cost of services and declining revenues are common to the majority of health care organizations. To survive, health care organizations need excellent leadership to be efficient in the use of the limited resources and to be effective in the provision of services to customers. Leaders who have the vision of what can be accomplished effeciently and face challenges, and who have the ability to work with and empower others should be promoted. Joint efforts by employers and universities in providing leadership assessment and training should be encouraged. Training and empowerment of health care leaders together with restructuring of the health care system would bring a significant change in the management of the Palestinian heath care organizations (Abu-Hamad, 2001).

Leadership behavior, such as providing vision, empowerment, showing respect, maintaining equal opportunities, growth challenging are contributing factor to job satisfaction (Dunham-Taylor, 2000; Morrison, Jones & Fuller,



1997). To be effective visionary leaders, Palestinian managers have to work with their employees toward creating an inspired shared vision for their organization (Bass, 1985). Through building a shared vision, expectations of employees and the factors influencing their satisfaction can be endorsed. Thus, the goals of both employees and their organizations will be addressed, consequently, the sense of ownership and commitment to the organizations is increased. The researcher believes that the sense of organizational ownership in Palestine needs to be carefully considered and empowered. Health care professionals need to feel secure and that promotion and rewards are fairly distributed based on productivity and performance. Palestinian institutions have to develop reward systems to incorporate both intrinsic and extrinsic rewarding opportunities. Part of the intrinsic incentive can include rewarding a person with additional exciting assignments, more freedom to pursue work of interest to that person and more involvement in making decisions. The extrinsic motivation could include salary increase and bonuses. Health care managers have to create and maintain an organizational culture that reflect equity, transparency, and openness. This culture improves employees' commitment and satisfaction. Managerial roles need to be enhanced especially in managing their organization's culture which reflects concern both for people and organizations (Henderson, 1995).

Based on the results of this study, health care professionals' autonomy ought to be built on by developing and implementing shared governance practices. Shared governance practices enhance participation in decision making process and autonomous performance. Integrating work empowerment strategies, such as access to information, feedback, guidance, and resources would support the implementation of a shared governance philosophy (Keenan, 1998). Therefore, a managerial approach that supports autonomy and set the stage for professionals to control decisions related to their work will enhance staff's job satisfaction. Employees should be allowed to participate in decisions pertinent to their work. Moreover, health



professionals' educational institutions need to consider the concept of autonomy from the beginning by setting more liberal strategies that improve professional autonomy (Moloney, 1992). This concept should be integrated in designing, implementing and evaluating its curricula.

The results of this study could be used in understanding the patients' views, which are essential if services are to be developed or improved. It could be used also if new services are planned or to be changed. Patient satisfaction surveys should be encouraged to gain knowledge about patients' values and expectations and to evaluate the quality of services. It is expected that changes in the health care system in Palestine will continue to evolve and it will go hand by hand with the national development, so it is important to survey consumers with regard to their satisfaction. Dissemination of results to health care leaders and providers may assist in developing strategies for the future of health care.

Quality improvement Programs should be designed based on the results of the study and include the followings:1) Developing or reorganizing patients discharge plans and instructions for better and easier understanding 2) Changes in housekeeping and cleaning of patients' areas especially bathrooms 3) Introducing improvement in the physical and environmental conditions of the hospitals. Patient satisfaction is considered a valid indicator of the quality of care (Merkouris, et.al, 1999).

Health care managers should place an increased emphasis on both employee and patient perceptions of satisfaction when developing the organizations' strategic plans. When health care professionals are satisfied with their work, their performance can be improved and their interpersonal relationship with patients are more likely to be effective (Healy & Mackay, 1999).

Formal and continuing education programs for both nurses and physicians should address essential leadership training where curiosity and critical thinking are encouraged. Quality improvement, team building, and



project development are the main areas for training. Management skills should not be learned only by trial and error.

This study contributes to providing useful information about perceived leadership behavior, leaders characteristics, demographic and personal qualities of health care professionals and their job satisfaction. This study also reveals the value of leadership behaviors to job satisfaction of health professionals and their patient satisfaction in the Palestinian culture.

### **Recommendations for Future research**

Clearly, this is a topic in need of further research. The generalizability and significance of any finding never comes from a single study. It is valuable taking into account the limitation of this study and to overcome them through investigating larger samples and different design. Hospitals from the south of West Bank and Gaza Strip can be included. A larger sample and a more controlled design might lead to more concrete conclusions. The followings are some of the areas that needs to be studied:

- Further exploration of the relationship between leadership behavior, job satisfaction and patient satisfaction using a larger size sample (30-40 units) is recommended. However, the cost of doing such research may be prohibitive.
- It is worthwhile to conduct this study in the primary health care settings especially at this stage of reforming and development of the health care system in Palestine.
- It would be helpful if a similar study is replicated using longitudinal research design.
- It is obvious that studies should be conducted to cover job satisfaction, burnout, and turnover intentions.
- There is need for further investigations into the relationship between personality characteristics (work motivation and positive affectivity) and job satisfaction.



- Future studies might address the relationship between health care professionals' satisfaction and quality of health care indicators, beside patient satisfaction, such as client compliance with treatment, patient (client) marketing and mortality and morbidity data.
- Replication of the study and adding variables identified as important in the literature that could increase the variance in job satisfaction and patient satisfaction such as life satisfaction in general and type of clinical service.
- Follow up and continuous assessment of job satisfaction and turnover intentions.
  - Future studies must evaluate the advantages and challenges of developing, promoting and implementing transformational leadership behavior to meet the continuous and rapid changes in the health care environment.
- TF leadership could be studied in relation to outcomes such as leadership effectiveness, innovativeness and quality improvement.
- Replication of the study after three to five years, especially after the transitory period, when Palestine is liberated and the building, reforming and developing of the Palestinian health care organizations and system are established.

## **Conclusions**

This study provided data obtained from health care professionals and patients from two hospitals in Palestine, one governmental and the other non-governmental. Findings of this study are instructive in several aspects. Results of this study have important implications for managers and administrators of health care organizations. Overall, this study has made five important contributions.

1. The findings suggest that emphasis should be placed on transformational leadership behavior in preparing health care managers and leaders. It is important for top health care managers to use transformational leadership behaviors to establish standards for organizational leadership.



2. Results of this study show that in order to understand employees' job satisfaction, the researcher must examine carefully the effects of environmental factors, job characteristics, leadership behavior and personality dimensions.

3. The results add strength to the claim that individual employees should have autonomy over their work to be satisfied and productive. Nurses and physicians, along with administrators and hospitals boards should be involved in decision making related to the quality of services, patient care and safety and future development plans. Employees must also feel well integrated with their immediate colleagues.

It is recommended that management enhance autonomy of staff members by allowing them freedom to exercise their skills, and carry out their responsibilities without undue supervision, monitoring and control. At the same time they should promote a sense of appreciation and cooperation. Since nurses are the major health care providers, attention to this group is crucial if improvements in health care is to occur.

4. Patient satisfaction is a multidimensional concept. Factor such as: interpersonal relationship, accessibility, continuity of care, health teaching, approachability, information sharing, physical environment and finance, all influence patient satisfaction.

5. This study provided an opportunity to test the psychometric properties of three instruments (MLQ-5x, Job satisfaction Questionnaire, and Patient satisfaction Questionnaire) in the Palestinian culture. Thus, these instruments could be used in future studies in Palestine and in other analogous cultures

### **Summary:**

This chapter integrates implications and recommendations based on the study findings. The researcher acknowledged three main themes that incorporate the major contributions in this study. The first theme is related to the Palestinian health care organizations. The second theme deals with the implication of the



research globally. The last theme discusses the contribution of the study to developing body of knowledge.



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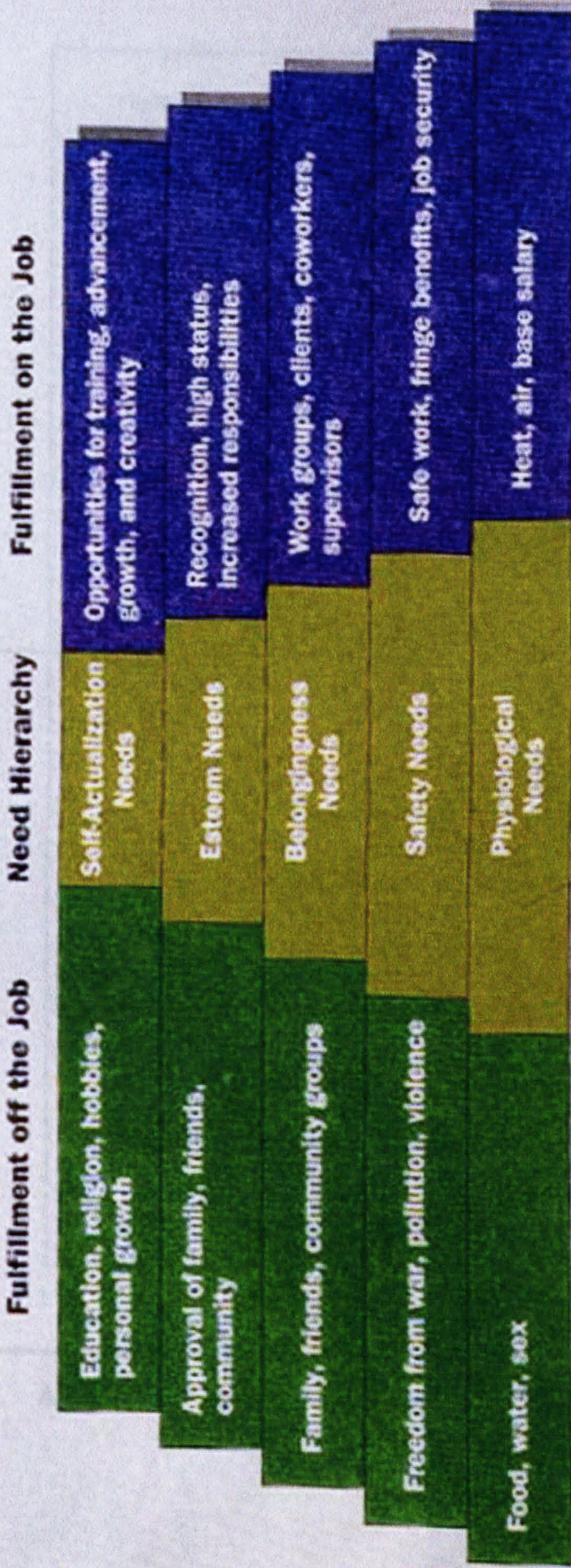


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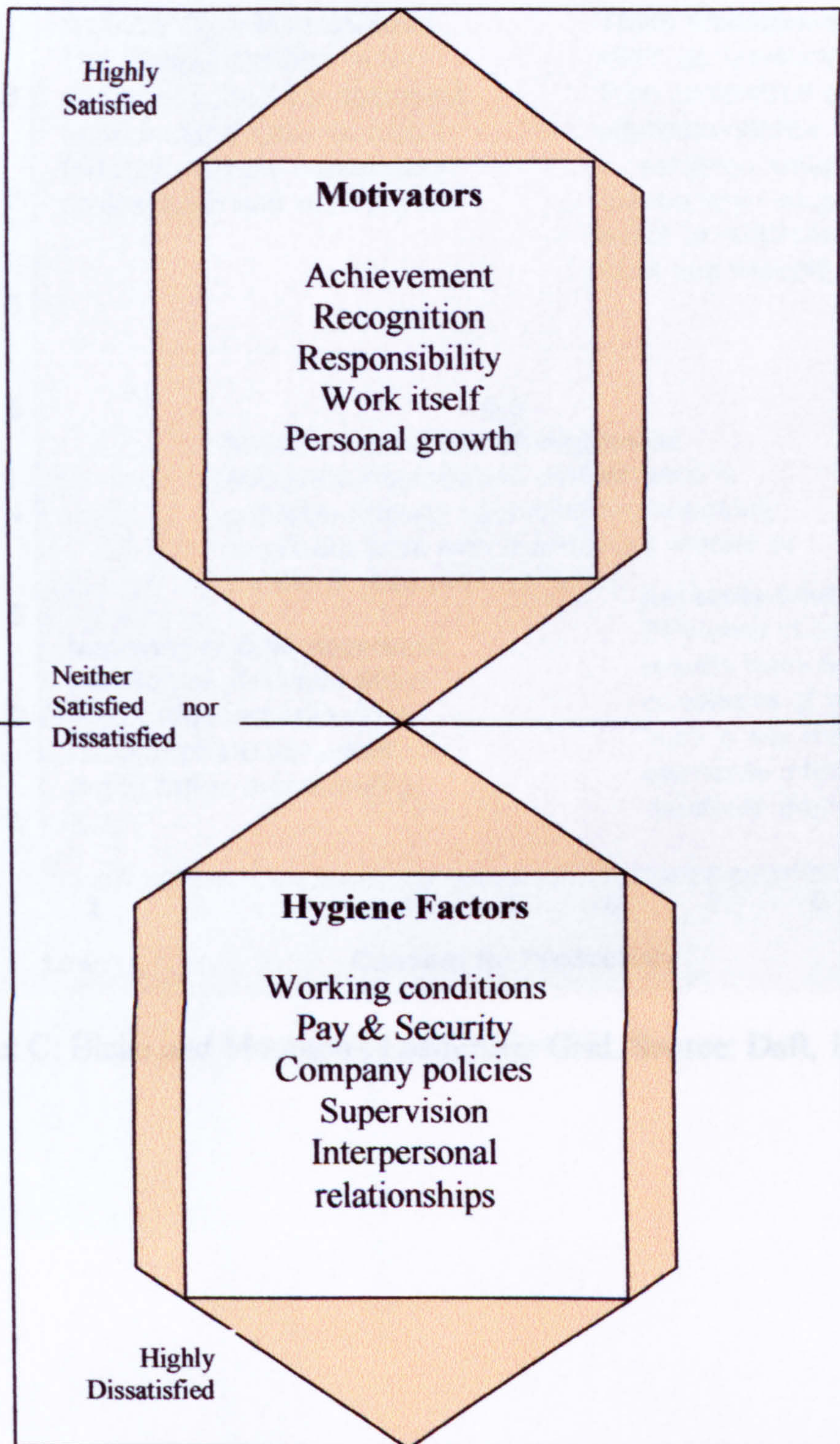


## Maslow's Hierarchy of Needs



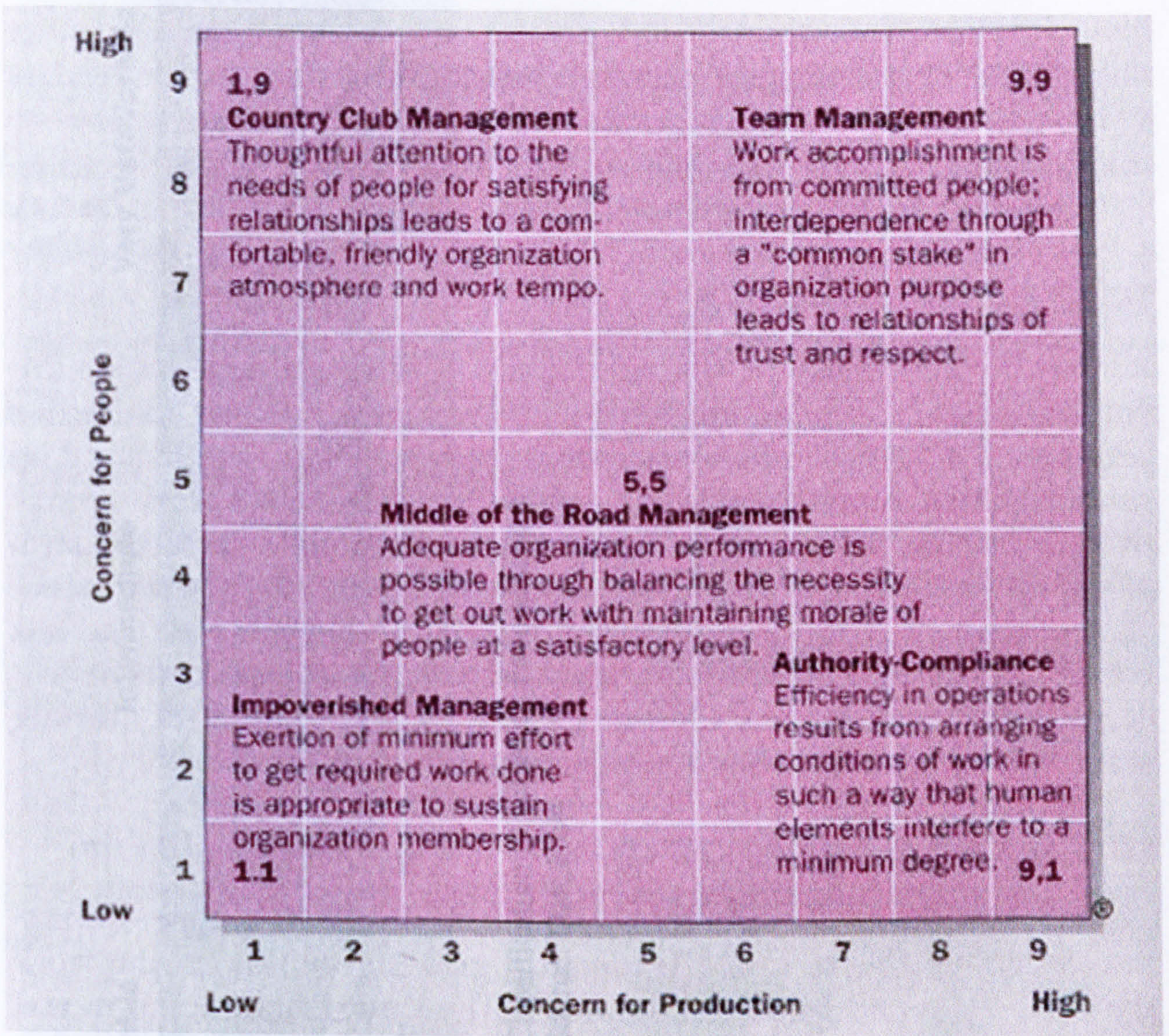
Appendix A: Maslow's Hierarchy of Needs. Source: Daft, 1994.





**Appendix B: Herzberg's Two-Factor Theory Adapted from Daft, 1994**





Appendix C: Blake and Mouton's Leadership Grid. Source: Daft, 1994.



### Fiedler's Classification of Situation Favorableness

	Very Favorable		Intermediate				Very Unfavorable	
	I	II	III	IV	V	VI	VII	VIII
Leader-Member Relations	Good	Good	Good	Good	Poor	Poor	Poor	Poor
Task Structure	High	High	Low	Low	High	High	Low	Low
Leader Position Power	Strong	Weak	Strong	Weak	Strong	Weak	Strong	Weak

Appendix D: Fiedler's Classification of Situation Favorableness.  
Source: Daft, 1994.



Situation		Leader Behavior		Impact on Follower		Outcome
Follower lacks self-confidence	⇒	Supportive leadership	⇒	Increase confidence to achieve work outcome	→	More effort; Improved satisfaction and performance
Ambiguous job	⇒	Directive leadership	⇒	Clarify path to reward	→	More effort; Improved satisfaction and performance
Lack of job challenge	⇒	Achievement oriented leadership -	⇒	Set high goals	→	More effort; Improved satisfaction and performance
Incorrect reward	⇒	Participative leadership	⇒	Clarify follower's needs and change reward	→	More effort; Improved satisfaction and performance

Appendix E: Path-Goal Situations and Preferred Leader Behaviors. Adapted from Daft, 1994.



## Appendix F

### Job Satisfaction Questionnaire

Dear Sir / Madam,

I am a PhD student, currently undertaking my research project. The main concern of my research is the issue of job satisfaction and patient satisfaction as a way of exploring management culture at two local hospitals: Makassed, and Ramallah.

It is very important that you fill in the questionnaire as carefully as possible. It will take you 10-15 minutes to fill in the questionnaire. Instructions for completing the questionnaire are contained in the following pages. When you have completed it, please put it in the box provided, in the reception area in your hospital within ten days.

I would like to assure you that the information you give in the questionnaire will be treated with total confidence and will only be used for research purposes. You are, therefore, not required to put your name on the questionnaire.

Completion of the questionnaire is entirely voluntary. Participation or non-participation in the study will not affect your status in any way.

Your cooperation in completing this questionnaire is greatly appreciated. If you have any question about the study, please contact the undersigned at 6272776 or 2955610.

Thank you for your cooperation

Yours faithfully,  
Asma Imam



**Part I: Demographic and personality variables.**

Please answer the following questions by putting X in the space provided.

1. Gender

----- A. Female      ----- b. Male

2. Marital status

----- A. Single                      ----- b. Married      ----- c. Divorced  
----- D. Separated                      ----- e. Widowed

3. Age

----- A. 20 or below                      ----- b. 21-30                      ----- c. 31-40  
----- D. 41-50                      ----- e. 51-60                      ----- f. Over 60

4. Academic background (highest degree attained)

----- A. Diploma                      ----- b. Baccalaureate degree  
----- C. Higher diploma                      ----- d. Master's degree  
----- e. Other, please specify -----

5. Professional background

----- a. Practical nurse      ----- b. Registered nurse  
----- c. Resident (Physician)      ----- d. Specialist  
----- e. Other please specify -----

6. Area of work

----- 1. Medical department  
----- 2. Surgical department  
----- 3. Obstetric /gynecology department  
----- 4. Orthopedic department  
----- 5. I.C.U.  
----- 6. C.C.U.  
----- 7. Others, please specify -----

7. Number of years of work in this hospital.

----- a. 6-11 months                      ----- b. 1-3 years                      ----- c. 4-6 years  
----- d. 7-10 years                      ----- e. 11-20 years  
----- f. Over 20 years

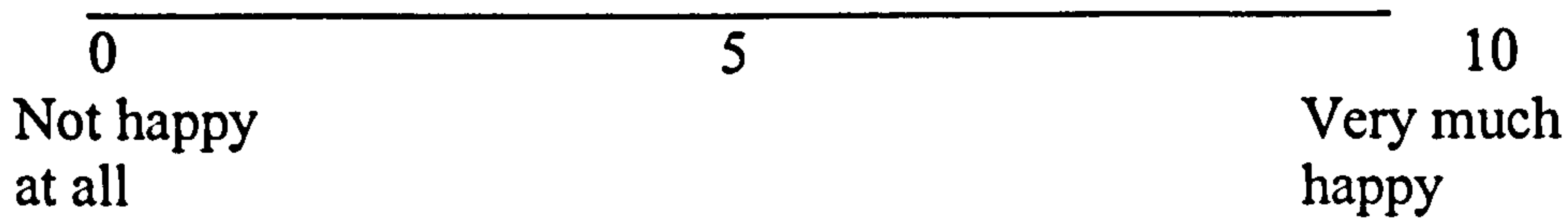
8. Your work in this hospital

----- a. Full-time                      ----- b. Part-time

9. Your feeling about work in general

----- a. Extremely important part of my life  
----- b. Important part in my life  
----- c. Not sure about its importance  
----- d. Somehow important part in my life  
----- e. Not at all important

10. In a continuum from 0-10 how happy do you feel in your life?



**Part II : Satisfaction.**

**A. General satisfaction**

Please consider the following aspects of your life at the present moment and indicate how satisfied you feel .

Item	Strongly satisfied	Satisfied	Uncertain	Dissatisfied	Strongly dissatisfied
11. The house or flat you live in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The region that you live in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Your standard of living, the things you can buy and do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. The way you spend your leisure time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Your present state of health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. The education you have received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. What you are accomplishing in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. What the future seems to hold for you.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Your social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Your family life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. The present political situation in Palestine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Freedom and democracy in Palestine today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. The state of law and order in Palestine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. The cultural values in Palestine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Status of women in Palestine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. The way women are treated in Palestine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. The way individuals are selected for jobs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. The way individuals are hired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. The way individuals are promoted to higher positions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Your work opportunities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Your professional growth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Taking all things together, how would you say things are these days? Would you say you are :

- a. Very happy
- b. Fairly happy
- c. Not too happy
- d. Not at all happy



## B. Job Satisfaction

Please consider the following aspects of your present job and indicate how satisfied you feel.

Item	Strongly satisfied	Satisfied	Uncertain	Dissatisfied	Strongly dissatisfied
33. The freedom to choose your own method of working.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. The amount of responsibility you are given.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Your opportunity to use your abilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. The opportunities to make your own decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Your inputs into decision that affect your practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Your ability to set the pace of your own work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Initiating changes in the way work is done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. The chance to do different things from time to time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. The freedom to use your own judgement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. The chances of promotion in your work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Your chances of promotion as compared with your colleagues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. The recognition you get for good work as compared to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Your rate of pay as compared to your colleagues who are at the same level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. The way performance appraisal is conducted at your employment site.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. The way reward is distributed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. The amount of variety in your job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. The feeling of doing something which is really worthwhile.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Achieving something that you personally value.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. The input you have into major organizational decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. The work you do is appreciated by administration and your colleagues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. The chance to be "somebody" in the community as a result of your job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Item	Strongly satisfied	Satisfied	Uncertain	Dissatisfied	Strongly dissatisfied
54. Relationship with your fellow workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. The way your coworkers get along with each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Relationship between management and workers in your unit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Group participation in the unit activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Discussion of work problems with coworkers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Appreciation among staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Your rate of pay.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. Your pay compared to the amount of work you do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Your expectations for salary increase.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. The way your unit is managed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. The competence of your superior in making decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. The way the hospital is managed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66. The attention paid to suggestions you make.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. The kind of communication you receive from your immediate superior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. Your immediate superiors appreciation for your work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. The way hospital policies are communicated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. The recognition you get for good work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71. The opportunity to learn new things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72. The opportunity to have challenging work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73. Extending your range of abilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
74. The opportunities for professional growth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75. The feeling of accomplishment you get from the job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76. The level of security you feel in the job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
77. Your feeling about compensation, health insurance and fringe benefits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
78. Your feeling about working conditions in the hospital.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
79. Your feeling about work environment in the hospital.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
80. Your work load in general.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
81. Time available for you to conduct research.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	<b>Item</b>	<b>Strongly satisfied</b>	<b>satisfied</b>	<b>Uncertain</b>	<b>Dissatisfied</b>	<b>Strongly dissatisfied</b>
82.	Time available for your own professional growth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
83.	Your feeling about patient demands, and work load.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
84	Overall how satisfied are you with your current job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Appendix G

### Patient satisfaction questionnaire

#### Instruction for the interviewer:

1. Introduce your self to the patient and inform him/her about the purpose of the study.
2. Assure the patient that his or her answers are confidential and will be used for research purposes only.
3. Explain to the patient that the interview will take 15-20 minutes and if he/she feels uncomfortable he/she can ask to stop the interview.
4. Inform patient that his/her participation is entirely voluntary and participation or non-participation in this study will not affect the treatment and care he/she might need in the future.
5. Assure patient that we are only interested in his/her opinion or impressions. There are no right or wrong answers.
6. Explain to the patient that these statements are pertinent to his/her recent stay at the hospital.
7. Inform patient that for each statement, there are five choices and the patient should indicate the choice which best describes his/her level of satisfaction. The choices are strongly agree, agree, uncertain, disagree, and strongly disagree.
8. Ask the patient to share any comments' either good or bad, about the services he/she received during his/her stay in the hospital.

Asma Imam, 1999



Department : \_\_\_\_\_  
 Patient's age: \_\_\_\_\_  
 Patient's sex: \_\_\_\_\_  
 Patient's years of  
 education in school and  
 universities : \_\_\_\_\_

**Items related to admission procedure:**

	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree	Comments
1. It took me a long time when I arrived at the hospital until I was taken to my room.	1	2	3	4	5	
<b>Items related to doctors</b>						
2. Doctors let me tell them everything that I think is important.	5	4	3	2	1	
3. I hardly ever see the same doctor during my stay in the hospital.	1	2	3	4	5	
4. Doctors are thorough when examining me.	5	4	3	2	1	
5. Doctors act like they are doing their patients a favor by treating them.	1	2	3	4	5	
6. Doctors tell their patient what to expect during treatment.	5	4	3	2	1	
7. If I have a medical question, I can ask my doctor for help without any problem.	5	4	3	2	1	
8. Doctors in this hospital treat their patients with respect.	5	4	3	2	1	
9. Doctors explain the patient's medical problem to him/her.	5	4	3	2	1	
10. Doctors are as thorough as they should be.	5	4	3	2	1	
11. Doctors make the patient feel foolish.	1	2	3	4	5	
12. Doctors explain the side effects of the medicine they prescribe.	5	4	3	2	1	
13. Doctors do care if their patients are worried.	5	4	3	2	1	
14. Doctors respect their patient's feelings.	5	4	3	2	1	
15. Doctors explain to patients why they order lab tests, x-ray and certain treatment.	5	4	3	2	1	
<b><u>Items related to nurses</u></b>						
16. Nurses do their best to keep the patient from worrying.	5	4	3	2	1	
17. Nurses advise patients about ways to avoid illness or injury.	5	4	3	2	1	
18. The care I have received from nurses during my stay in the hospital is just about perfect.	5	4	3	2	1	
19. Nurses do care if patients worry.	5	4	3	2	1	
20. Nurses explain to the patients about treatment.	5	4	3	2	1	
21. Nurses check patients to see how they are doing.	5	4	3	2	1	
22. Nurses let me tell them everything that I think is important.	5	4	3	2	1	
23. Nurses answer call lights very quickly.	5	4	3	2	1	



		Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree	Comments
24.	Nurses act like they are doing patients a favor in taking care of them.	1	2	3	4	5	
25.	If I have a question, I can ask nurses for help without any problem.	5	4	3	2	1	
26.	Nurses in this hospital treat patients with respect.	5	4	3	2	1	
27.	Nurses give treatment and nursing care (eating, bathing, dressing, getting into chair) quickly when asked.	5	4	3	2	1	
28.	Nurses told next shift what was happening with my care.	5	4	3	2	1	
	<u>Items related to other hospital staff (laboratory, x-ray, food service, physical therapy... etc)</u>						
29.	Hospital staff work well together .	5	4	3	2	1	
30.	All hospitals workers make sure privacy is respected.	5	4	3	2	1	
31.	I trust the skills and abilities of hospital workers.	5	4	3	2	1	
32.	Hospital workers explain to me what they are doing when taking care of me.	5	4	3	2	1	
33.	Hospital staff treat patient with respect and kindness.	5	4	3	2	1	
34.	Hospital staff explain to patients what they are doing when taking care of them.	5	4	3	2	1	
35.	Hospital staff do care if patients worry.	5	4	3	2	1	
	<u>Items related to your daily care</u>						
36.	Hospital workers are polite, helpful, respectful, and are there when needed.	5	4	3	2	1	
37.	My special needs and desires are taken care of .	5	4	3	2	1	
38.	Food is of good quality and is served at the right temperature	5	4	3	2	1	
39.	I am treated in a kind , caring, and friendly way.	5	4	3	2	1	
	<u>Items related to hospital environment</u>						
40.	My room is clean, and is quiet.	5	4	3	2	1	
41.	The telephone, lights, bed controls, and call button work and are easy to reach.	5	4	3	2	1	
42.	Signs and directions are easy to follow	5	4	3	2	1	
	<u>Items related to your family</u>						
43.	My family and visitors are treated in a kind, caring, and friendly way.	5	4	3	2	1	
44.	My family has a nice waiting area.	5	4	3	2	1	



		Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree	Comments
45.	Visiting times are good for your family	5	4	3	2	1	
46.	The people you wanted to know about your status are kept up-to-date while you are in the hospital;	5	4	3	2	1	
	<b><u>Items related to patient education</u></b>						
47.	Tests, treatments, diet, use of equipment, and medications are explained in a way you can understand.	5	4	3	2	1	
48.	Results of tests, treatments, medications, and procedures are explained in a way you can understand .	5	4	3	2	1	
	<b><u>Items related to preparation for discharge</u></b>						
49.	Discharge instructions are clear and complete	5	4	3	2	1	
50.	Information is provided about possible problems to watch for after you go home	5	4	3	2	1	
51.	You could understand the instructions the hospital gave you when planning for discharge	5	4	3	2	1	
52.	Referrals to community services and / or your private doctor are made if needed.	5	4	3	2	1	
	<b><u>Items related to your bill</u></b>						
53.	Your hospital bill is received right away, is correct, and is easy to understand	5	4	3	2	1	
54.	The amount charged for medical care and hospital services is reasonable.	5	4	3	2	1	
55.	Medical insurance coverage should pay for more expenses than it does.	5	4	3	2	1	
	<b>Overall Satisfaction</b>						
56.	I am very satisfied with the care I received in this hospital.	5	4	3	2	1	

**General Information**

57. Will you return to this hospital again?  Yes  No.
58. Will you recommend this hospital to others?  Yes  No.

59. If you could change one thing about your stay, what would it be?

Describe : -----  
-----  
-----



60. Did anything happen, good or bad, that you had not expected?  
Describe : -----  
-----  
-----
61. How have you gotten better as a result of your stay at this Hospital?  
Describe: -----  
-----  
-----
62. Was there any time when you felt your condition was discussed with  
someone you did not want to have that information discussed with.  
If yes, explain: -----  
-----  
-----
63. Have you been a patient at this hospital over the past year ?  
If yes, how many times? -----  
-----  
-----
64. Why were you admitted to the hospital?  
-----  
-----  
-----
65. How long were you in the hospital this time?  
-----  
-----  
-----
66. In what region do you live?  
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1690 Woodside Road, Suite 202 Redwood City, CA 94061  
650-261-3500 fax 650-261-3505 www.mindgarden.com

Asma Zahra  
PO Box 51 671  
Jerusalem, Via Israel Israel

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Invoice Number: 11906

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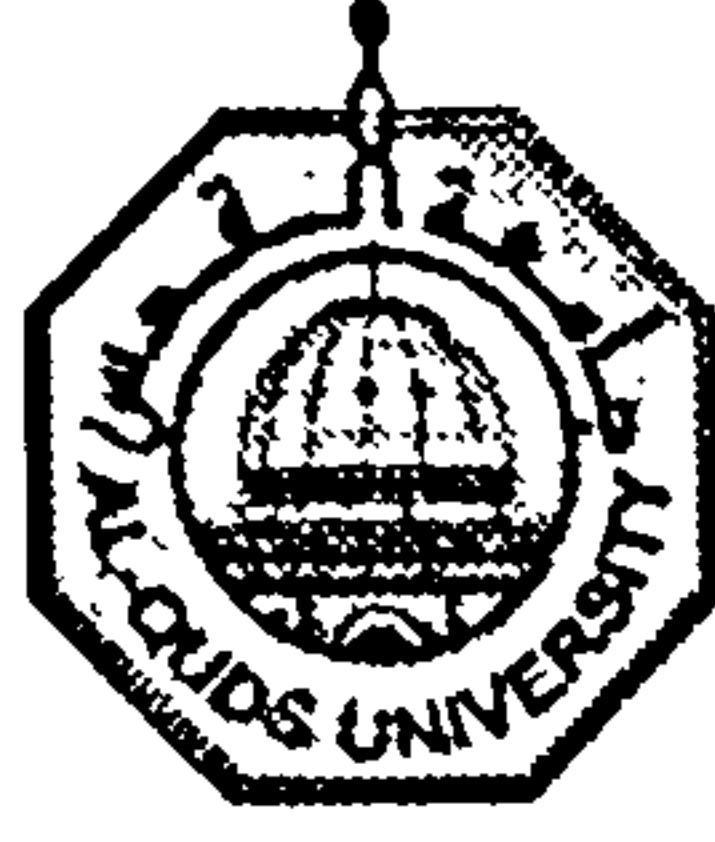
MIND GARDEN, INC.  
By Anne Tucker  
Anne Tucker - Director  
Date August 30, 1999

I AGREE TO THE ABOVE CONDITIONS  
By Asma Zahra  
Asma Zahra  
Date 17th August 1999



بسم الله الرحمن الرحيم

**Al-Quds University**  
**Office of Research**  
**Jerusalem**



**جامعة القدس**  
**مماحة البحث العلمي**  
**القدس**

التاريخ: ١٩٩٨/٩/٣٠

**Ms. Asma Imam-Zahra**

I would like to inform you that the committee has discussed your application about:

السيدة: أسمى الإمام - زهره

نفيد سيادتكم علما بأن اللجنة قد ناقشت طلبكم حول موضوع:

**Testing the relationship between staff satisfaction and patient satisfaction as a way of exploring the management culture.**

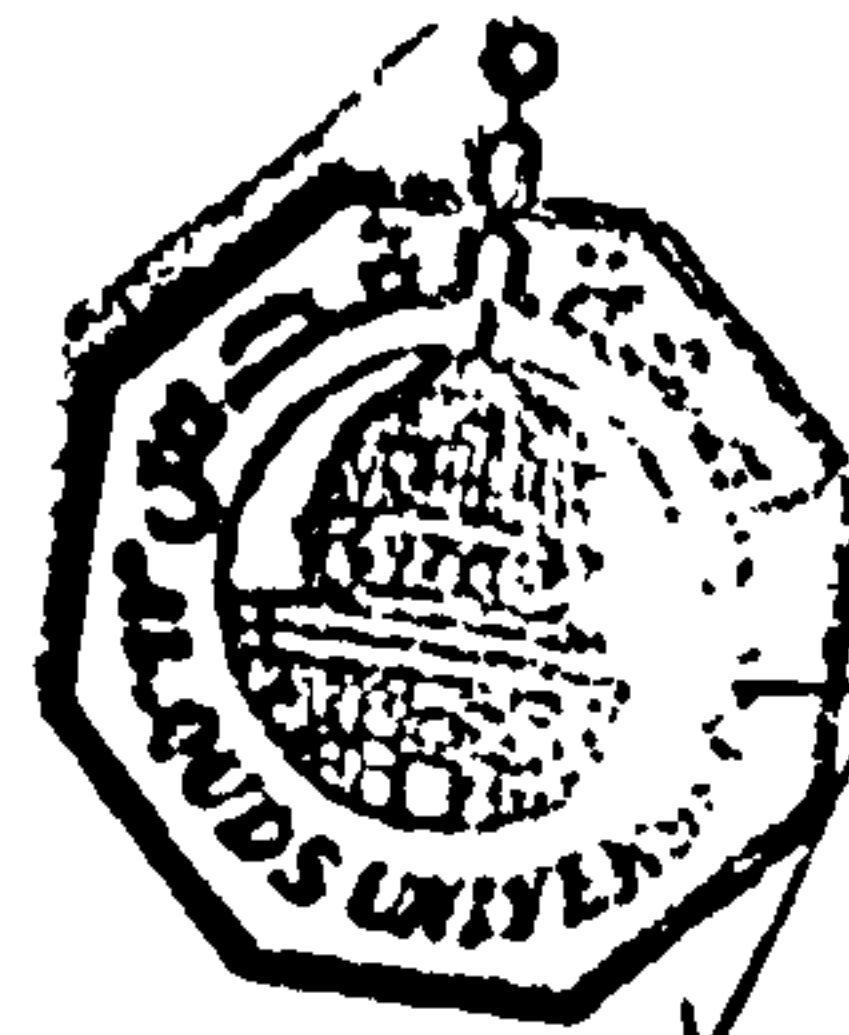
اختبار العلاقة ما بين رضا الموظفين ورضا المرضى كوسيلة لإيضاح الجو الإداري

**On its meeting on September 1998  
And decided the following  
Approval of the project**

في جلستها المنعقدة بتاريخ أيلول ١٩٩٨  
وقد تم الاتفاق على:  
الموافقة على البحث المذكور أعلاه

د. زياد عابدين

رئيس اللجنة



التوقيع:

**Administration Office**  
8 Nur Al- Din St. P.O.Box 51000  
Jerusalem  
Tel: 6274979,6274980, 6261490  
Fax: 6277166  
zabdeen@planet.edu

الإدارة العامة  
٨ شارع نور الدين. ص.ب ٥١٠٠٠ للقدس  
تلفون: ٦٢٦١٤٩٠، ٦٢٧٤٩٧٩، ٦٢٧٤٩٨٠  
فاكس: ٦٢٧٧١٦٦



Palestinian National  
Authority  
Ministry of Health  
General Hospital Directorate  
Nablus  
Tel/Fax : 09-384740  
384773-384774-385956  
P.O : 14



السلطة الوطنية الفلسطينية  
وزارة الصحة  
الإدارة العامة للمستشفيات في  
محافظة الضفة الغربية / نابلس  
تلفاكس : ٠٩-٣٨٤٩٥٦  
٣٨٤٧٧٣-٣٨٤٧٧٤-٣٨٤٧٤٠ / ص.ب : ١٤



الرقم : د / ١١ / ٥٢٠  
التاريخ : ٢١-٨-٩٩

الأخ مدير مستشفى رام الله المحترم

تحية طيبة وبعد :

الموضوع : اسوي الامام

يرجى من حضرتكم تسهيل مهمة المذكوره اعلاه في عمل دراسته في الاقسام  
التاليه : الجراحه العامه ، اقسام العنايه المكثفه ، الباطني ، امراض النساء .

راجياً تعاونكم معنا .

مع الاحترام ،

الدكتور موسى أبو ذويب  
مدير عام الاداره العامه للمستشفيات

سنة / الاضد اسم الامام المحترم



MAKASSED ISLAMIC  
CHARITABLE HOSPITAL,  
MOUNT OF OLIVES  
Jerusalem

P.O.Box: 19482  
Tel.: 02-6270222  
Fax: 02-6288392



مستشفى  
جمعية المقاصد الخيرية الإسلامية  
القدس

ص.ب. ١٩٤٨٢  
تلفون: ٠٢-٦٢٧٠٢٢٢  
فاكس: ٠٢-٦٢٨٨٣٩٢

Rif.No. ....  
Date: .....

٣٢٩/٩/٥

٧ آب ١٩٩٩

رقم الشارة  
التاريخ:

حضرة السيدة أسمى الإمام المحترمة ،  
كلية المهن الصحية ،  
البييرة  
فاكس : ٢٩٥٧٠٧٢

تحية طيبة وبعد ،

بالإشارة إلى رسالتك المؤرخة ٣ آب ١٩٩٩ بخصوص طلبك لإجراء دراسة في المستشفى  
حول "العلاقة ما بين الرضى الوظيفي ورضى المرضى من العناية المقدمة لهم" .

فإنه لا مانع لدى إدارة المستشفى من منحك هذه الفرصة لإجراء البحث على أن يتم تزويدنا  
بنسخة عن الدراسة .

وتفضلوا بقبول فائق الاحترام ،

الدكتور سالم أبو رميله  
المدير الطبي

نسخة : رئيس قسم التمريض

الواردة ١٤/١٠/١٩٩٩  
الكاتب: ١٩/١٠/١٩٩٩

نموذج رقم ٧٢٠٢١٩٠