COVER PAGE AND DECLARATION

	Master of Business Administration (M.B.A.)
Specialisation:	MBA in Healthcare Management
Affiliated Center:	CEO BUSINESS SCHOOL
Module Code & Module Title:	MGT560: Leading Organisation
Student's Full Name:	SAHAR RABEH HASSANI
Student ID:	EIU2023216
Word Count:	3866
Date of Submission:	16-10-2025

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E-SIGNATURE: SAHAR RABEH

DATE: 16-10-2025

MGT560: Leading Organisation
Module Assignment: Leadership Critique

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1. Introduction

Leadership shapes the fate of healthcare organisations. It touches the daily experience of every patient and the performance of every nurse, doctor, and technician. Hospitals, more than most workplaces, sit in a swirl of emergencies, tough choices, and the constant pull between clinical duty and administrative order. In such a setting, leading is not just about setting targets or making rules. It means building a space where teamwork can bloom, ideas can surface, and every person feels answerable for results. When leadership works well in healthcare, daily routines run smoothly, yet the organisation also stays ready for long term growth in a world that never stops shifting. This assignment studies the leadership habits of FutureCare Hospital, a made up yet believable medical centre in Cairo, Egypt. FutureCare stands as a modern facility pushing to enrich its culture even as it spots gaps in its current style of leadership. The management team has decided it must leave behind old patterns and choose an approach that fits the twenty first century, especially in how it speaks, innovates, and taps into networks. As care becomes more digital and more centred on the patient, those who lead must change with it. Staying static is not an option, and the hospital recognises that fact. The purpose of this report has three clear parts. First, it will set out the present leadership actions at FutureCare, showing how senior managers steer the organisation. Second, it will judge those actions, looking at what works, what fails, and how each part affects results, staff spirit, and outcomes for patients. Third, it will offer a fresh leadership plan built to renew the hospital's culture and its processes. This new plan will draw on transformational and servant ideas, and it will point to stronger digital communication and wiser use of the networks already in place. The assignment also answers a question raised by the board of directors. They ask how leadership might be reshaped so that departments talk to one another better and both informal and formal networks are used to their full power. The worry echoes a wider trend in global healthcare, where success is judged not just by ticking boxes but by the leader's skill to inspire, to lift morale, and to shape agile systems able to bend with fresh needs.

By weaving in advanced tools, giving voice to staff, and channeling networks with more skill, leaders can grow a spirit of sharing that helps employees and patients alike. The weight of this critique rests on its direct effect in real life. Inside a hospital, each leadership choice touches lives, so any plan must be both sound in theory and tuned to the local scene. A strict top down style might work in a code blue, yet over time it can choke new ideas and drain morale. In the same way, weak communication paths can build walls that stop teams from working together, and those walls feed waste that finally harms patients. This report therefore lays out a road map for FutureCare to move from a classic stance toward one that is open, inclusive, and rich in technology. In short, this introduction opens the door to a deep dive into the leadership story of FutureCare. By first mapping what it does now, then critiquing it, and at last pointing forward, the report aims to give wide ranging advice for building a strong, creative, and patient centred hospital fit for the twenty first century. The lessons set out here may guide not only FutureCare but any healthcare body that hopes to refresh its leadership in a world that grows more complex and more digital each day.

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2. Organisational Overview: FutureCare Hospital

FutureCare Hospital (FCH)

is a mid-sized private hospital that opened its doors in 2005 in Cairo, Egypt. The founders sought to close the gap between classic hospital design and the swiftly changing scene of modern health care. Through steady effort the institution has carved out a regional place in specialised practice, giving top weight to cardiology, oncology, and emergency medicine while still running broad general services. Each year roughly 150,000 patients from Cairo and nearby governorates walk through its halls, a crowd that brings many languages, ages, and needs.

Workforce

The hospital employs more than 1,200 people. Inside that number sit about 200 physicians, 600 nurses, and 400 staff members who handle administration and daily support. This varied team forms the true spine of FCH, keeping the wards active around the clock so that care stays safe and centred on each patient. Doctors share training gained both in Egypt and abroad, which

boosts clinical standing, while nurses practise not only sharp technical tasks but also clear talk, cultural care, and tight teamwork, skills that matter greatly when a single shift can touch a broad slice of the city. These combined capabilities add up to a service culture admired by visiting professionals.

Organisational Structure

Seen from a structure angle, FCH breaks into three large clusters:

- **Clinical Departments**: cardiology, oncology, emergency care, surgery, paediatrics, and maternity, each steered by a senior consultant who reports up to the Chief Medical Officer (CMO).
- **Administrative Departments**: finance, human resources, procurement, and patient services.
- **Support Services**: IT, security, and maintenance, providing the needed backbone for smooth running.

The three-tier layout sets clear lines of duty yet also calls for strong leadership to weave information and effort across the different rooms, wards, and offices.

Mission, Vision, and Values

- **Mission**: *"to deliver world-class healthcare with compassion, innovation, and integrity."*
- **Vision**: to rise as a leading name in the Middle East and North Africa (MENA) region, prized for top results, research strength, and an excellent patient journey.
- **Core Values**: empathy, teamwork, innovation, and accountability — values that drive daily work and shape expectations for every leader.

These guiding ideas show up in bedside routines, policy meetings, and staff reviews alike.

Technology and Innovation

In bricks and wires FCH has poured large sums into technology over the past decade. A modern electronic health record (EHR) platform binds patient data across all rooms, letting doctors and nurses tap live charts with a click. A telemedicine wing covers follow-up visits, especially in

oncology and long-term disease management. The in-house research centre runs clinical trials and teams with universities in the chase for new cures.

Yet even with shiny systems in place, many staff still lean on plain email and paper memos when talking across departments, a habit that breeds slow loops and, now and then, late decisions.

Governance and Leadership

FutureCare Hospital works inside a governance frame led by a **board of directors** and a **senior executive team**.

- **CEO**: steers long-term plans and answers to the board.
- **CMO** and **COO**: split clinical and administrative control.

The set-up gives steadiness. Still, the style on the floor is often marked as hierarchical, with few openings for mid-level managers or clinicians to weigh in on strategy. That central grip has helped with tight rules yet it has pushed aside many bottom-up ideas.

Strengths and Weaknesses

- **Strengths**: safe, steady care; excellence in cardiology and oncology; reputation as a referral hub.
- **Weaknesses**: high turnover among young nurses and office staff; thin empowerment; weak internal communication; lack of staff voice in decisions.

3. Current Leadership Practices

Inside FutureCare Hospital (FCH) leadership largely follows a transactional, hierarchical pattern, and faint authoritarian streaks appear as well. Across the years this method has turned into the default culture of leadership, moulding decision routes, information channels, and the way staff see their place in the organisation. The hospital reaches clinical excellence and stays within regulatory lines, yet the same framework plants limits that curb innovation, dampen engagement, and slow collaboration between departments.

3.1 Leadership Style Observed

The executive tier, guided by the CEO, adopts a top-down style. Senior leaders set strategy while department heads carry it out. Open debate seldom occurs. Instead, instructions arrive through formal directives, policies, or circulars. The focus sits on compliance, efficiency, and sticking to set rules, a clear sign of a transactional mindset. Staff gain rewards when they follow procedure and hit targets. Creative thinking or fresh ideas get scant attention.

Authoritarian streaks surface most in emergencies. Senior consultants or heads act alone, with no consultation. Such decisiveness can save lives during high-stakes events. Yet it bleeds into daily work where teamwork and open talk would serve better. The outcome is a climate in which employees see themselves as order takers instead of partners in growth.

3.2 Strengths of Current Practices

- **Clear Accountability**: Roles and responsibilities sit in sharp focus so staff know what the job demands. Such clarity cuts ambiguity and aids control in critical moments.
- **Consistency in Standards**: The transactional setup keeps protocols intact, especially in sensitive areas like cardiology and oncology where any slip could harm patients.
- **Rapid Response in Emergencies**: A centralised style allows fast moves when action cannot wait, as in mass-casualty events or sudden outbreaks.
- **Compliance with Regulations**: A firm hierarchy keeps healthcare policies, accreditation rules, and safety norms in check, shielding the hospital from legal or reputational harm.

These benefits clarify how the hospital has held its standing as a trusted provider in Egypt. Yet the very practices that secure control and consistency sow long-term problems.

Limitations in Healthcare	Advantages in Healthcare	Characteristics	Leadership Style
Discourages innovation, rigid	Ensures compliance & order	Rule-based, reward & punishment system	Transactional
Can be time-consuming, needs strong leaders	Enhances innovation & staff engagement	Visionary, motivating, empowering	Transformational
May delay decision-making in crises	Boosts morale, reduces turnover	Focus on serving employees' needs	Servant Leadership
Creates fear, low staff satisfaction	Effective in emergencies	Top-down, strict control	Authoritarian

3.3 Weaknesses of Current Practices

The weak spots of FCH leadership emerge when we look at morale, communication flow, and the spark of innovation.

- **Limited Communication**: Talk runs mostly through memos, emails, or set meetings, leaving real-time teamwork scarce. Departments stay in silos, slowing patient coordination and admin tasks.
- **Low Staff Engagement**: Nurses and admin staff feel undervalued because their input rarely shapes hospital choices. Turnover rises, most notably among younger workers.
- **Resistance to Innovation**: The transactional lens pays for compliance instead of risk-taking. Staff hesitate to test new methods or pitch improvements because they doubt support.
- **Overdependence on Senior Leadership**: When top executives make nearly all choices, mid-level managers hold little freedom. The bottleneck drags decisions in routine cases and limits growth chances for future leaders.

3.4 Impact on Organisational Culture

The chosen style leaves a deep mark on FutureCare Hospital culture. Heavy stress on hierarchy breeds caution. Staff aim to dodge errors instead of chase innovation. An air of dependence on leaders grows, crowding out shared ownership of goals. On top of this, communication walls sap cooperation between clinical and admin teams, blocking wide projects like digital change or cross-unit research.

Culture touches patient outcomes too, though less visibly. Slow interdepartmental talk can stretch waiting times for results or treatment plans. When nurses feel detached, their drive to exceed basic duties falls, which dents patient satisfaction and care quality.

3.5 Leadership Development and Training

The hospital offers programmes on clinical skills and rule compliance yet gives little room to leadership growth. Heads rise through seniority or technical skill instead of proven leadership strength. This cycle cements hierarchy and blocks new leaders who might spark collaboration and fresh ideas. In a modern hospital where agility and clear talk matter, the absence of solid leadership training is a serious void.

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4. Critique of Current Leadership Practices

Assessing the leadership routines at FutureCare Hospital (FCH) uncovers a lively mix of benefits and drawbacks. The transactional, pyramid style has fulfilled certain day to day needs, yet it has also bred obstacles that slow the organisation’s future growth and resilience. The critique that follows points out not only the pieces that function, but also the parts that must shift dramatically if the hospital hopes to flourish in the twenty first century.

4.1 Positive Aspects of Current Leadership

Though imperfect, the present system still delivers clear gains:

- **Strong Regulatory Compliance:**
  Healthcare sits inside one of the most rule bound domains. FCH's firm ladder shaped model guarantees that national rules, safety codes, and accreditation demands are met with care. This sharp focus on compliance keeps lawsuits at bay and brands the hospital as a safe dependable place for patients.

- **Decisive Emergency Response:**
  When events such as pile up accidents or sudden cardiac arrests strike, speed determines survival. The directive stance taken by senior leaders fits these moments well because commands move fast and are obeyed without pause. Rapid resource mobilisation has therefore pushed the hospital's emergency name recognition higher.

- **Clear Chain of Command:**
  A transactional outlook prizes crisp lines of duty. Staff understand exactly who receives reports and which steps to follow. This removes ambiguity during tense clinical moments where even a second of doubt can threaten lives.

These positives prove that FCH's structure carries value. Yet they mostly succeed in immediate, operational frames rather than in nurturing lasting innovation, agility, and talent growth.

4.2 Negative Aspects of Current Leadership

The weak spots in FCH's approach overshadow its gains when the broader strategic scene is weighed:

- **Lack of Innovation:**
  The reward for simple rule keeping, not for bold thought, dominates the culture. Fresh ideas on patient service, research, or digital change rarely surface. Modern hospitals must ride waves such as artificial intelligence, telemedicine, and unified electronic records, but FCH's stiff hierarchy drags its pace.

- **Weak Communication Systems:**
  Dependence on memos, emails, and formal meetings blocks fluid teamwork. Units function as islands, creating waste in care coordination. For instance, slow exchanges between cardiology and oncology have at times lengthened patient waits.
- **Low Employee Engagement:**
  Polls indicate that staff, especially nurses and newer hires, feel unappreciated and far from the circle of decision making. This absence of voice lifts turnover. Each exit inflates hiring costs and fractures continuity of care.
- **Overdependence on Senior Leaders:**
  Decision power held tight at the top heaps stress on executives while sidelining mid level managers. Bottlenecks emerge for non urgent choices and rising leaders miss chances to learn.

4.3 Organisational Consequences

The drawbacks carry visible ripple effects for FCH:

- **Cultural Impact:**
  The tall structure breeds caution and rote obedience rather than open teamwork and fresh thinking. Staff grow hesitant to flag waste or suggest fixes.
- **Patient Outcomes:**
  Even with strong crisis work, thin links across departments can dent the routine patient journey. Fragmented chatter in oncology, for example, has led to uneven follow up for chemotherapy clients.
- **Strategic Stagnation:**
  In a fierce health market, hospitals must keep inventing. FCH’s current stance clings to the status quo instead of driving shifts, exposing it to rivals that use nimble and inclusive leadership.

4.4 Comparison with Best Practices

Studies in hospital leadership show that transformational and servant models outperform older styles in today's settings. Transformational leaders spark enthusiasm, invite novel ideas, and paint a vivid vision, while servant leaders centre on the health and career rise of their teams. Measured against these standards, FCH's transactional, top down approach seems dated and too small for the demands of digital medicine, workforce engagement, and organisational elasticity.

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5. Proposed Leadership Strategy Plan

FutureCare Hospital (FCH) stands at a critical crossroads where its leadership must evolve to meet the changing demands of 21st century healthcare. While the current transactional and authoritarian styles have kept the ship steady, they are not enough for sparking fresh ideas, building teamwork, or driving digital change. This section sets out a new leadership strategy plan that reshapes leadership practice at FCH. The plan blends transformational leadership with servant leadership, stressing inclusion, clear communication, and smart use of organisational networks.

5.1 Evaluation and Revision of Current Leadership Policy

The current leadership policy at FCH leans hard on compliance, authority, and top down decision making. This has brought some quick operational wins yet limited the hospital's power to innovate, adapt, and keep talent. A policy update must start with the truth that healthcare leadership in the 21st century is not only about control, it is about shared vision, teamwork, and empowerment.

Key Revisions Proposed:

- **From Control to Empowerment:**
  Mid level managers and clinical team leaders should gain wider room to make decisions.

Instead of waiting for top sign off, they should guide daily operational tweaks, staff schedules, and patient flow. This trims bottlenecks and speeds up action.

- **From Compliance to Innovation:**
  Rules will still stand firm, yet leadership policy should add rewards for new ideas. A system of praise and bonuses can spotlight departments that dream up and roll out better patient care or efficiency moves.
- **From Hierarchy to Collaboration:**
  Policies should call for cross departmental work groups that meet each month to tackle shared issues like patient experience, digital change, or infection control. Each group should bring in voices from all levels—executives, doctors, nurses, and admin staff—for diverse input.
- **Leadership Development Framework:**
  FCH must back leadership growth programmes, offering sessions in communication, emotional intelligence, conflict handling, and digital skills. Staff who show leadership promise should be spotted early and given space to build their talents.
- **Feedback Oriented Policy:**
  The hospital should live a culture of steady feedback. Leadership reviews must weigh not only patient results and compliance numbers but also staff happiness scores, idea counts, and communication quality.

Expected Outcomes of Policy Revision:

- Reduced staff turnover thanks to stronger empowerment.
- Quicker decision making and problem solving inside departments.
- More fresh ideas in patient care and hospital work.
- A leadership pipeline that readies FCH for coming challenges.

By changing policy in this way, FCH can keep its reliable operations while crafting a setting that matches what today's healthcare staff and patients expect.

5.2 Influence of Chosen Leadership Style on Culture

Using a transformational servant leadership mix will deeply shift the culture of FCH. Culture is often called “the way things are done” and leadership sets these habits and beliefs.

Transformational Leadership Influence:

- **Vision and Inspiration:** Leaders will share a clean vision for the hospital—becoming a top centre of patient guided, tech powered care in the region. This sparks staff to line up their work with big goals.
- **Encouraging Innovation:** Transformational leaders build safe zones for trial and error. Staff will feel bold in offering tweaks to patient care or workflow without fear of blame.
- **Recognition and Motivation:** Reward plans like “Innovation of the Month” boosts morale and feeds a spirit of excellence.

Servant Leadership Influence:

- **Empathy and Care:** By meeting employee needs, servant leaders grow trust. Nurses often left out of choices will feel heard when leaders truly listen.
- **Empowerment and Growth:** Servant leaders put professional growth first. Classes and clear career paths will drive loyalty and cut turnover.
- **Community Focus:** Servant leadership fits the wider mission of healthcare service. This mindset will soak into FCH’s culture, making patient well being the chief mark of success.

Cultural Shifts Expected:

- From a culture of compliance → to a culture of steady improvement.
- From rigid hierarchy → to joint teamwork.
- From fear of mistakes → to learning and growth.
- From limited talk → to open, multi channel dialogue.

The hospital's identity will move from steady yet rigid to one known for innovation, compassion, and teamwork. This shift lifts staff spirit and also raises patient trust and happiness.

5.3 Departmental Communication Plan (21st Century Tech)

One of FCH's big issues is slow interdepartmental communication. To fix this, a full digital communication plan must be rolled out, using modern tools that give speed, clarity, and teamwork.

Proposed Communication Tools:

- **Unified Digital Platform:** Bring in Microsoft Teams or Slack for inside talk. These tools give real time chat, video calls, and shared documents across teams.
- **Electronic Health Records (EHR) Expansion:** Improve the present EHR so it shares patient data smoothly across clinics. Links with mobile devices let doctors and nurses check info at the bedside.
- **Leadership Live Sessions:** Weekly or two weekly live Q&A sessions where executives answer staff questions straight, boosting trust and openness.
- **Mobile Application:** Build an inside hospital app to push instant news on shifts, policy tweaks, and team alerts.
- **Anonymous Feedback Channel:** A digital drop box so staff can voice concerns without fear.

Communication Protocols:

- Daily huddles (10–15 minutes) in every department to scan priorities.
- Weekly cross departmental sync meetings.
- Monthly all staff town halls to track progress on big goals.

Expected Benefits:

- Fewer silos and stronger team play across clinical and admin units.
- Faster fixes of patient care coordination snags.
- Higher staff morale through clear talk.
- Tighter link between strategy and frontline work.

This plan turns communication from a slow, stiff process into a lively, two way system that backs FCH's dream for modern, patient centred care.

Proposed Improvement with 21st Century Tech	Current Use in FCH	Communication Tool
Replace with instant messaging platforms	Overused, slow response	Emails & Memos
Hybrid meetings via Zoom/Teams	Time-consuming	Physical Meetings
Shared dashboards & cloud-based records	Siloed, limited transparency	Departmental Reports
Integrated VoIP with patient record systems	Not recorded or traceable	Phone Calls

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5.4 Organisational Networks and Future Utilisation

Organisational networks at FCH include both formal lines (departments, committees, reporting links) and informal ties (peer help, friendship). At present, leadership barely taps these networks, limiting the hospital's reach for shared knowledge and pooled resources.

Formal Networks:

- Clinical departments (cardiology, oncology, emergency).
- Administrative departments (finance, HR, procurement).
- Committees for infection control, ethics, and quality assurance.

Informal Networks:

- Nurse peer groups that swap stories and good practice.
- Doctor collaborations across departments for tough cases.

- Social groups that build community outside work hours.

Future Utilisation of Networks:

- **Cross Functional Innovation Hubs:** Form project teams from many departments to tackle challenges like cutting patient wait time or adding AI to diagnostics.
- **Knowledge Sharing Platforms:** Launch an intranet or knowledge base where staff post case notes, lessons, and research news.
- **Mentorship Programmes:** Pair senior doctors and admins with newer staff, feeding leadership growth and knowledge flow.
- **External Networks:** Grow ties with universities, research bodies, and telemedicine firms to pull outside expertise into FCH's system.

Leadership Role in Network Utilisation:

- Map networks to spot key connectors.
- Urge teamwork between formal and informal groups.
- Credit input from informal circles in formal choices.

Expected Outcomes:

- More fresh ideas through cross team problem solving.
- Stronger sense of community among staff.
- Better pull of outside knowledge into hospital work.
- Growth of a flexible, ready organisation.

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6. Conclusion

The examination of leadership at FutureCare Hospital (FCH) shows a clear shift. The facility once relied on transactional and authoritarian habits to keep order and gain compliance. That approach no longer matches the restless pace of modern healthcare. Today, organisations must satisfy regulators, spark patient centred innovation, lift staff morale, and master digital change all at once. One point stands out. Leadership is more than authority, it is vision, empathy, teamwork, and agility. The review uncovered gaps in several areas, most notably staff dialogue, innovation, and cultural openness. A tight hierarchy can silence frontline voices holding vital knowledge. Missing modern communication tools, teams retreat into silos that sap energy and spirit. Without a structured leadership pathway the hospital risks watching its talent walk to bolder employers. These issues are common in the sector, yet they pose urgent threats to lasting success and growth. The suggested leadership strategy offers a practical route ahead. Moving from control toward empowerment will let FCH tap the creative and professional spark of its people. Blending transformational ideas with servant values keeps leaders both bold and caring. They can aim high while still guarding the growth and wellness of staff. Updating leadership rules to weave in innovation, cooperation, and feedback will turn continuous improvement into an everyday habit. The plan also respects how vital technology and networks are in twenty first century care. A full digital communication map will break silos, speed information, and boost openness. Deeper use of organisational networks, formal as well as informal, will spread knowledge, nurture mentoring, and fan innovation across the hospital. These actions will help FCH not just face problems but shape its own path in the sector. In closing, sound leadership is the bedrock of success in healthcare.

7.References

1. Al-Sawai, A. (2013). Leadership of healthcare professionals: Where do we stand? *Oman Medical Journal, 28*(4), 285–287. https://doi.org/10.5001/omj.2013.79

2. Avolio, B. J., & Bass, B. M. (2004). *Multifactor leadership questionnaire: Third edition manual and sampler set*. Mind Garden.

3. Bass, B. M., & Riggio, R. E. (2006). *Transformational leadership* (2nd ed.). Lawrence Erlbaum Associates.

4. Boamah, S. A., Spence Laschinger, H. K., Wong, C., & Clarke, S. (2018). Effect of transformational leadership on job satisfaction and patient safety outcomes. *Nursing Outlook, 66*(2), 180–189. https://doi.org/10.1016/j.outlook.2017.10.004

5. Collins, D., & Holton, E. (2004). The effectiveness of managerial leadership development programs: A meta-analysis of studies from 1982 to 2001. *Human Resource Development Quarterly, 15*(2), 217–248. https://doi.org/10.1002/hrdq.1099

6. Cummings, G. G., Tate, K., Lee, S., Wong, C. A., Paananen, T., Micaroni, S. P., & Chatterjee, G. E. (2018). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies, 85*, 19–60. https://doi.org/10.1016/j.ijnurstu.2018.04.016

7. Day, D. V., & Antonakis, J. (Eds.). (2012). *The nature of leadership* (2nd ed.). SAGE Publications.

8. Dinh, J. E., Lord, R. G., Gardner, W. L., Meuser, J. D., Liden, R. C., & Hu, J. (2014). Leadership theory and research in the new millennium: Current theoretical trends and changing perspectives. *The Leadership Quarterly, 25*(1), 36–62. https://doi.org/10.1016/j.leaqua.2013.11.005

9. Firth-Cozens, J., & Mowbray, D. (2001). Leadership and the quality of care. *Quality in Health Care, 10*(Suppl 2), ii3–ii7. https://doi.org/10.1136/qhc.0100003

10. Goleman, D. (2000). Leadership that gets results. *Harvard Business Review, 78*(2), 78–90.

11. Greenleaf, R. K. (2002). *Servant leadership: A journey into the nature of legitimate power and greatness* (25th anniversary ed.). Paulist Press.

12. Klein, K. J., Ziegert, J. C., Knight, A. P., & Xiao, Y. (2006). Dynamic delegation: Shared, hierarchical, and deindividualized leadership in extreme action teams. *Administrative Science Quarterly, 51*(4), 590–621. https://doi.org/10.2189/asqu.51.4.590

13. Kotter, J. P. (2012). *Leading change*. Harvard Business Review Press.

14. Marquis, B. L., & Huston, C. J. (2021). *Leadership roles and management functions in nursing: Theory and application* (10th ed.). Wolters Kluwer.

15. Northouse, P. G. (2022). *Leadership: Theory and practice* (9th ed.). SAGE Publications.

16. Oreg, S., & Berson, Y. (2019). Leaders' impact on organizational change: Bridging theoretical and methodological chasms. *Academy of Management Annals, 13*(1), 272–307. https://doi.org/10.5465/annals.2016.0138

17. Sfantou, D. F., Laliotis, A., Patelarou, A. E., Sifaki-Pistolla, D., Matalliotakis, M., & Patelarou, E. (2017). Importance of leadership style towards quality of care measures in healthcare settings: A systematic review. *Healthcare, 5*(4), 73. https://doi.org/10.3390/healthcare5040073

18. Spinelli, R. J. (2006). The applicability of Bass's model of transformational, transactional, and laissez-faire leadership in the hospital administrative environment. *Hospital Topics, 84*(2), 11–19. https://doi.org/10.3200/HTPS.84.2.11-19

19. Stanley, D. (2012). Clinical leadership and innovation. *Journal of Nursing Education and Practice, 2*(2), 119–126. https://doi.org/10.5430/jnep.v2n2p119

20. Yukl, G. (2013). *Leadership in organizations* (8th ed.). Pearson Education.